JAIL SUICIDE/MENTAL HEALTH UPDATE

(A joint project of the National Center on Institutions and Alternatives and the National Institute of Corrections, U.S. Department of Justice)

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MODEL SUICIDE PREVENTION PROGRAMS PART II

Why do some jail systems experience an inordinate number of inmate suicides or deaths attributed to obvious deficiencies while others of comparable size are spared the tragedy? Some observers would call it good fortune, while others believe that "attitude" and comprehensive policies and procedures are the keys to suicide prevention in correctional facilities (Hayes, 2005). The ***Update*** *has continually stressed that negative attitudes (e.g., "If someone really wants to kill themselves, there's generally nothing you can do about it") impede meaningful jail suicide prevention efforts.*

Our most loyal readers will recall that the ***Update*** *profiled model jail suicide prevention programs several years ago (Volumes 7 and 8 in 1998). In our last issue, the Albany County (New York) Correctional Facility was profiled. Continuing with this issue, we are revisiting the topic by examining several model suicide prevention programs operating in jail systems of varying sizes throughout the country. Programs have been evaluated (and on-site case studies conducted) according to the following criteria:*

- *Intake screening to detect both current and prior suicidal behavior, as well as further and periodic assessment of suicide risk by mental health staff;*
- *Suicide prevention training for correctional, medical, and mental health staff;*
- *Levels of communication between outside agencies, among facility staff, and with the suicidal inmate;*
- *Suicide-resistant, protrusion-free housing of suicidal inmates;*
- *Levels of supervision for suicidal inmates;*
- *Timely emergency intervention by correctional and medical personnel following a suicide attempt;*
- *Provision of critical incident stress debriefing to affected staff and inmates, as well as completion of a multidisciplinary mortality review following an inmate suicide and/or serious suicide attempt; and*
- *A low rate of inmate suicides for an extended period of time.*

We continue our special series by highlighting the suicide prevention program currently operating within the Orange County Sheriff's Department in Santa Ana, California. The program was previously profiled in the Summer 1998 (Volume 8, Number 1) issue of the ***Update****.*

Orange County Sheriff's Department

Headquartered in Santa Ana, California, the Orange County Sheriff's Department administers five jail facilities: Central Men's Jail (1,447-bed capacity), Central Women's Jail (356 beds), Intake and Release Center (865 beds), James A. Musick Facility in Irvine (713 beds), and the Theo Lacy Facility in Orange (over 2,000 beds and growing). As of August 2005, the average daily population of the entire Orange County jail system exceeded 6,500. It is the 11th largest jail system in the United States, and the 2nd largest system in California.

As can be seen by Table 1, however, despite severe overcrowding problems that have plagued the jail system for many years, the Orange County Sheriff's Department (OCSD) has an incredible track record for preventing inmate suicides. During a 10-year period from 1995 through 2004, there were only 4 inmate suicides in a jail system that had over 660,000 admissions — an average of 1 suicide every 165,000 admissions. In addition, the suicide rate in the OCSD jail system during this period was 7.7 deaths per 100,000 inmates — an incredible rate that is even far lower than that of the general population.

According to the most recent data, there were 34 suicides in local and county jails within California during 2004. As shown by Table

INSIDE. . .

2, these deaths resulted in a suicide rate of 44.1 per 100,000 inmates, while the 10-year rate was 52.1. The data also indicates that the suicide rate has been steadily declining in the past several years — a trend that is consistent with national statistics (see accompanying article on page 6 of this issue).

The Orange County Sheriff's Department has maintained the lowest inmate suicide rate among the largest county jails in California, as well as a rate far below the average of all jails in the state Why such success? There are many reasons, but the most visible was the presence of John "Rocky" Hewitt, Assistant Sheriff for Jail Operations, an ex-Marine who had a no-nonsense approach to suicide prevention. "Jail suicides are simply not acceptable. They are not tolerated in the community, therefore, they will not be tolerated here," Assistant Sheriff Hewitt told the ***Update*** in 1998. As a 30-year veteran of the agency, he strongly believed that "the jail is a microcosm of the community. In the community, crimes are prevented by police officers walking a beat. In our jail system, staff make their rounds like they're walking a beat. Suicides are prevented because our staff are always walking, always observing, they also care about their job and the people they're responsible for."

Rocky Hewitt retired in 2003 but his successor appears to be as passionate about suicide prevention efforts in the jail system. "There is a clear expectation within the department that it's everyone's job to prevent suicides in the jail, including sheriff's, medical and mental health staff," Assistant Sheriff Kim Markuson told the ***Update***. "We certainly stress the team concept and encourage the development of working very closely with the medical and mental health staff. The success we have experienced with suicide prevention is indicative of those positive relationships and the spirit of cooperation that exists."

The Program

The current suicide prevention program in the Orange County Sheriff's Department (OCSD) was formalized in January 1988 in conjunction with the opening of the 865-bed Intake and Reception Center (IRC). All inmates enter the jail system through the IRC, a facility that averages between 150 and 200 admissions per day. Each inmate is seen by a registered nurse from Correctional Medical Services (a division of the Orange County Health Care Agency) who completes an "Intake Screening and Triage Form" that includes basic suicide risk inquiry: "Have you ever tried to harm yourself or take your own life? When?" and "Are you now thinking of harming yourself?" In addition, the OCSD classification deputy reviews the automated inmate management system to determine whether the inmate was a medical, mental health, or suicide risk during a prior incarceration within the OCSD. Should the nurse (or any other IRC staff) feel that an inmate is in need of further assessment, an immediate referral is made to the Health Care Agency's Correctional Mental Health (CMH) staff who are also stationed in the intake area. Classification staff can also access the management system to review information regarding an inmate's recent sentencing hearing. They can then inform CMH staff about an inmate's lengthy sentence so that assessment of their suicide risk due to "court shock" (i.e., receiving a more severe sentence than anticipated) can be performed.

CMH staff, who are on-site in the jail system 24 hours a day, include psychiatrists, psychologists, psychiatric nurse practitioners, clinical social workers, psychiatric nurses, and mental health specialists. To determine whether suicide precautions are necessary for a referred inmate, CMH staff conduct a suicide risk assessment. The assessment process measures the lethality of the suicide risk according to the following five factors:

Ideation/Plan: How long thinking of suicide; To what extent are plans made; Lethality of means; Time frame of plan

Resources: How alone is the person at risk; Explore support systems

History: Prior suicide attempts; Lethality of prior attempts; Family history of suicide; Psychiatric history/mental illness

Stressors: Events leading to current feelings; Recent loss; Problems to be "solved" by suicide

Symptoms: Drug/alcohol use; Psychiatric symptoms; depression/anxiety; hopelessness/helplessness; Tunnel vision

Should CMH staff determine that the inmate is at risk for self-destructive behavior, suicide precautions are implemented and the individual is assigned to either a mental health housing pod at the IRC or the Infirmary at the Central Women's Jail. Although the suicide precautions are tailored to the individual needs of the inmate at risk, they normally include the initial use of safety gowns and "mental health observation" or cell restriction. In extreme cases, an inmate may be temporarily housed in one of the jail system's eight safety cells or placed in a restraint chair, but only with the authorization from a CMH psychiatrist. According to CMH policy and practice:

> The decision to place a patient into Mental Health Observation is individualized and based upon the clinical picture of a specific patient. Every effort will be made through intensive treatment and monitoring to place the individual in less restrictive housing as soon as clinically feasible. Patients treated in Mental Health Observation present actions, i.e., danger to self or others, and behaviors resulting from a mental condition which in the opinion of a qualified mental health professional require close observation and seclusion afforded by Mental Health Observation. Protective Housing can be used when clinical information has been collected that demonstrates a clear probability that a patient as a result of a mental disorder will attempt to harm himself or others if he/she is not highly supervised and/or placed in a safe housing environment. Mental Health Observation will not, under any circumstances, be used for punishment, retaliation for stubborn or uncooperative behavior, or as a form of intimidation. Mental Health Observation will not be used as a routine admitting procedure in the mental health intensive treatment areas. Each patient placed in

Single Cell Protective Housing will have the appropriateness of the housing assignment reviewed on a daily basis.

When an inmate's level of suicide risk has been reduced to a safely manageable level, the individual is transferred to either a less restrictive housing area (e.g., step-down mental health unit) or to a general population unit. An inmate cannot be removed from suicide precautions without the authorization of a CMH psychiatrist. Upon transfer to alternate housing, the inmate continues to receive mental health services as clinically indicated. These services may include medication management, individual and/or group therapy, case management, and discharge planning. Finally, community linkage with local mental heath services are prioritized to ensure continuous treatment and long-term suicide prevention for the inmate. Currently, over 540 inmates are on the CMH caseload.

Inmates placed on suicide precautions receive supervision from both correctional officers and CMS nursing staff at staggered 30-minute intervals, thereby ensuring that each inmate is seen by either an officer or nurse every 15 minutes. The IRC's mental health housing area is staffed by two correctional officers and two nurses at all times. The cells in this unit (the only area in the entire jail system that is single-celled), as well as the holding cells on the first floor of the IRC, contain large Lexan panels that cover the entire door providing full visibility and direct line of sight to staff. In extreme cases, including those in which inmates are temporarily placed in a restraint chair, correctional staff provides constant observation. In addition, all inmates placed on suicide precautions are seen daily by CMH staff, including an initial first day evaluation by a psychiatrist. The cases of inmates held on suicide precautions for more than a week are reviewed during the Jail Acute Services Team meetings which are held twice a week. There is an average of 12 inmates on suicide precautions each day in the OCSD.

Sherri Curl is the current CMH Administrative Manager. Despite an increasing inmate population and mental health caseload, coupled with a cutback of CMH staff, she remains enthusiastic about her team's ability to prevent inmate suicides. According to Ms. Curl, "Even though the CMH staff has been reduced, our staff continues to perform impressive work including; providing suicide prevention and mental health training to the OCSD Jail Academy and staff in-services to all departments inside the facilities. The well trained multidisciplinary CMH team, low personnel turnover, and a stable psychiatric staff are keys to CMH's success, which in turn contributes to our successful collaborative, interdepartmental suicide prevention team."

Communication and Referral

Although an estimated 70 percent of referrals for suicide risk assessments are initiated during the intake screening and triage stage, a significant amount of referrals occur during other portions of an inmate's incarceration and are initiated by correctional staff. Perhaps contrary to most jail systems, correctional officers in the OCSD are encouraged, both through instructions from their superiors and during their annual training with CMH, to maintain a dialogue with inmates in their housing units. In addition, although all inmates in most areas of the OCSD jail system are observed at a minimum of 30-minute intervals, they are encouraged to maintain continuous movement in the housing areas. According to Undersheriff Hewitt, "Walking around and interacting with inmates is the key.

Table 1
ORANGE COUNTY SHERIFF'S DEPARTMENT
AVERAGE DAILY POPULATION AND INMATE SUICIDES
1995 to 2004*

YEAR	AVERAGE DAILY POPULATION	SUICIDES	RATE
1995	5,123	0	0
1996	5,199	1	19.2
1997	5,280	0	0
1998	5,375	1	18.6
1999	5,035	1	19.8
2000	4,891	0	0
2001	4,602	0	0
2002	4,909	0	0
2003	5,245	0	0
2004	5,842	1	17.1
1995-2004	**51,501**	**4**	**7.7**

*Source: Orange County Sheriff's Department

Table 2
LOCAL AND COUNTY CALIFORNIA JAILS
AVERAGE DAILY POPULATION AND INMATE SUICIDES
1995 to 2004*

YEAR	AVERAGE DAILY POPULATION	SUICIDES	RATE
1995	71,107	55	77.3
1996	72,029	55	76.3
1997	76,906	47	61.1
1998	79,149	30	37.9
1999	76,312	33	43.2
2000	74,937	26	34.6
2001	73,828	42	56.8
2002	75,156	38	50.5
2003	75,264	32	42.5
2004	76,940	34	44.1
1995-2004	**751,628**	**392**	**52.1**

*Source: California Department of Justice's Criminal Justice Statistics Center

The more you interact the less chance there is of an incident, including a suicide attempt."

Suicide prevention training and awareness are also critically important to the Orange County Sheriff's Department. All correctional staff receive at least two hours of pre-service suicide prevention training at the OCSD training academy, followed by a four-hour block of advanced training during their first year of employment in the jail system. In addition, quarterly in-service suicide prevention training is provided to all correctional staff, as well as to all CMS and CMH personnel. The training is supplemented with viewing of *ON YOUR WATCH: The Challenge of Jail Suicide*, and award-winning DVD (see page 5). According to Dr. Sandy Rogers, CMS Service Chief for the Branch Jails, "Even veteran Sheriff's staff is reoriented to suicide prevention during briefings at least once a year before the holidays. They are reminded that these are hard times for inmates and to be on the lookout for despondency or excessive anger in inmates. Following these briefing reminders, the number of referrals from our deputies to mental health staff always increases."

Two years ago, CMH began to provide suicide prevention training to OCSD personnel assigned to the Orange County courthouses, including bailiffs and deputies supervising the holding cells. "Who better to evaluate 'court shock,' than someone who is sitting and observing an inmate during trial," said Dr. Rogers.

All correctional staff are also trained and certified in standard first aid and cardiopulmonary resuscitation. Yet perhaps the most vivid reminder of suicide prevention training in the OCSD is the requirement of all correctional staff to carry a pocket-sized laminated card that contains the following:

Inmate Is At Risk of Suicide If:

First Offense	First 24 Hours
Long Sentence	Personal Tragedy
Violent History	Suicide History
Family Suicide	Mentally Ill
Stigma	Publicity
Drugs/Alcohol	Pillar of Society

Culture Considers Suicide Honorable

A Suicidal Inmate Will:

Look Sad	Look Tired
Not Sleep	Not Eat
Feel Hopeless	Worthless
Withdraw	Refuse Treatment
Give Things Away	Write a Will
Suddenly "Improve"	Look Angry

CALL CORRECTIONAL MENTAL HEALTH!

The idea for the laminated cards belongs to Undersheriff Hewitt. The cards are more symbolic then instructional, and that is really the intent. "Those cards are part of the uniform," stated Dan Jarvis, Administrative Lieutenant and Acting Facility Commander at the IRC in 1998. "Every time I change my uniform I have to take the card out of my breast pocket and put it in my fresh uniform. Whatever type of subliminal reminder it is, it reinforces this administration's message that suicides will not be tolerated," said Lieutenant Jarvis, who died tragically last year.

Another critical component of the OCSD's suicide prevention program is one that cannot be easily written in a departmental procedure — the multidisciplinary team approach. Correctional, medical and mental health staff do not simply tolerate each other, they genuinely like each other and have worked well together as a team for many years. Regular weekly meetings are held where representatives of the three disciplines discuss management of acute cases; monthly meetings are used to discuss ongoing systemic issues. According to Lieutenant Jarvis, "There are no walls between the different professions. We all get along. We're from different schools and different philosophies, but share the same commitment to inmate safety." Adds Dr. Jose Flores-Lopez, Chief Psychiatrist for CMH, "The high level of professionalism is what makes the team concept work. They respect our opinion and we respect their input. We can all sit down and have a dialogue that resolves the problem."

Kevin Smith, formerly the CMH Service Chief at the Central Complex, believes that custody, medical, and mental health staff have developed "an extremely effective system of checks and balances that begins from the point the arrestee walks through the sally port. The process begins when the arresting officer expresses a concern for an inmate to the booking deputy or when medical staff identify a problem during intake screening, and continues when mental health staff perform a suicide risk assessment upon referral, often from correctional staff in the housing units. If an inmate's suicide risk is not identified at one level, it normally will be at the next." According to Mr. Smith, who worked in the jail system for 18 years before being named division manager of the county's adult mental health services earlier this year, "Instead of pointing the finger at who should be responsible for identifying or safely managing suicidal inmates, or where every inmate with a suicide risk should be conveniently housed, the philosophy and language shared by custody mental health and medical personnel are that inmate suicides are *our* risk, and it is *our* need for preventing suicide and getting the inmate the help they need. There are separate departments with separate duties and functions, but there is no division of responsibility for preventing suicides within the OCSD. It still takes a team to prevent inmate deaths."

The case study of Barbara Hoffman best illustrates this collaborative approach. Ms. Hoffman (a pseudonym) was a 42-year-old woman arrested on February 23,1998 and charged with prostitution and possession of a syringe. She was transported to the IRC and denied any current or previous medical, mental health, or suicide risk problems. Although Ms. Hoffman was somewhat uncooperative during booking, the intake screening process was otherwise unremarkable and she was subsequently assigned to general population within the Central Women's Jail. Two days later on February 25, correctional staff found Ms. Hoffman attempting to hang herself in her cell. They quickly intervened, entered the cell, provided emergency medical treatment, and notified CMS nursing staff. Ms. Hoffman was immediately transported to a local hospital where she was treated and kept overnight for observation.

Ms. Hoffman was returned to the IRC the following morning and assessed by CMH staff. During the assessment, it was determined that she had used an alias during the booking process and had, in fact, a very troubled history. A divorced mother of a teenage daughter, Ms. Hoffman was estranged from most of her family due to a 23-year history of heroin addiction and prostitution. Although her psychiatric history remained unknown, Ms. Hoffman had a previous arrest history, including a 1996 incarceration in the OCSD's jail system in which she was observed by correctional staff attempting to her hang herself with strips from a mattress pad. During the most recent assessment by CMH staff on February 26, Ms. Hoffman appeared calm and denied any current suicidal ideation. Based upon an examination by a CMH psychiatrist, she was diagnosed as suffering from schizoaffective disorder, opiate dependence, impulse control disorder, and personality disorder.

As a result of the psychiatric assessment, Ms. Hoffman was placed on suicide precautions in the Infirmary at the Central Women's Jail, which included issuance of a safety gown and removal of her mattress. One hour later, however, she became highly agitated, screaming "I don't want to be in here," and repeatedly banged her head against the cell wall. Observers believed that she was going through drug withdrawal. CMH staff were summoned and, despite their best efforts, Ms. Hoffman continued her acting out and self-abusive behavior. In order to prevent further injury she was placed in a restraint chair, given psychotropic medication, and received constant observation from correctional staff. Less than three hours later, Ms. Hoffman was removed from the restraint chair and returned to the Infirmary where she remained cooperative. A mattress was returned to her cell. Over the next two weeks, Ms. Hoffman

ON YOUR WATCH: The Challenge of Jail Suicide

Tired of watching the same old training videotape on suicidal inmates that is not only outdated but poorly produced. Good news. A DVD is now available to supplement your suicide prevention training workshop. Written, directed, and produced by Dan E. Weisburd, an Academy Award nominee, ***ON YOUR WATCH: The Challenge of Jail Suicide*** presents seven short vignettes portraying the experiences of several individuals prior to, and during, their arrest and the tragic events that occurred following their initial incarceration. This 110-minute DVD is very polished and the production, filmed by an Emmy Award winning director of photography, includes 35 actors, as well as numerous correctional officers, mental health and medical professionals, and inmates. ***ON YOUR WATCH: The Challenge of Jail Suicide*** also includes a companion CD-ROM that offers a lesson plan outline for both one-hour and full-day suicide prevention training, as well as articles on active listening and jail suicide liability.

For more information regarding the availability and cost of ***ON YOUR WATCH: The Challenge of Jail Suicide***, contact the California Institute for Mental Health, 2125 19th Street, Sacramento, California 95818, (916/556-3480), or at http://www.cimh.org

responded well to voluntary medication and regular therapy with her CMH psychiatrist and case manager (a psychiatric nurse). She was then discharged from suicide precautions, but remained in the Infirmary an additional week for intensive therapy. In mid-March, Ms. Hoffman was transferred to general population housing, continued to receive treatment and monitoring from CMH staff, and began participating in a limited jail work program.

On July 17, 1998, Barbara Hoffman was released from custody and placed in a residential treatment facility specializing in dual-diagnosed patients that was arranged by her CMH case manager. As a result of her case, OCSD staff are now instructed during the booking process to not only check the computerized jail records for an arrestee's prior incarceration in the OCSD, but to also check the jail records for all aliases used by the arrestee.

Administrative Review

The Hoffman case is certainly not the first example of the OCSD revising its policies and procedures following a critical incident. In fact, following each of the four inmate suicides that occurred between 1990 and 1996, revisions were made to either suicide prevention practices and/or the jail systems' physical plant. In each case, the OCSD (with participation from both CMH and CMS) conducted an administrative review that included a: 1) critical review of the circumstances surrounding the incident; 2) critical review of jail procedures relevant to the incident; 3) synopsis of all relevant training received by involved staff; 4) review of pertinent medical and mental health services/reports involving the victim; and 5) recommendations, if any, for change in policy, training, physical plant, medical or mental health services, and operational procedures.

For example, in February 1990, Inmate P.A declined to go to dinner with other inmates and was left alone in a dormitory unit at the Central Women's Jail. Upon returning to the unit, correctional staff found the inmate hanging from a fixed metal rod in the shower area. As a result of her death, all fixed shower rods were removed and replaced with breakaway rods. In addition, the OCSD revised their policies to prohibit any inmate from remaining alone in a dormitory unit. In December 1993, Inmate E.C. received an 84-year sentence for sexually molesting his daughters. He had been a financially successful businessman, as well as prominent member of the Asian-American community. Following his sentencing hearing, he was returned to the Central Men's Jail and subsequently found hanging in his cell. As a result of his death, the OCSD issued the pocket-sized laminated cards containing potential high risk warning signs for suicidal behavior to all correctional staff. In addition, policies were revised to require that all inmates sentenced to death or to long prison terms (i.e., 25 years to life) would be automatically referred to CMH staff for suicide risk assessment.

In May 1994, Inmate T.H. was a mentally ill offender living in the sheltered living unit (used as a step-down housing assignment) at the Central Women's Jail. Although CMH staff was aware of her prior history of suicidal behavior, she had not displayed any recent ideation. The inmate was subsequently found hanging from the top bunk of her sheltered living unit cell. As a result of her death, top bunks were removed from all cells in the sheltered living unit, and any inmates with either a current or prior history of suicidal behavior were prohibited from being housed in the unit. In August 1996, following her return from the local hospital for unrelated medical treatment, Inmate R.D. was housed in the Infirmary. Soon thereafter, the inmate was found hanging from a ceiling grate in her cell. She had been observed by nursing staff 15 minutes earlier and appeared calm and relaxed. Although the metal grates contained fine mesh screening, as a result of her death, all grates were removed from the Infirmary cells at the facility. In addition, policies were revised to require that all inmates returning from the hospital would be automatically assessed by CMH staff. Finally, because three of the four inmate suicides within the OCSD were female victims, policies were revised to require that all inmates housed in the Central Women's Jail Infirmary were to be assessed each shift by CMH staff.

Conclusion

In January 2004, a 38-year-old male inmate committed suicide by hanging in the Central Men's Jail. It marked the first suicide in the Orange County Jail system in four years and over 250,000 admissions. Despite this death, the Orange County Sheriff's Department certainly exemplifies the best in suicide prevention programming. The immense size of the jail system does not impede the proper identification, referral and management of inmates at risk for suicide. When asked in 1998 to address the view held by many jail administrators throughout the country that inmate suicides simply cannot be prevented, the late Lieutenant Jarvis responded without hesitation: "When you begin to use excuses to justify a bad outcome, whether it be low staffing levels, inadequate funding, physical plant concerns, etc. — issues we also struggle with each day — you lack the philosophy that even one death is not acceptable. If you are going to tolerate a few deaths in your jail system, then you've already lost the battle.

For further information on suicide prevention efforts within the Orange County Sheriff's Department, contact either Kim Markuson, Assistant Sheriff-Jail Operations, (714/647-1815; e-mail: kmarkuson@ocsd.org), or Sherri Curl, CMH Administrative Manager, (714/647-4158; e-mail: scurl@ochca.com), Orange County Sheriff's Department, 550 North Flower Street, Santa Ana, California 92702.

References

Hayes, L. M. (2005). "Suicide Prevention in Correctional Facilities," in *Handbook of Correctional Mental Health*, edited by C.L. Scott and J.B. Gerbasi, American Psychiatric Publishing, 69-88. ❑

The Jail Suicide Rate is Dropping

According to a recently released report from the U.S. Justice Department's Bureau of Justice Statistics (BJS), the suicide rate in local jails fell from 129 per 100,000 inmates in 1983 to 47 per 100,000 in 2002. The findings, released in August 2005, are from

the first BJS report on inmate deaths mandated by the Death in Custody Reporting Act of 2002 (Public Law 106-297).

Suicides had been the leading cause of jail inmate deaths in 1983, but the death rate from illnesses and natural causes (69 per 100,000 inmates) was higher in 2002. State prison suicide rates, which have historically been much lower than the rate in jails, also dropped sharply, from 34 per 100,000 state prisoners to 14 per 100,000 in 2002.

During 2002, the latest year for which such data are available, there were 978 jail inmate deaths and 2,946 state prisoner deaths from all causes. During the same year, suicides accounted for 314 jail inmate deaths and 168 state prisoner deaths. Fewer than 50 deaths in either local jails (20) or state prisons (48) were homicides. During 2002, the nation's smallest jails (fewer than 50 inmates) had a suicide rate five times higher than the largest jails (2,000 or more inmates).

For the three-year period from 2000 through 2002, White jail inmates were six times more likely to commit suicide than African American inmates and more than three times more likely than Hispanic inmates. The male suicide rate in local jails (50 per 100,000 inmates) was more than 50 percent higher than that of female inmates (32 per 100,000). Violent offenders had a suicide rate (92 per 100,000) triple that of non-violent offenders (31 per 100,000).

Almost half of the jail suicides during the three-year period occurred during the inmate's first week in custody. Suicides in state prisons were much less concentrated in the period close to admission, with only 7 percent of the suicides occurring during the first month. Approximately 80 percent of the jail and prison suicides occurred in the inmate's cell, but the time of day did not appear to be a factor.

The report, *Suicide and Homicide in State Prisons and Local Jails* (NCJ-210036), was written by BJS policy analyst Christopher J. Mumola. Following publication, the document can be accessed at: www.ojp.usdoj.gov/bjs/abstract/shsplj.htm. ❑

Bradich v. City of Chicago: Deliberate Indifference for Failure to Promptly Initiate Life-Saving Measures

On July 1, 2005, the United States Court of Appeals for the Seventh Circuit ruled that, if officers within a City of Chicago's Police Department Lockup Facility failed to initiate cardiopulmonary resuscitation on an inmate that had attempted suicide by hanging and then waited 10 minutes to summon medical assistance, such inaction could be found to be deliberately indifferent and serve as a basis for liability in the inmate's subsequent death. The decision in ***Bradich v. City of Chicago*** *(No. 04-3626, 2005, U.S. App. Lexis 1313, 7th Cir.) is reprinted below.*

Before EASTERBROOK, KANNE, and SYKES, Circuit Judges.

EASTERBROOK, Circuit Judge.

When police arrested Melvin Bradich on October 23, 1999, he was drunk — fitting, as the reason for his arrest was a warrant for

WE'RE STILL LOOKING FOR A FEW GOOD PROGRAMS

Future issues of the ***Jail Suicide/Mental Health Update*** will be devoted to exemplary suicide prevention programs operating within correctional facilities throughout the country. Does your facility's suicide prevention policy contain, and do your practices reflect, the following critical elements?

- Intake screening to detect both current and prior suicidal behavior, as well as further and periodic assessment of suicide risk by mental health staff;
- Suicide prevention training for correctional, medical, and mental health staff;
- Levels of communication between outside agencies, among facility staff, and with the suicidal inmate;
- Suicide-resistant, protrusion-free housing of suicidal inmates;
- Levels of supervision for suicidal inmates;
- Timely emergency intervention by correctional and medical personnel following a suicide attempt;
- Provision of critical incident stress debriefing to affected staff and inmates, as well as completion of a multidisciplinary mortality review following an inmate suicide and/or serious suicide attempt; and
- A low rate of inmate suicides for an extended period of time.

If you believe your correctional facility operates an exemplary suicide prevention program, and would like it to be considered as a possible case study in an upcoming issue of the ***Update***, please send copies of your suicide prevention policy, screening/assessment forms utilized to identify suicidal inmates, and total number of suicides and your facility's average daily population for each year from 1995 thru 2004 to:

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driving while intoxicated. He was no stranger to the lockup; this was his twenty-fourth arrest. Police booked him and put him in a cell at the stationhouse, pending his arraignment and transfer to the county jail. At this point matters departed from routine, because within 90 minutes Bradich had hanged himself. Officers could not revive him, nor could an emergency medical team dispatched by the fire department.

Delores Bradich, his mother and the administrator of his estate, contends that the arresting officers, the lockup keepers, and the City of Chicago all violated his constitutional rights by failing to protect him from the risk of suicide and react properly once they discovered the hanging. The district court granted summary judgment in defendants' favor, ruling that the Estate has not established that any of them had exhibited deliberate indifference to Bradich's mental-health needs before the hanging or his parlous condition afterward. 2004 U.S. Dist. LEXIS 2478 (N.D. Ill. Feb. 17, 2004).

Many of the Estate's claims can be dispatched swiftly. The arresting officers did not violate any of Bradich's rights by taking him into custody on an outstanding warrant and handing him over at the lockup for detention. The lockup keepers did not display deliberate indifference to a substantial risk of suicide by putting Bradich in a regular cell, and allowing him to keep his civilian clothes, rather than placing him on suicide watch or sending him to a hospital until he sobered up. (On the constitutional deliberate indifference standard for pretrial detainees' medical needs, see *Bell v. Wolfish*, 441 U.S. 520, 535 n.16 (1979); *Matos v. O'Sullivan*, 335 F.3d 553, 556-57 (7th Cir. 2003).) Bradich had been arrested many times before yet never attempted to injure himself, and he did not have a mental-health history implying any disposition toward suicide. That the lockup had experienced two (unsuccessful) suicide attempts by other prisoners during the preceding month does not imply that Bradich posed any elevated risk of suicide.

The Estate contends that intoxication substantially increases the suicide risk but offers no medical or psychiatric evidence to support that proposition. Bradich may have taken barbiturates as well as alcohol (he had some tablets in his pocket when arrested, though no drugs other than alcohol were detected in his blood after his death), but again the Estate does not offer data or expert testimony suggesting that the combination predisposes to suicide, let alone that the lockup keepers knew of this enhanced risk. We canvassed some of the data in *Jutzi-Johnson v. United States*, 263 F.3d 753 (7th Cir. 2001), and need not repeat what was said there. This is a weaker case (with respect to the events that preceded the hanging) than was *Jutzi-Johnson*, where we held even a negligence standard had not been met.

As for Chicago: municipalities are not vicariously liable under 42 U.S.C. §1983 for their employees' errors. See *Monell v. New York City Department of Social Services*, 436 U.S. 658 (1978). They are liable only for their own policies. The record in this case shows that some of these policies were not followed — for example, the City's rules called for close monitoring of the cells (intoxicated prisoners must be checked in person or by closed-circuit video every 15 minutes), and the lockup keepers did not follow this rule. The record suggests that they were playing cards and watching television instead of watching the monitors that displayed what the prisoners were doing. None of Chicago's policies is constitutionally inadequate; indeed, the Estate does not take issue with any of them. Its argument, rather, is that Chicago did not ensure that all of its employees followed all of its policies all of the time. That theory of liability is incompatible with *Monell*.

The Estate does not argue that the City systematically fails to enforce its written policies and instead maintains informal policies that violate the Constitution. The record does not contain data implying that the suicide rate in Chicago's lockups is abnormally high. The Estate concentrates on the facts of this case, and the employment history of the lockup keepers on duty, rather than anything from which an informal policy of general applicability could be inferred. That one lockup keeper was not retrained according to the City's policies is a shortcoming in the enforcement of sound policies, not an independent violation of the Constitution. See *Collins v. Harker Heights*, 503 U.S. 115, 122-24 (1992).

What happened after the hanging, however, has more potential to produce liability. Officers Hilbring, Simmons, and Walker were on duty in the stationhouse. Simmons and Walker testified by deposition that they noticed Bradich hanging about 6:15 p.m. and ran to his cell. According to their depositions, Bradich appeared to be alive. They had trouble opening the cell door because of the way Bradich had tied the ligature. Simmons obtained a knife from the kitchen, and the officers used this to free Bradich from the ligature and open the cell door. Simmons and Walker were joined by Captain Hilbring, the watch commander, who had come down from the second floor in response to the commotion. Simmons shouted at, slapped, and shook Bradich in an attempt to restart his breathing. (Of the three, only Hilbring has training in cardio-pulmonary resuscitation, and Hilbring did not use his knowledge; shouting, slapping, and shaking are not CPR techniques.) Only after these efforts failed did Walker call for medical personnel. The ambulance was dispatched at 6:25 P.M., implying that the trio at the lockup had waited ten minutes to summon assistance. By the time paramedics reached his cell at 6:34 P.M., Bradich was dead.

These times could be inaccurate. But on summary judgment, when the non-moving party receives the benefit of all reasonable inferences, see *Hunt v. Cromartie*, 526 U.S. 541 (1999), we must assume that the officers took ten minutes to seek help — and that they wasted much of that interval.

Defendants describe themselves as frantically trying to save Bradich during those ten minutes, and this is why the district judge concluded that deliberate indifference had not been established. Maybe it was negligent of officers who did not know (or did not use) CPR techniques to make a rescue attempt, the district judge thought, but the officers were doing their best. The problem with this view is that it draws inferences in the officers' favor rather than the Estate's.

Why did it take all three officers to provide unhelpful assistance? Two might have done what they could, while the third phoned for help (which would take only a minute) and then rejoined the others. Why did two officers who lacked CPR training think that they should shout at a hanging prisoner rather than call for help? Why did the officer with CPR training not use his skills? The Estate's preferred answer is that the three officers are dissembling about

their activities during the critical ten minutes. As the Estate sees things, delay in calling for outside assistance was a deliberate choice, not a side effect of devoted rescue attempts.

The Estate believes that the three officers spent most of the ten minutes altering their log books and tidying the cell to disguise their violations of required procedures. Medical personnel found Bradich wearing a T-shirt that the lockup keepers said had been the ligature; this was unusual, to say the least. Perhaps, the Estate suggests, the officers disposed of the actual ligature and other items to hide the fact that they had allowed Bradich too much clothing and other forbidden things in his cell. In this court, defendants say that Bradich had at least three T-shirts, two of which he used to make the ligature; but why was all this clothing in his possession? Some changes were made in the log books during the ten minutes; defendants concede that they noted the suicide attempt in their logs, and if they took the time to do that (itself a violation of regulations) maybe they erased or rearranged other entries to cover the traces of improper conduct following Bradich's arrest. Protecting one's employment interests while an inmate chokes to death would exemplify deliberate indifference to serious medical needs. See *Tlamka v. Serrell*, 244 F.3d 628 (8th Cir. 2001); *Ellis v. Washington County*, 198 F.3d 225 (6th Cir. 1999). That failing would lead to liability if an earlier call for help could have saved Bradich's life, a question on which the evidence is skimpy. And if the Estate is right about what happened during the ten minutes, the lockup keepers are not entitled to qualified immunity: no reasonable officer could think that the Constitution allowed him to cover up his own misconduct at the expense of a prisoner's life.

Further proceedings may vindicate the lockup keepers' position that the delay was much less than ten minutes and that they provided well-meaning, if inept, care in the interim, but matters are too uncertain to allow summary judgment. The judgment of the district court with respect to Hilbring, Simmons, and Walker is vacated, and the case is remanded for trial. With respect to all other defendants the judgment is affirmed. ❑

News From Around the Country

Offered below are brief stories regarding inmate suicide, offenders with mental illness, and other related topics that have recently occurred and/or been reported throughout the country.

Maryland

On June 30, 2005, the U.S. Justice Department announced a settlement agreement with the state regarding conditions of confinement in two of its juvenile justice facilities: the Cheltenham Youth Facility in Cheltenham and the Charles H. Hickey, Jr. School in Baltimore. The settlement resolves a 20-month investigation into the facilities. The agreement, filed with the United States District Court for the District of Maryland, requires the state to implement reforms to ensure that juveniles in the facilities are protected from harm and provided legally adequate services, including suicide prevention, mental health and medical care, and special education.

"We are pleased with the state's cooperation and willingness to implement meaningful reforms at these two facilities, both of which

have long and troubled histories," Bradley J. Schlozman, Acting Assistant Attorney General for the Civil Rights Division, said in a press release. "If juvenile offenders are to be put on the path to law abiding and productive lives, they must not be subjected to the kind of conditions that have plagued Hickey and Cheltenham in the past."

The Department's investigation revealed numerous civil rights violations, including physical abuse of juveniles by staff, deficient suicide prevention measures, inadequate medical and mental health care, and legally insufficient special education services. Under the terms of the agreement, the state will address and correct all of the violations identified by the Department. With regard to suicide prevention and mental health, the agreement requires the following:

Suicide Prevention

- **Implementation of Policy:** The State shall take all reasonable measures to assure that all aspects of its Suicide Prevention Policy are implemented.

- **Suicide Risk Assessments:** Timely suicide risk assessments, using reliable assessment instruments, shall be conducted at the facilities: a) for all youth exhibiting behavior which may indicate suicidal ideation; and b) when determining whether to place a youth on suicide precautions or change the level of suicide precautions. Suicide risks assessment shall be conducted by a qualified mental health professional. If no such professional is available to conduct the assessment due to exceptional circumstances, it shall be conducted by another staff member who has received specific training in conducting such assessments. Youth shall not be removed from suicide precautions by anyone other than a qualified mental health professional.

- **Mental Health Response to Suicidal Youth:** Youth at the facilities who demonstrate suicidal ideation or attempt self-harm shall receive timely and appropriate mental health care by qualified mental health professionals. This care shall include helping youth develop skills to reduce their suicidal ideations or behaviors, and providing youth discharged from suicide precautions with adequate follow-up treatment.

- **Supervision of Youth at Risk of Self-Harm:** The State shall sufficiently supervise newly-arrived youth, youth in seclusion and other youth at heightened risk of self-harm to maintain their safety.

- **Housing for Youth at Risk of Self-Harm:** The State shall take all reasonable measures to assure that all housing for youth at heightened risk of self-harm, including holding rooms, seclusion rooms and housing for youth on suicide precautions, is free of identifiable hazards that would allow youth to hang themselves or commit other acts of self-harm.

- **Restrictions for Suicidal Youth:** Youth in the facilities on suicide precautions shall not be restricted in their access to programs and services more than safety and security needs dictate.

- **Documentation of Suicide Precautions:** The following information shall be thoroughly and correctly documented, and provided to all staff at the facilities who need to know such information: a) the times youth are placed on and removed from precautions; b) the levels of precautions on which youth are maintained; c) the housing location of youth on precautions; d) the conditions of the precautions; and e) the times and circumstances of all observations by staff monitoring the youth.

- **Access to Emergency Equipment:** Direct care staff at the facilities shall have immediate access to appropriate equipment to intervene in the event of an attempted suicide by hanging.

- **Suicide and Suicide Attempt Review:** Appropriate staff shall review all completed suicides and serious suicide attempts at the facilities for policy and training implications.

Mental Health

- **Adequate Treatment:** The State shall provide adequate mental health and substance abuse care and treatment services (including timely emergency services) and an adequate number of qualified mental health professionals. Psychiatric care shall be appropriate to the adolescent population of the

UPDATE
ON THE INTERNET

Recent issues of the ***Jail Suicide/Mental Health Update*** are now available on the Internet at:

www.ncianet.org/cjjsl.cfm

Check us out on the Web!
www.ncianet.org/cjjsl.cfm

Other jail/juvenile suicide prevention and jail mental health resources, including several recent articles by Lindsay M. Hayes, can be found at the following web sites:

www.hhpub.com/journals/crisis/1997
www.nicic.org/jails/defrault.aspx
www.ojp.usdoj.gov/managingoffenders/mentalhealth.htm
www.ncjrs.org/html/ojjdp/jjjnl_2000_4/sui.html
www.pbstandards.org/resources.aspx
www.gainsctr.com

facilities and shall be integrated with other mental health services.

- **Establishment of Director of Mental Health:** The State shall designate a director of mental health. The director shall meet minimum standards, as specified by the State, to oversee the mental health care and rehabilitative treatment of youth at the facilities by performing the tasks required by this Agreement, including: a) oversight of mental health care in the facilities, including monitoring the performance of psychologists, counselors and psychiatrists, and developing and implementing policies and training programs; b) monitoring of whether staffing and resources are sufficient to provide adequate mental health care and rehabilitative treatment services to the facilities' youth and to comply with this Agreement; and c) development and implementation of a quality assurance program for mental health care.

- **Admissions Consultation and Referral:** If a youth presents at admission to a facility with mental health needs which cannot be met safely at the facility, the State shall transfer the youth promptly to appropriate settings that meet the youth's needs. Qualified mental health professionals shall be readily available for timely consultations regarding admissions decisions.

- **Mental Health Screening:** The State shall develop and implement policies, procedures and practices for all youth admitted to the facilities to be screened comprehensively by qualified mental health professionals in a timely manner utilizing reliable and valid measures. If, due to exceptional circumstances, no such professional is on-site to conduct the screening, it shall be conducted by another staff member who has received specific training in conducting such assessments and reviewed by a qualified mental health professional.

- **Mental Health Assessment:** Youth in the facilities whose mental health screens indicate the possible need for mental health services shall receive comprehensive, appropriate and up-to-date assessments by qualified mental health professionals.

- **Treatment Plans:** Youth in the facilities in need of mental health and/or substance abuse treatment shall have an adequate treatment plan, including a behavior management plan, as appropriate, which shall be implemented in the facilities.

- **Mental Health Involvement in Housing Decisions:** The State shall adequately consider mental health issues in providing safe housing for youth in the facilities.

- **Informed Consent:** Consistent with State law, the State shall, prior to obtaining consent for the administration of psychotropic medications, provide youth and, as appropriate, their parents or guardians with information regarding the goals, risks, benefits and potential side effects of such medications offered for their treatment, as well as an explanation of what the consequences of not treating with the medication might be, and whether a recommendation is made in a dosage or manner not recognized by the United States Food and Drug Administration.

- **Mental Health Medications:** The State shall take all reasonable measures to assure that psychotropic medications are prescribed, distributed, and monitored properly and safely. The State shall provide regular training to all health and mental health staff on current issues in psychopharmacological treatment, including information necessary to monitor for side effects and efficacy.

- **Mental Health and Developmental Disability Training for Direct Care Staff:** The State shall develop and implement strategies for providing direct care and other appropriate staff with training on mental health and developmental disabilities sufficient for staff to understand the behaviors and needs of youth residents and supervise them appropriately.

- **Transition Planning:** The State shall take all reasonable measures to assure that staff create appropriate transition plans for youth leaving the facilities. Such plans shall appropriately consider each youth's length of stay and subsequent placement. Plans shall include providing the youth and his or her parents or guardian with information regarding mental health resources available in the youth's home community; making referrals to such services when appropriate; providing appropriate orders for the continuation of prescribed medications; and providing assistance in making initial appointments with service providers.

The *Memorandum of Agreement Between the United States and State of Maryland* can be accessed at the Justice Department's website: http://www.usdoj.gov/crt/split/documents/ split_maryland_agree_6-29-05.pdf

Texas

In August 2005, a mentally ill inmate at the Dallas County Jail was left in his cell without running water for four days after an officer apparently violated a year-old policy and ordered the water turned off without getting higher approval. Fortunately, according to jail officials, the inmate's physical health was not adversely affected. But the incident caused an outcry among mental health advocates because it comes a year after a high-profile case in which an inmate nearly died after water in his cell had been turned off for two weeks.

"It's still hit and miss in the Dallas County Jail," said David Finn, an attorney who filed a federal suit against the county for the family of James Mims, a mentally ill the inmate who nearly died of dehydration and kidney failure in April 2004 after jail officers turned off the water supply to his cell for almost two weeks (see ***Jail Suicide/Mental Health Update***, Volume 13, Number 3, Winter 2004, pages 16-17). "It would seem high time that an outside investigation be initiated into these continuing barbaric procedures," he told *The Dallas Morning News* on August 17, 2005. "They've been going on for five to 10 years, and it's painfully obvious that our local leaders are unwilling or unable to change things."

Sergeant Don Peritz, a spokesman for the Dallas County Sheriff's Department, said that when Sheriff Lupe Valdez heard about the latest incident, she checked on the inmate's condition and called for an internal investigation. He said the sheriff was "furious" about the apparent violation.

Gil Martinez, 30-years-old, had been arrested on a misdemeanor criminal trespass charge. On August 3, he was being held in a special observation cell on the fourth floor of the Dallas County Jail's west tower when he apparently flooded the cell by clogging up the toilet. A jail officer assigned to the floor then shut off the water in Mr. Martinez's cell. For days later on August 7, another officer noticed that the water was off and informed a supervisor. Mr. Martinez, suffers from mental illness, was then examined by a nurse for dehydration. Two medical staff also noticed that the inmate had been without water for several days, and also never notified supervisors until August 7.

Shortly after the Mims incident in April 2004, the Sheriff's Department updated its policy on turning off water in the cells of disruptive inmates. Sergeant Peritz told *The Dallas Morning News* that the revised policy now requires that an officer who observes an inmate flooding his cell is to notify a supervisor, who then advises the jail commander. The jail commander makes the decision on whether to shut off the water. If the water is turned off, it must be turned back on within 24 hours, and it must also be back on to allow three successive eight-hour shifts a chance to flush the toilet. In addition, there must be face-to-face contact with the inmate twice every hour while the water is off, and the inmate must be given three opportunities a day to receive drinking water.

In the Martinez case, none of the protocol was apparently followed. "I'm grateful they have these new policies in place, but this incident tells me the staff is not always aware of the importance of the policies," said Vivian Lawrence of the Mental Health Association of Dallas. She also questioned why it took four days for someone else on both the jail and medical staffs to notice the water had been shut off. "Do they have no reporting during the day? Do they just come and go? Is there no accountability to their superiors?" she asked. In an e-mail to Sheriff Valdez, Ms. Lawrence further asked, "What possible explanation could there be for any human being to be without water for five days? What needs to happen for this behavior to change?"

Commissioner Kenneth Mayfield, chairman of a committee to improve the much-maligned health care in the jail, told *The Dallas Morning News* that Sheriff Valdez "has to get hold of her employees and tell them to quit treating people like that." He said additional sensitivity training for both new and veteran employees was essential to help officers understand how to properly handle inmates who are mentally ill.

Ms. Lawrence has repeatedly offered to train jail staff at the convenience of the sheriff's department. According to Commissioner Mayfield, the sheriff has previously stated that she welcomed such offers for free training, but it would be costly to the department in both overtime pay and scheduling. The commissioner said the cost should not prevent the training from taking place. "We should be able to just sit down and work that out," he said. Ms. Lawrence said she has even offered to provide training on Saturdays on her own time, and she already provides training for new recruits. But, according to Ms. Lawrence, new employees often start work before they receive their academy training, and it is difficult for her in four hours to counter what the recruits learn from veteran employees. That is why training for veteran jail staff is critical.

The Martinez incident was the latest of troubles that has besieged the Dallas County Jail system. In February 2005, a consultant hired by the county commissioners issued a scathing assessment of medical and mental health services for inmates. The following month, the Texas Commission on Jail Standards issued an inspection report that found 11 areas of non-compliance with state-mandated standards, including violations of staff-to-inmate staffing ratios, physical plant maintenance, and medical and mental health services.

West Virginia

In July 2005, a federal appeals court ruled that responsibility for two inmate suicides at a Randolph County Jail in Elkins should have been covered by the county's liability insurance. The U.S. Court of Appeals for the Fourth District voted unanimously to overturn an earlier decision by a lower court judge who ruled that the deaths were not accidents and, therefore, not part of the county's insurance coverage.

On September 3, 1998, Bobby Robinson committed suicide in the Randolph County Jail. Nine months later on June 11, 1999, Michael Everson committed suicide in the facility. Their respective estates filed appropriate lawsuits against both the sheriff and county commission in state court. The suits asserted claims of both negligence and deliberate indifference, and alleged "that the Sheriff and County Commission failed to provide the decedents with medical care that could have prevented the suicides and failed to training jail employees on the means and methods of identifying and taking precautionary measures to protect inmates with suicidal tendencies."

The Columbia Casualty Company, which provided liability insurance to the sheriff, and partially covered the county commission, subsequently decided to settle the lawsuits for $450,000 to the Robinson family, and $100,000 to the Everson family. But, Westfield Insurance Company, which provided liability coverage to the county commission, denied coverage and refused to provide a defense in the case. They claimed that their policy for the county commission only provided coverage if the injury or

damage was "caused by an 'occurrence.'" An occurrence was defined as "an accident, including continuous or repeated exposure to substantially the same general harmful conditions." An inmate suicide, the company argued, was not an accident because the act was intentionally inflicted. Columbia Casualty subsequently sued Westfield Insurance in federal court seeking a declaration that Westfield was partly liable for the settlements, costs, and fees that Columbia incurred in defending and settling the lawsuits. In June 2003, a federal district court judge sided with Westfield Insurance and ruled that inmate suicides could not be considered accidents.

In May 2004, Columbia Insurance then sought relief from the federal appeals court, who, in turn, asked the West Virginia Supreme Court of Appeals for its opinion since the original inmate lawsuits had been filed in state court. The question asked of the state Supreme Court was simply and direct: "Under West Virginia law, were the suicidal deaths of Robinson and Everson, either or both, 'occurrences' within the meaning of the Westfield Insurance Company commercial general liability policy at issue in this case?" On June 10, 2005, the West Virginia Supreme Court of Appeals answered the federal appeals court's certified question with a simple "Yes." As such, on July 25, 2005, the U.S. Court of Appeals for the Fourth District vacated the lower federal court opinion and ruled that Westfield Insurance was indeed responsible with Columbia Insurance for all defense costs associated with the Robinson and Everson lawsuits. The federal appeals court decisions in *Columbia Casualty Insurance v. Westfield Insurance Company* (No. 03-1811), 378 F.3d424 (4th Cir. 2004), can be found at its website: www. ca4.uscourts.gov

Missouri

Kurt Hartzell, 29-years-old, was found dead in his holding cell at the Arnold Police Department on June 30, 2005. He reportedly hung himself with a bed sheet. His father, Robert Hartzell, claims he has been told few details about the death by the police department, including the reason his son was in jail although "I understand it was for (unpaid) traffic tickets." Mr. Hartzell recently told the *Jefferson County Journal* that "the way they're handling this, it just seems like they're trying to cover their (backsides)."

Police Chief Robert Shockey asked the Jefferson County Sheriff's Office to investigate the death. The police chief confirmed the death took place and called the incident a "tragedy," but initially refused to release any further details, citing the ongoing investigation. Chief Shockey said the sheriff's department was brought in to analyze the incident "with a fresh pair of eyes."

Although investigators initially released few details about the death, they apparently told Mr. Hartzell that his son was despondent and reported "seeing apparitions." He wondered why officers were not paying closer attention to his son's cell, which was monitored by closed circuit television (CCTV). It was a question he said investigators declined to answer during an initial meeting. "I think the jail has an obligation to watch their prisoners, because they know what condition they're in," he said.

Jail Mental Health Services Initiative from the National Institute of Corrections (Jails Division)

Nearly 6 to 8 percent of the more than 10 million annual commitments to jails are individuals with severe mental illnesses. Many sheriffs and jail administrators view the challenge of responding to the needs of this population as one of the major issues in jail management. In response, the National Institute of Corrections (NIC) has worked collaboratively with the National Institute of Mental Health for the past several years, and more recently, with the Substance Abuse and Mental Health Services Administration's Center for Mental Health Services to increase and improve these services. As a result of these collaborations, the NIC Jails Division has developed a mental health initiative for jails.

An important component of the initiative is the offering of regional workshops conducted in collaboration with state, regional, and local jurisdictions. The 21-hour regional workshops will be provided upon request to help small and medium-sized jails enhance mental health services and service delivery for inmates. Several jurisdictions in a region can each send a three-person team consisting of a jail administrator, a representative of the jail's community mental health provider, and the person who coordinates mental health services for inmates. Each workshop will include: overview of the problem, planning principles, contract development, leadership and managing change, implementation strategies, staffing and cross-training, and coalition building. The workshops are conducted at the request of a host agency, which is responsible for furnishing the training rooms and equipment. The NIC Jails Division provides two trainers, the curriculum and training materials. Participants are responsible for their own expenses.

In addition to the workshops, the NIC Jails Division's mental health initiative includes the following services:

- **On-site Technical Assistance**: This assistance usually consists of an assessment of a jail system's mental health needs, *but also can be targeted at suicide prevention issues in the jail*;
- **Newsletter**: The NIC Jails Division funds the ***Jail Suicide/Mental Health Update***, a newsletter which is distributed free of charge on a quarterly basis;
- **Information Resources**: The NIC Information Center has compiled a jail mental health information resource order form that contains 22 items. The form is available at the mental health workshops held in Longmont, Colorado and at regional sites. It can also be obtained by calling the Information Center at (800) 877-1461.

For more information on the NIC Jails Division's mental health initiative, on-site technical assistance, and the mental health workshops, contact the agency at (800) 995-6429, or visit their website at: www.nicic.org

Robert Hartzell said his son had been using methamphetamine for almost a decade and believed his drug use may have played a role in the suicide. He said he tried many times to get his son help and believed incarceration could have blocked his access to the drug, potentially providing him an opportunity to break the addiction. "You try to help your children, sometimes you can't," Mr. Hartzell told the *Journal*.

On August 4, 2005, the Arnold Police Department announced that 16 employees had been disciplined as a result of the Kurt Hartzell's death. According to Arnold City Attorney Bob Sweeney, 14 of the employees were police officers. The other two are police dispatchers, who were fired. Two of the police officers resigned, four officers received demotions and six officers received suspensions without pay ranging from one to five days. Two more police officers received reprimands. City Attorney Sweeney told the *St. Louis Post-Dispatch* that the employees were disciplined for "a widespread violation of policy....ranging from how paperwork was filed to how the inmate was observed." Because Mr. Hartzell was housed in a CCTV-monitored cell, his suicide was videotaped and investigators utilized the tape in conducting their review.

Despite the disciplinary action, Hartzell family members still complained that they have received very little information regarding the death. Bobby Hartzell, the decedent's brother, said he wanted to know why the police employees were disciplined. "The city and the police aren't giving us any information," he told the *Post-Dispatch*. His step-mother, Michelle Hartzell, said the city was not treating the family with respect. "All we want to know is what happened. No one even told us that the investigation was over," she said.

According to Captain Ralph Brown of the Jefferson County Sheriff's office, his agency completed its investigation in July and it was the Arnold Police Department's decision not to release the report. Finally, following numerous inquiries, the investigative report was released in mid-August by City Attorney Sweeney. In acknowledging that Kurt Hartzell's death was preventable and more than 15 employees had been responsible for supervising only 3 inmates, the city attorney told a local television station that "when we looked at our policies and procedures, we realized that wasn't the case and there was human error involved."

Investigators found that Kurt Hartzell had been identified as suicidal, placed on suicide precautions, and housed in a cell that contained CCTV monitoring. The human error included the fact that he was then given a bed sheet, as well as held in the cell for more than 24 hours without an assessment from a mental health professional — both in violation of jail policy. In addition, several staff were apparently unaware that the inmate was on suicide precautions and failed to monitor his cell. Staff also failed to quickly respond to Mr. Hartzell's cell and initiate life-saving measures when he was subsequently found hanging by the bed sheet. The Hartzell family is now considering legal action against the city of Arnold and its police department.

Ohio

A death row inmate who committed suicide at the Mansfield Correctional Institution in May 2005 was likely dead almost four hours before his body was found, indicating a serious violation of prison policy, according to a report on the death released by the state Department of Rehabilitation and Correction (DRC) in late August 2005. Two correctional officers were fired, and a captain was disciplined, following the suicide of Martin Koliser. The death row inmate, who had been sentenced to die for killing a Youngstown police officer in 2003, used a nylon belt that he tied around the frame of his bunk bed to hang himself.

Death row inmates are required to be observed at 30-minute intervals. In Mr. Koliser's case, DRC investigators determined that the last cell check occurred at 1:30am on May 6, and his body was not found until almost four hours later at 5:30am. According to the *Associated Press*, the DRC report also found numerous other problems in the handling of the suicide, including inadequate documentation of the officers' activities at night, broken first aid kits, and a failure to regularly carry out emergency drills for responding to suicide attempts.

DRC investigators estimated that Mr. Koliser's suicide occurred between 1:30am and 2:00am, contradicting a coroner's report which concluded that he died at approximately 5:30am. They based their estimates upon interviews with inmates, other officers, and a videotape taken when Mr. Koliser's body was found that showed lividity and rigor mortis. Other death row inmates had told investigators that officers routinely skip nightly rounds of the housing unit.

Shortly after the firings, the Ohio Civil Service Employees Association (the largest state employees union) filed an appeal to have the officers reinstated. "I'm confident that when all the facts come out, they will be returned to duty," Mansfield-based union steward Michael Miller told the *Associated Press*. The union also plans to ask the Richland County Coroner Stewart Ryckman to investigate why the DRC and autopsy reports differed significantly on the time of Mr. Koliser's death — a critical factor to the firings. Dr. Ryckman had concluded that, based on his body temperature when found, Mr. Koliser died at approximately 5:30am.

Andy Douglas, director of the union, argued that the DRC should not have relied on statements from death row inmates regarding how frequently officers conduct rounds. "They have zero credibility and have an interest in creating major problems for prison staff," he told the *Associated Press*. Jo Ellen Lyons, DRC spokeswoman, replied simply, "We believe the report speaks for itself."

Utah

Blake Ludlow worked during the day at his grandpa's Ford dealership in Santaquin, changing oil, snacking on circus peanuts and making customers laugh. After eight-hour shifts, he would head to Spanish Fork where he spent his nights — in jail. Ludlow phoned home from the work-release program to tell his mom he was safe. He never forgot. On the weekends, when he wasn't allowed to leave, the clean-cut kid passed the time reading or playing cards with the other Utah County Jail inmates, talking about his family.

On Saturday, Jan. 15, he didn't call home. Ludlow's mother, Karen Montague, received a phone call early Sunday morning from her

parents. They told her the jail had called with bad news: Blake had attempted suicide by wrapping a sheet around his neck so tight that he stopped breathing. By the time they arrived at Utah Valley Regional Medical Center, Blake Christian Ludlow had died.

Ludlow's death was the first of four suicides in the Utah County Jail this year — already a record number for a single year. In the previous seven years, seven inmates committed suicide. The four suicide deaths set off alarms. As a result, jail staff formed a new committee to re-evaluate jail protocol and training. They also added a step to the screening procedures for every inmate who enters the jail. "Hopefully, this is just a statistical anomaly, as far as numbers," said Utah County Sheriff James Tracy. "We certainly are doing everything in our power to prevent all (suicides). That is our institutional objective — to have no suicides. That is drilled into everybody all the time."

But the families who lost sons, brothers and husbands still have questions about protocols followed by staff at the Utah County Jail. Were they monitored enough? Did they take note of the inmates' mental states? What went wrong? And what could have been prevented? "You never think you're going to lose one of your kids like that," Montague said. "I'm not really bitter towards the jail. I'm just concerned about…what they can do to prevent this."

Behind Bars

The hallways at the jail are sterile, lined with unbreakable, bulletproof windows. Inmates look out from one of 12 living areas — or pods — named after Utah ski resorts. There's Aspen, Alta, Snowbird, Brighton. In each pod's common room there's a TV and a small bookshelf with worn-out copies of popular novels. Collect-call telephones line the wall. Court numbers and attorney names are posted on the bulletin board. There are two floors of cells, a staircase in the middle. When the inmates aren't playing checkers, writing letters or watching TV in the common room they stay in their cells, waiting for meal time or visiting hours. They get three meals a day, two visits a week.

The pods are direct-supervision areas. A control desk — marked off by thick, red lines on the floor that inmates cannot cross — is for the housing officer who pulls 12-hour shifts. The officer is the regulating force, keeping the peace and the remote control. They monitor inside-the-jail activity as closely as they can, but it's a 1-to-64 ratio.

Utah County is one of only a handful of jails in the nation that functions under the "direct supervision" philosophy. Other jails use a linear, cell-block philosophy with security cameras. Tracy said he thinks a housing officer is more effective than a camera, as his or her presence sets the tone for the inmates and helps prevent inmate-on-inmate violence. But the number of inmates the guard must supervise continues to grow, in large part because of a countywide population explosion that impacts the jail as well. Now, many inmates are housed two to a room to accommodate the influx.

Currently, there are 651 inmates. When the Spanish Fork-based facility first opened in 1997, the average number of those incarcerated at any one time was a little more than 200. The county is in the process of approving funds and starting to work on building six additional pods that can hold 64 inmates each. But even with the new buildings, Tracy said the extra beds won't stay empty for long.

Preventing the Problem

A jail officer heads door-to-door, tapping a round metal button on each cell's door frame with what looks like a fat blue marker. That marker-like object — called "The Pipe" — is used by the jail staffer, first as he touches a dime-size object on the cell door, then on one of nine similar metal buttons in an electronic notebook. Each of the nine buttons corresponds to a certain behavior, such as standing, sleeping, eating, yelling or bizarre actions. With each tap of the electronic pipe, the officer makes a downloadable record of his 15-minute-interval visit to each inmate in the medical unit. This procedure is used throughout the jail, though not with the specific descriptions of the medical area.

The Pipe is one element of the jail's monitoring process, but the full screening starts much earlier — right at the beginning of the path from patrol car to pod. Each inmate is carefully screened because jail personnel know the first 72 hours of incarceration are the most crucial. Mental-health screening and the suicide-prevention process starts immediately upon arrival.

All new inmates are asked a standard list of questions about their mental health, whether they've had any emotional issues or troubles in their life or if they have a history of depression. Mental-health professionals use suicide prevention screening guidelines to ascertain if the inmate has suicidal thoughts, has attempted suicide before and to note whether he or she appears overly anxious, angry or afraid. Those who answer yes to suicide-related questions or raise other red flags are put on "suicide watch," then interviewed by mental-health personnel and placed in a special area where a jail staffer can check them every 15 minutes with a specific monitoring procedure. This constant supervision is effective because it creates a check on inmates that have been identified as having mental-health or physical-health issues.

However, the problem arises when inmates don't notify personnel that they are entertaining suicidal thoughts or perhaps suffer from depression. If the staff doesn't know about a problem and the warning signs are muted, they can't do much, Tracy said. Often, instead of speaking up and getting the necessary help, the inmate remains silent and heads to a pod. And the suicide-screening process only happens once unless sudden warning signs emerge. It's now the housing guard's responsibility to monitor the emotional status of his inmates, watching for those warning signs. But with only 109 full-time deputies and 18 part-timers, maintaining constant communication with each individual inmate is a daunting challenge.

"It takes only 3 to 5 minutes to kill yourself," said Tracy. "We have (almost) 700 inmates. To check every one of them 24 hours a day, no more than 3 to 5 minutes apart? I'd need triple the

staff to guarantee never a suicide. But our operational goal is to prevent as many suicides as we can…..if somebody attempts it, we do everything we can to eliminate the problem and then treat the inmate."

Comparing the Facilities

The Salt Lake Metro Jail uses screening procedures similar to the Utah County Jail, placing those with questionable stability in individual cells with nothing but a blanket. That's to prevent inmates from using an article of clothing to harm themselves. In 2004, Salt Lake jail personnel stopped 67 suicide attempts with no successful suicides. The facilities are similar in size. Last year, the metro jail booked some 16,000 people. The Utah County Jail booked 12,000. "We do everything possible to prevent (suicides)," said Salt Lake Sheriff Sgt. Paul Jaroscak. "Aside from literally strapping someone down, it would be impossible to prevent every single possibility, but we do our best to eliminate as many as possible."

But no jail can ever be "suicide-proof," says Anthony Callisto Jr., chief deputy of the Onondaga County Sheriff's Office in Syracuse, N.Y., and past president of the American Jail Association. "It's impossible to design it that way." Callisto said his facility generally sees 30 attempted suicides a year, most of which are unsuccessful thanks to astute and trained staff. Yet even with careful monitoring, competent staff and bare surroundings, inmates can still find ways to kill themselves.

Death by asphyxiation — hanging — is the most common method, Callisto said. Unlike the typical image of a noose, inmates can cut off the air supply by wrapping a towel, a sheet or even socks around their necks. In less than 3 minutes, a person will pass out, then become oxygen deprived, which eventually causes death. Ten of the 11 Utah County Jail suicides since 1998 were by asphyxiation, Tracy said. The other happened when an inmate jumped from a higher level of the jail.

The third person to commit suicide at the Utah County Jail this year, Aaron William Colby, 36, hanged himself April 24 in the bathroom of the booking area. The jail staff started CPR but stopped once they realized Colby was completely unresponsive, and the ambulance team's defibrillator indicated that his heart was not responding to the resuscitation efforts.

The Questions Left Behind

For five years, Blake Ludlow had struggled with a heroin addiction. Although he had graduated from a substance abuse program, the sway of getting high was too strong — and he couldn't stay clean for very long. Because Ludlow was older than 18, his mother couldn't force him to attend other drug-treatment programs. She said other people told her jail would be the best place for her son, to help him get clean and turn his life around. So Montague turned her son in for stealing, hoping he could get the help he needed.

"It was hard for me, because, I hate to say this as a parent, but when he got put back in work release, I was relieved — (because) I know where he was at every night," Montague said. "I felt he was safe there. When you've had a kid on drugs and tried so many things, when they're in (jail) somewhere, you hate it, too, but you know where they are, that they're not out (on the street)." But when Ludlow learned he would be going back to jail, he got scared about being found with heroin in his system, his mother said. So he quit cold turkey.

That was Jan. 11. He was picked up by police the next day — and died four days later. "Blake just didn't seem like the suicidal type," Montague said. "I personally think the withdrawals were more than he could handle. I ask myself over and over and blame myself sometimes. It's been really hard."

Ludlow's mom said she wonders about the screening process. Maybe there should be a new drug-test policy for inmates before they start the work-release program so jail staffers know how to deal with those who are going through dangerous and painful withdrawals. But for Ludlow, the precaution still might not have been enough. The drug cycles through the body in 72 to 80 hours. Had he been tested right away, they would have seen the heroin in his system. But five days later, on his toxicology report, Montague said he was clean.

A drug test might also have made a difference for Ronald Forbush, 42, who died at the jail in April. Ronald Forbush loved working on cars and spent time with his dad, farming family land in Springville. Although Maurice Forbush worked with his son frequently, he never thought substance abuse was an issue. "We never knew about it," he said. "It was kind of hard for me to tell if he was on drugs because I wasn't looking for it to start with." But the signs started getting worse, especially when Ronald Forbush's habits moved from alcohol to drugs. Then, he started stealing to support his heroin habit. He was arrested. And after he missed a court appearance in April, the police started looking for him.

His mother, Sharon Forbush, said he called her one night, vowing he wasn't going back to jail. Sharon Forbush, worried her son would get in worse trouble if he continued to run and hide, told his parole officer where he was staying, and her son went back to jail. He checked in Thursday, April 7. He died the next Monday, April 11. "They told me, 'Well, we interviewed him. We checked him really good. We didn't think he was on drugs. We had no indication that he was on drugs,"' Sharon Forbush said of her conversation with jail officials. However, her two other sons saw Ronald Forbush the night he was picked up, and they told her he was obviously under the influence. "Part of the reason he was picked up was for possession (of drugs)," Sharon Forbush said. "They should have known that he was on drugs — or a drug user."

The jail also never labeled Forbush as a suicide risk, something that worried his mother. She said jail personnel told her there had been no indication he was suicidal. "Why aren't they interviewing them better?" she said. "Just because somebody says, 'No I'm not suicidal,' do you leave it at that? I've never been suicidal, but I don't think I'm going to run tell somebody if I am."

Prisoner Pressure

Jeremy John Wilkins, 30, had a lot to think about when he went to jail. The Pleasant Grove man was booked into the jail in May after police arrested him for allegedly attempting to burn down his mother's home. Accompanying charges included drug possession,

domestic violence and possession of a dangerous weapon. Wilkins, a devoted father who loved computers and technology, had struggled with drug problems, stemming from an addiction to painkillers, and was under the influence when he ignited his mother's basement, said his brother Brandon Wilkins. "He was definitely on something that night…..my mom could tell he was in a state when all that happened," Brandon Wilkins said.

Once at the jail, Jeremy Wilkins requested a quiet place to stay and recover and was placed in the frequently monitored medical unit. However, as he started to come off the drugs, his family said the consequences of his actions became real. "The possibility of jail for that long; I don't think he could handle that," Brandon Wilkins said. "I'm sure it was drugs, mixed somewhat (with) coming-off effects, withdrawal. That would be tough on me — to do something, then all of a sudden realize what I had done." Although Jeremy Wilkins was being carefully watched in the medical unit, he used a bed sheet to hang himself.

There is pressure inherent in incarceration, enough to be a factor in some suicides. However, consequences of drug use also play a major role, especially because the possession of any drug other than marijuana is a felony. "The way that we have labeled people with felony convictions makes it more difficult for them than it used to be," said Richard Gale, a defense attorney known for his work with the Utah County Public Defender's Association. "Now there's so many things that are felonies — (they have a) real hard time living a normal life." And if drugs have been a part of that "normal life," he said, it becomes even more difficult to find a sense of balance, especially behind bars. "I think sometimes they're euphoric out of custody, when on the drugs," Gale said. "Then, they get put into jail, and when they get put into jail, they start sobering up and then everything — reality — comes crashing down and it just seems overwhelming to them."

And watching for those warning signs of depression — even if the inmate didn't raise red flags during initial screenings — is the housing officer's job, Tracy said. Inmates who talk about traumatic life experiences such as the loss of a job, removal from a position of power or the shocking nature of their alleged crimes are flashing bright warning signs. But other hidden issues might be harder to detect without thorough screening and continued monitoring.

"If they're prominent (in the community), sure logic would tell you that you have to be especially careful — but there's not a hard or fast rule at all, except to do a good screening," said forensic psychologist Stephen L. Golding. Golding, who teaches at the University of Utah, said it's difficult to pinpoint a single factor that would lead someone to take their own life. "The only thing that makes any sense is to say that the emotional reaction of individuals, especially the large proportion of people who are mentally ill, is always a cause for concern, both in entering the system and thereafter," he said. "It depends upon there being adequate screening and monitoring. (That's) where the interventions need to take place."

Stopping the Suicides

Improved screening is the focus at the Utah County Jail now. Jail personnel will soon implement a new screening form to be filled out by the officer who brings someone to the booking area, said Lt. Scott Carter, jail programs supervisor. The officer will record his or her experience with the person before he arrived at the jail. Was there a fight? Was the individual emotionally distressed? Were there drugs involved? These first-hand observations will help jail personnel know more about the new inmate and any circumstances that might not have come out through the previous screening procedures alone. This was one of the ideas that came out of a new suicide prevention committee.

"Some people think we're not doing anything, that if some guy wants to commit suicide and tries, he's successful," Tracy said. "That's not the case at all." The committee meets each Thursday to share ideas and develop new policies that might be more effective in suicide prevention. The jail nurse, housing sergeant, a member of the public defender's office, as well as a representative from the Utah County Attorney's Office were invited to participate with jail staff on this committee. "Our goal is to evaluate policies and make recommendations for changes in policies, to look at procedures and identify things that can be changed, improved," Carter said. Jail personnel are deeply affected by each death, he added, and they want to do everything they can to prevent it.

The jail's policies are based on national standards, but adopted and modified to fit the specifics of the Spanish Fork location. Yet even with the best planning, some tragedies do occur. However, it's not as easy as simply changing one policy to eliminate inmate suicide, said Utah County Commissioner Jerry Grover. "If it was that easy," Grover said, "we would have done it."

Not only will the jail be starting a review process, but new computer software will now make tracking both suicides and attempted suicides easier. Often, the few suicides overshadow all the prevented tragedies, especially because in the past, attempted suicides were not recorded as dutifully as were the completed suicides.

The same night of the last successful suicide in May, two other attempts were foiled. June 22 would have been Blake Ludlow's 21st birthday. His mom threw a party for friends and family, and they talked about the man they loved. Montague and her family are still going to counselors, sharing their story with others and trying to come to terms with their loss. The harsh reality of drug use and suicide are issues the Montagues know about on a personal level. They've learned important lessons — but at a steep price. "He talked about (drug use)," Montague said. "He hated it. He felt the drugs were controlling him, not him controlling the drugs. He wanted to do what was right…..I think with Blake it had been a big fight. And he lost."

South Carolina

Antonio Richburg, was booked into the Alvin S. Glenn (Richland County) Detention Center in Columbia on March

22, 2005. Charged with assault and battery, the 29-year-old man had been previously diagnosed with schizophrenia and bipolar disorder. Mr. Richburg threatened suicide shortly after his confinement and was transferred to Just Care, Inc., a private mental health facility in Columbia. On April 7, he was returned to the county jail, but subsequently attempted to hang himself. Mr. Richburg was transferred back to the mental health facility on April 13. Two weeks later on April 27, a Richland County probate judge ordered jail staff to comply with a treatment plan for Mr. Richburg that was developed by Just Care, Inc. He was returned to the jail again on May 11 with a three-day supply of his psychotropic medication. Beginning on May 14, medical staff failed to dispense his medication on a daily basis. On May 16, Mr. Richburg sharpened a toothbrush and cut himself. Three days later on May 19, he wrote a letter to his wife and complained about not receiving his psychotropic medication for almost a week. On May 20, 2005, Mr. Richburg was found hanging in his cell and pronounced dead shortly thereafter.

The above chronology was developed by a special Richland County coroner's jury impaneled to conduct an inquest of Antonio Richburg's death. In July 2005, the six-member jury heard testimony from more than a dozen witnesses and concluded that Mr. Richburg died "due to a lack of standard of care by providers" at the Alvin S. Glenn Detention Center. The verdict did not identify specific individuals. Coroner Gary Watts, who presided over the rarely used court proceeding, told *The State* that the jury's ruling allows him to meet with the county solicitor to pursue possible criminal charges through the county grand jury. Asked who might be targeted, Mr. Watts told the newspaper that "I think it's fairly obvious that the whole issue is about medical care, so it falls back on Prison Health Services….If it hadn't been for the inaction of other people, he would still be alive," the coroner said. Richland County had contracted with Prison Health Services (PHS) to provide medical services at the county jail since 2001.

During the inquest, Coroner Watts engaged in a tense exchange with Adriane Gillespie, a jail nurse who testified she made a "grammatical error" when she noted in Mr. Richburg's medical file that she had received a prescription order for him on May 11, although she acknowledged the order was not actually given until nearly a week later. "Miss Gillespie, we've had nothing but mis-documentations," the coroner said. "It seems very strange to me that when the only time something is documented, it is the wrong date and the wrong time." Chief Deputy Coroner Ted Kennedy testified that Nurse Gillespie told him that she and other staff nurses did not always follow protocols in administering medications, although he added that she refused to admit to that in writing.

The chief deputy coroner also testified that another nurse, Vera Hanna, told him she had "never seen anything like the medical department at the jail," and that she "knows a lot of information that could get a lot people in trouble." Ms. Hanna, a registered nurse who no longer works at the 836-bed jail, testified that understaffing was a problem in the eight months she worked at the facility. She said she often was the only nurse on her shift. "When you have one medical staff (worker) for the whole facility, you can't follow protocol," she told jurors.

In August 2005, the family of Antonio Richburg filed a lawsuit against both Prison Health Services and Adriane Gillespie for failing to provide adequate mental health services to him. "We want to get this matter in front of a jury as quickly as possible," said attorney Dick Harpootlian, who represents the Richburg family and handled two other recent wrongful death lawsuits against Richland County and PHS. "Maybe we can save some lives," he told *The State*.

Mr. Harpootlian also represented the family of Marc Washington, an inmate that committed suicide in the jail in 2003. In that case, Mr. Washington tried to hang himself with his shirt and then with a string from his gym shorts shortly after his jail admission on October 17, 2003. He was subsequently transported to a forensic hospital. Shortly after his return to the jail 10 days later, Mr. Washington's hospital records were faxed to medical staff at the facility. Although the records did not contain a doctor's order recommending that he needed to be placed on suicide precautions, the accompanying fax cover sheet did indicate that the inmate should be observed for continued "suicidal gestures." Mr. Washington, however, was not placed on suicide precautions. Less than 10 hours later, he was found hanging from his cell door and later pronounced dead. A subsequent investigation found that a social worker from the state hospital made three attempts to notify medical staff at the jail that Mr. Washington should be placed "on suicide watch for suicidal gestures." Investigators also found that the inmate had not been observed by jail staff for over six hours. Two correctional officers later resigned after jail logs were found to be falsified to reflect that 30-minute cell checks were made (see ***Jail Suicide/Mental Health Update***, Volume 12, Number 3, Fall 2003, pages 14-15). The Washington lawsuit against the state hospital, county, and PHS was recently settled for approximately $185,000.

Dave Almeida, executive director for the state chapter of the National Alliance for the Mentally Ill, who attended the coroner's inquest of Mr. Richburg's death, told *The State* that Richmond County should consider terminating its contract with PHS. "This is the third death of an inmate during the time Prison Health Services was responsible for mental health treatment," he said. "Three deaths later, it just defies explanation as to why those gaps were not addressed the first time." In a prepared statement, PHS spokeswoman Susan Morgenstern declined comment on the latest lawsuit, citing patient confidentiality. But she defended the company's reputation. "Our staff works hard every day to provide quality health care services to our patients," she said. "We believe they do a commendable job."

In early September 2005, the Richland County Council voted unanimously to end its contract with PHS.

New Jersey

Timothy Greever, 22-years-old, was booked into the Salem County Correctional Facility in Woodstown on May 20, 2005 for violation of a restraining order. He was also battling a heroin addiction and thought to be going through withdrawal at the 416-bed county jail. Several days later on May 24, he was seen jumping feet-first off the second floor railing in his assigned housing unit. Mr. Greever sprained his ankle and, given the 10-foot distance of the jump, jail personnel were not particularly suspicious of the incident. "We figured if it was any attempt at suicide, he wouldn't have jumped feet first," Warden James Hefner told *Today's Sunbeam*. A few hours later, however, Mr. Greever fell down a flight of stairs, prompting suspicion and his placement under suicide precautions. He was subsequently assessed by a clinician from Healthcare Commons, the jail facility's mental health contractor, and a determination was made that Mr. Greever was not suicidal. On Thursday, May 26, he attended a court

hearing regarding the restraining order. Several hours later at approximately 2:30pm, jail staff found him hanging from a ceiling vent by a bed sheet. He was later pronounced dead.

Four weeks later on June 28, Lewis Sinclair, Jr. entered the Salem County Correctional Facility on a charge of violation of probation. While being transported to a court hearing that same day, he threatened suicide and was subsequently placed on suicide precautions. The 18-year-old was then assessed by a clinician from Healthcare Commons. He remained on suicide precautions. On July 9, jail staff found the young Mr. Sinclair hanging from a ceiling vent by a bed sheet. He was later pronounced dead. Following the death, Sheriff John Cooksey told *Today's Sunbeam* that "When dealing with this type of individual, we follow the directions of mental health professionals and use standard procedures in corrections. However, if someone has determined they are going to harm themselves it is very difficult to prevent that."

On September 9, 2005, Christopher Wilson became the third suicide victim in the county jail. The 21-year-old was found hanging from the top bunk in his cell by a bed sheet. He was later pronounced dead. The incident is still being investigated, but it is believed that Mr. Wilson was initially placed on suicide precautions and later removed from such observation prior to his death. His mother, Emily Wilson, was determined to learn what happened to her son, as well as the other two suicide victims. "I'm going to find out why this keeps happening," she told *Today's Sunbeam*. "I'll get to the bottom of this."

Sheriff Cooksey told the newspaper that his department has taken steps to prevent future suicides. For example, following Mr. Sinclair's death in July, the county purchased mesh screening to cover approximately 600 ventilation grilles in the facility. In addition, a new mental health provider has been hired, county freeholders have approved emergency funding to hire an on-site psychologist, and intake screening procedures are being revised to better assess suicide risk. The sheriff has also requested additional suicide prevention training of his staff. "This is an unfortunate incident," he said. "Our administration, medical staff and correctional officers are professionals and work hard to prevent these types of incidents."

Indiana

Juveniles accused of crimes need to be screened for mental-health problems and should be provided treatment when necessary, the Indiana State Bar Association told state legislators on October 4, 2005. "Ignoring children with these needs results in higher recidivism rates and increased public spending, particularly in terms of public safety, incarceration, and public welfare costs," attorney JauNae Hanger, an author of a report containing the association's recommendations, said in a statement. The report lays out 25 recommendations for state and local governments and the judicial system, culled largely from discussions at a summit last year called "Children, Mental Health and the Law."

Representatives of the bar association presented findings from the report at a meeting with the Commission on Mental Health, a legislative study group. The goal was to address the growing problem of juvenile offenders with mental-health issues. According to the Association's report, the vast majority of detained youth in the state are not screened, assessed or treated, even though more than half have mental-health or substance-abuse problems. "The consequences for these children can be severe," the report says. "When children with disabilities go without appropriate services, they may stay incarcerated two to three years longer than other children, and their risk of recidivism increases dramatically." The report cited research that found meaningful treatment programs can reduce recidivism and future involvement in the juvenile justice system by 25 percent to 80 percent.

Among the report's recommendations:

- A standard statewide program for screening, assessing and treating all youth who enter the juvenile justice system should be developed and implemented. The screening would not only help ensure that new detainees are not a threat to themselves or to others, but could also provide data that policy makers need to develop better programs in the future.

- Low-risk children with mental-health needs should be diverted to community-based treatment programs, rather than to juvenile detention centers. A pilot program should be developed that would divert some children from the juvenile justice system and focus instead on their mental-health treatment.

- More screening and assessments need to be used in the foster-care system and other family programs to identify children with mental-health needs before they become part of the juvenile justice system.

- Require that all juveniles be appointed attorneys to make sure they are mentally competent to stand trial. Currently, juveniles have a constitutional right to counsel but, in practice, many go without representation. Identify more state, federal and local funding to provide mental-health services to children.

- Create more programs in schools to help children with mental-health needs — they need to be treated before they cause problems in school and are expelled.

"There's a lot of students who get pushed through the education system without a recognition of illness, learning disabilities, retardation, addictions, eating disorders," Larry Landis, executive director of the Indiana Public Defender's Council, told *The Courier-Journal*. "The people who see them are not necessarily trained in spotting and detecting and differentiating between a kid who's high on marijuana or someone with a mental deficiency or illness or severely depressed." Many of the crimes youth commit are "kids acting out" because they are abused or neglected or because they can't cope, Mr. Landis stated. "There's a desperate cry for attention and help," he added. "And the juvenile justice system is supposedly designed to help kids…..but it's more of a punishment-based model."

The report's recommendations are similar to those that mental-health advocates have sought for years, said Steve McCaffrey, president of the Mental Health Association in Indiana. But he still welcomed the report. "Broadening the advocacy groups in this area to include the legal community as well as others can only help," Mr. McCaffrey told *The Courier-Journal*. "The more we're able to include the legal community, the better it will be for kids."

For more information on the report, contact the Indiana State Bar Association, One Indiana Square, Suite 530, Indianapolis, IN 46204, (800) 266-2581; e-mail: isbaadmin@inbar.org

California

More than 100 patients, including suspects awaiting trial and defendants who have been found not guilty by reason of insanity, sit on a waiting list to be admitted to Napa State Hospital, which is already above capacity. A county deputy public defender said her client has been languishing in Marin County Jail in San Rafael for almost four months after being declared mentally incompetent to stand trial on attempted rape charges. "They sit here for a long time," public defender Deborah Lewis told the *Marin Independent Journal* after a recent court hearing in October 2005. "We need to get more hospitals but nobody wants to fund it." Her client, William Velkoso, has schizophrenia and was ordered to Napa State Hospital for treatment, but the facility has no available beds.

The transfer of a mentally incompetent defendant from county jail typically takes several weeks, according to Ms. Lewis. With the backlog, suspects are waiting months. Mr. Velkoso's "rights are being violated," she said. "It's really a lose-lose situation for anyone. They can't get a speedy trial because we can't get them to the hospital to get ready for trial."

Kirsten McIntyre, a spokeswoman for the state Department of Mental Health, said hospitals are doing everything they can to make more room for patients. "The trouble is there is a cap on how many patients we can have," Ms. McIntyre said. "If we don't have the space, we don't have the space."

The embattled Napa State Hospital is undergoing a series of changes after a recent scathing U.S. Justice Department report that found systemic problems at several state hospitals, including patients who overdosed on illegal drugs or were left for up to 12 hours in soiled diapers. Stephen Mayberg, the head of the state Department of Mental Health, assured officials that the problems are being addressed during testimony last month before a state Senate committee. Among the problems, the Justice Department investigators found that some patients went as long as four weeks without a bath at the Napa facility. One patient strangled his roommate, another assaulted other patients at least 20 times in five months, and several patients hanged themselves. The June 2005 investigative report regarding conditions at the Napa State Hospital can be accessed at the Justice Department's website: http://www.usdoj.gov/crt/split/documents/napa_findlet_6-27-05.pdf ❑

JAIL SUICIDE/MENTAL HEALTH UPDATE

This technical update, published quarterly, is part of the National Center on Institutions and Alternatives (NCIA)'s continuing efforts to keep state and local officials, individual correctional staff, mental health/medical personnel, and interested others aware of developments in the field of jail suicide prevention and jail mental health services. Please contact us if you are not on our mailing list. Readers are encouraged to offer opinions and/or submit pertinent materials for inclusion into future issues.

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Unless otherwise noted, all articles appearing in this newsletter are written by Lindsay M. Hayes, Editor/Project Director.

AVAILABLE JAIL/PRISON/JUVENILE SUICIDE PREVENTION MATERIALS

And Darkness Closes In...National Study of Jail Suicides (1981)
National Study of Jail Suicides: Seven Years Later (1988)
Training Curriculum on Suicide Detection and Prevention in Jails and Lockups—Second Edition (1995)
Curriculum Transparencies—Second Edition (1995)
Prison Suicide: An Overview and Guide to Prevention (1995)
Juvenile Suicide in Confinement: A National Survey (2004)
Jail Suicide/Mental Health Update (Volumes 1-12)

For more information regarding the availability and cost of the above publications, contact either:

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