JAIL SUICIDE/MENTAL HEALTH UPDATE

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THE TRAGIC LIFE OF BRENDA MOMBOURQUETTE

According to available records, 42-year-old Brenda Mombourquette was first confined in the Monroe County Jail in La Crosse, Wisconsin on September 18, 2002 for various charges, including theft, violation of probation, and possession of narcotics. An intake medical screening form was completed by booking staff. It appeared mostly unremarkable, except the top of the form, which solicited the booking officer's visual opinion of the inmate, was not completed. The bottom of the form indicated that Ms. Mombourquette admitted to having a prescription for Zoloft, a psychotropic medication. Nursing staff subsequently called her fiancée who agreed to bring the medication to the jail. The following day, Ms. Mombourquette submitted an inmate medical request form asking for relief from Oxycontin withdrawal. Nursing staff subsequently contacted her counselor from Franciscan Skemp Healthcare Clinic and scheduled the clinician to visit the inmate that day. On September 21, Ms. Mombourquette submitted another inmate medical request form complaining of anxiety.

On September 26, Ms. Mombourquette was seen again by nursing staff complaining of anxiety. According to the nursing notes, the inmate was "tearful — upset about not being with her children — states 'I am so stupid' — states she has been having anxiety attacks while in jail — states she doesn't fall asleep until 4am." She was then seen by the jail's physician's assistant who prescribed Lorazepam. Ms. Mombourquette submitted another inmate medical request form the following day stating that the current one milligram dose of Lorazepam was ineffective. She requested an increase to two milligrams, stating "I can't deal with this anxiety another day." Ms. Mombourquette was released from the Monroe County Jail on September 30, 2002, with no indication that she had been further evaluated for an increase in medication.

On November 10, 2002, Ms. Mombourquette was again confined in the Monroe County Jail following her arrest on various charges, including burglary, bail jumping, and possession of drugs. An intake medical screening form was completed by booking staff and appeared unremarkable except for Ms. Mombourquette's admission that she had a prescription for Zoloft, a psychotropic medication. In addition, although she denied any prior history of psychiatric care, Monroe County Jail records clearly indicated that she had been seen by a clinician from Franciscan Skemp Healthcare Clinic in La Crosse during her September 2002 confinement, as well as being prescribed various psychotropic medications.

During the late morning of November 12, nursing staff were called to the shower area of Ms. Mombourquette's cellblock by other inmates who had found her lying on the floor in the prone position. Ms. Mombourquette stated that she was sitting on the toilet, became dizzy when starting to get up, and fell to the floor hitting her head. The inmate, who also became tearful, was taken to the emergency room of St. Mary's Medical Center for evaluation. She was returned to the jail approximately one hour later. A few hours later at approximately 2:00pm, Ms. Mombourquette's probation officer (Stan Roellich) came to the jail to interview the inmate. According to the shift log report for that day, Jail Officer Mary Stuart wrote that Mr. Roellich stated that "Mombourquette was sad and stating if she can not have her kids back what is the use of going on. Advised nurse of her attitude and feeling sorry for herself. Will keep an eye on her." Several hours later at approximately 8:18pm, the Shift Log Report indicated that the shift supervisor (Lieutenant David Schaldach) conversed with Ms. Mombourquette and wrote the following: "Talked with Mombourquette, very depressed, asked to talk to Tester, after talking with Tester she advised that she had nothing to live and couldn't make it in jail another night without killing herself." A subsequent entry by Lieutenant Schaldach indicated that Ms. Mombourquette had been seen by the jail nurse (Jeanne Reinart) and she was being moved "up front for observation" in the receiving cell.

According to the shift log report, Nurse Reinart called the jail at approximately 7:30am on November 13 and stated "we should keep an eye on" Ms. Mombourquette. Several hours later at approximately 4:45pm, Ms. Mombourquette requested to see a nurse. The jail officer (Lanita Leis) told the inmate to fill out an inmate medical request form. Ms. Mombourquette compiled and returned the completed form to the officer. The form stated "cut wrist." When the officer inquired further, Ms. Mombourquette stated she had cut her wrists and neck with the metal frames from her eyeglasses. The inmate was examined by the jail nurse (Candace Warner). A note, dated November 13, was later found in her cell stating: "Please give Kevin Wall permission to take any of my belongings such as papers, folders and license card and purse." Due to her self-injurious behavior (which was later treated

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with bandages at the hospital), a decision was then made to initiate a 72-hour emergency detention of Ms. Mombourquette for a psychiatric evaluation. Ms. Mombourquette was then transferred to the Gundersen Lutheran Medical Center in La Crosse for evaluation.

Ms. Mombourquette remained hospitalized for six days and was discharged back to the Monroe County Jail during the afternoon of November 18. Discharge instructions from the Gundersen Lutheran Medical Center listed the inmate's prescribed medication (Ultram, Ativan, Detrol, and Zoloft) as well as instructions for "suicide watch" upon return to the jail. However, upon her return to the facility, Ms. Mombourquette was inexplicably housed in South Block, a general population unit, without any suicide precautions. She subsequently submitted an inmate medical request form asking that her prescriptions be filled. She was seen soon thereafter by the jail nurse (Jeanne Reinart) and jail officer (Michael Wildes). Although she denied any current suicidal ideation, Ms. Mombourquette informed the nurse and officer that she had attempted suicide while at the hospital. According to the nurse's note, Ms. Mombourquette stated that "I hung myself in the bathroom with a sheet. I didn't really want to kill myself. The staff didn't check on me every 15 minutes — they were at a meeting."

On November 18, the daily pass-on log at the Monroe County Jail stated the following: "Mombourquette — Suicidal — tried to hang herself at Gunderson." The following day, Ms. Mombourquette submitted an inmate medical request form asking for Ultram (a painkiller) and a pillow and blanket due to pain in her knee. She was seen soon thereafter by a jail nurse (Candace Warner) and jail officer (Sande Wegner). According to the nurse's note, the inmate was given an extra pillow but the "extra blanket was not approved due to suicide gestures — will get thicker blanket instead." Nurse Warner also called the Gundersen Lutheran Medical Center and verified that Ms. Mombourquette had attempted suicide at the facility. The daily pass-on log was then amended to read: "Mombourquette S/BLK — Allowed to have another pillow, per nurse Candace. She now has two pillows. Also learned Mombourquette tried to hang herself while a Lax. Luth?" This notice was listed on the daily pass-on log each day from November 19 through November 22.

According to the shift log report for November 22, a facility-wide cell check (including South Block) was performed by a jail officer (Patricia Fish) at 2:36pm. Approximately 21 minutes later at 2:57pm, another jail officer (Anna Janusheske) found Ms. Mombourquette hanging from the bars in her cell by a towel (which was later determined to be a bed sheet). The officer called for assistance and then left the cell block area to open the door. In the meantime, another inmate (Julie Arttus) entered Ms. Mombourquette's cell and tried to lift the victim up in order to relieve pressure from the ligature. Two officers (Patricia Fish and Michael Wildes) and a nurse (Jeanne Reinart) subsequently responded to the scene, cut the ligature, placed Ms. Mombourquette on the bunk, and initiated cardiopulmonary resuscitation. Emergency medical services personnel subsequently arrived and continued life-saving measures. Ms. Mombourquette was then transported to St. Mary's Medical Center for further treatment. It was subsequently determined that she had suffered severe and permanent brain damage as a result of the suicide attempt.

The Lawsuit

In February 2006, the family of Brenda Mombourquette filed a lawsuit in the United States District Court for the Western District of Wisconsin in Madison. Named as defendants were Sheriff Charles Amundson, nurses Jeanne Reinart and Candace Warner, Lieutenant David Schaldach, and officers Sandi Wegner, Anna Janusheske, Mike Wildes, Janita Leis, Sue Wieman, and Patricia Fish. The federal complaint alleged that the defendants displayed deliberate indifference to Brenda Mombourquette, the proximate result of which was her serious suicide attempt in the Monroe County Jail on November 22, 2002.

The plaintiff was able to establish three main facts during the discovery phase of the lawsuit. *First*, there was overwhelming evidence to show that Brenda Mombourquette was a continuing risk for suicide in the Monroe County Jail, and that continuing risk was known to the defendants. *Second*, despite the knowledge that Ms. Mombourquette was at risk for suicide, the defendants ignored

NATIONAL STUDY OF JAIL SUICIDES

Through a cooperative agreement with the National Institute of Corrections (NIC), U.S. Justice Department, the National Center on Institutions and Alternatives (NCIA) is currently conducting a national study on jail suicides. The 18-month project, representing the third such national study conducted by NCIA for NIC (e.g., see *And Darkness Closes: A National Study of Jail Suicides* in 1981 and the *National Study of Jail Suicides: Seven Years Later* in 1988), will determine the extent and distribution of jail suicides (i.e., city, county, and police department facilities) during 2005 and 2006, and gather descriptive data on demographic characteristics of each victim, characteristics of the incident, and characteristics of the jail facility which sustained the suicide. NCIA will then develop a report of the findings to be utilized as a resource tool for both jail personnel in expanding their knowledge base, and correctional (as well as mental health and medical) administrators in creating and/or revising policies and training curricula on suicide prevention.

Data provided by individual agencies/facilities will be coded and held in the strictest confidence. Results of the study will be presented in summary fashion, thus preventing the linkage of any data to the particular agency/facility from which the information originated.

Initial surveys will be distributed in early 2007. Both NIC and NCIA would greatly appreciate the cooperation of all agencies/facilities receiving the initial survey request. For further information on the project, please contact Lindsay M. Hayes, Project Director, NCIA, 40 Lantern Lane, Mansfield., MA 02048, (508/337-8806), e-mail: lhayesta@msn.com

that risk by failing to place her on suicide precautions (or "suicide watch") and that failure resulted in her serious suicide attempt. *Third*, the Monroe County Sheriff's Department had grossly inadequate policies and practices in the area the suicide prevention (particularly levels of observation and safe housing) that were the proximate causes of Ms. Mombourquette's serious suicide attempt because it was reasonable to assume that the provision of grossly inadequate supervision for continuing suicidal behavior, as well as placement in a dangerous cell, would ultimately result in her suicide or serious suicide attempt.

Notice of Continuing Risk for Suicide

There was overwhelming evidence to show that Brenda Mombourquette was a continuing risk for suicide in the Monroe County Jail, and that continuing risk was known to the defendants. Jail officers, jail supervisors, and nursing staff disregarded this obvious risk by failing to take appropriate steps to ensure Ms. Mombourquette's safety during her confinement in the Monroe County Jail from November 10 thorough November 22, 2002. The risk was graphically exemplified by the following facts known to the defendants:

- She was known to suffer from depression and anxiety, and, in light of her legal problems, was deeply concerned about the custody of her two young children; she was observed to tearful, crying, and anxious on numerous occasions during confinement;
- She was taking a variety of psychotropic medication (Ativan, Detrol, Lorazepam, and Zoloft) to alleviate her mental illness;
- Her probation officer interviewed her on November 12 and told jail staff that she was sad, concerned about her children, and threatened suicide;
- A shift supervisor conversed with her on November 12 and described her as "very depressed" and "couldn't make it in jail another night without killing herself;"
- She engaged in self-injurious behavior by cutting her wrists and neck on November 13. As a result, a 72-hour emergency detention for a psychiatric evaluation was initiated. A suicide note was found in her cell;
- She attempted suicide by hanging while at the Gundersen Lutheran Medical Center;
- Upon discharge from the hospital on November 18, nursing and jail staff were instructed to place her on "suicide watch"; and
- She was not approved to receive an extra blanket on November 19 "due to suicide gestures."

Risk of Suicide Was Ignored by Defendants

Despite the knowledge that Ms. Mombourquette was at risk for suicide, the defendants ignored that risk by failing to place her on suicide precautions (or "suicide watch") and that failure resulted in her serious suicide attempt. For example, when Ms. Mombourquette threatened suicide on two separate occasions on November 12, jail and nursing staff chose not to place her on suicide watch; rather they decided to move her to a receiving cell (referred to as the "birdcage") and "keep and eye on her." Not surprisingly, she was able to engage in self-injurious behavior while in this observation cell. In addition, when Ms. Mombourquette was discharged from the Gundersen Lutheran Medical Center and returned to the Monroe County Jail on November 18 with explicit instructions for "suicide watch," jail and nursing staff chose not to place her on suicide watch; rather they decided to house her in a general population cell (in South Block). Even when confronted with a request by Ms. Mombourquette for an extra blanket on November 19, the jail nurse (Candace Warner) denied the request because of her "suicidal gesture," but allowed her to continue to be housed in a dangerous general population cell (that contained open-faced cell bars) with a bed sheet and without any increased observation by jail staff.

Further, the defendants chose not to solicit any input of the clinician (Kimberly Buchanan) from the Franciscan Skemp Healthcare Clinic when that clinician arrived to see Ms. Mombourquette on the day of her serious suicide attempt, nor did they ever seek the assistance of crisis intervention services from the Monroe County Human Services Department during her confinement. Ironically, Ms. Mombourquette had seen Ms. Buchanan shortly before her suicide attempt on November 22. It was suggested by counsel for the defendants that Ms. Mombourquette was provided a "suicide risk assessment" by Ms. Buchanan and found not to be suicidal. This position, however, was simply not supported by the facts in the case. Ms. Buchanan later testified during her deposition that she did *not* even recall specifically asking Ms. Mombourqette about the issue of suicide, and was *not* aware that she threatened suicide on November 12, *not* aware that she cut her wrists on November 13, *not* aware that her transfer to the Gunderson Lutheran Medical Center on November 13 was based upon an emergency detention for psychiatric evaluation, *not* aware that she attempted suicide at the hospital, and *not* aware that the discharge instructions from the hospital recommended that she be placed on suicide watch.

Finally, the deposition testimony of various defendants provides additional evidence that the management of Ms. Mombourquette's suicidal behavior was ignored in this case. Most deponents agreed that "suicide watch" in the Monroe County Jail meant observation at 15-minute intervals. All deponents agreed that Ms. Mombourqette was *not* on suicide watch at any point during her confinement in the Monroe County Jail. All deponents also agreed that observation of inmates on suicide watch and/or "special watch" should be documented in the shift log report. It was clear from review of the shift log report that Ms. Mombourquette was *not* observed on any "special watch" status. Nurse Reinart stated during her deposition that she interpreted the discharge instructions from the Gundersen Lutheran Medical Center to place Ms. Mombourquette on "suicide watch" to mean "observe her closely" and "it's up to the lead officer on how to carry that out." Nurse Reinart also stated that "I believed, with all the assessment tools that I have in my knowledge base, that she would be better off under close observation in general population because, like I said

before, sometimes if we put them on one-on-one or you put them up in the observation cell, that causes more anxiety and just escalates the situation." Such responses are faulty and simply contrary to Monroe County Jail policy. In fact, Nurse Reinart later acknowledged that there were no provisions for "one-on-one" observation in the jail.

Suicide watch in the Monroe County Jail meant observation at 15-minute intervals, not "observe closely" with the lead officer determining the frequency of observation. In addition, the policy did not provide the option for close observation in general population for suicidal inmates, rather the policy designated either the observation or a holding cell for suicide watch. Nurse Reinart's definition of "close observation" as simply "more frequent checks than the hourly standard" was simply not believable given Ms. Mombourquette's suicidal behavior.

Jail Officer Anna Janusheske stated in her deposition that "I don't know if we took any special checks on her, because she was in the block with five other girls, and they were locked in the day room from 8:00 o'clock in the morning to 1:00 in the afternoon." This response ignored the fact that there are more than five hours in a day and that Ms. Mombourquette's serious suicide attempt occurred in mid-afternoon when she was alone in her cell.

Perhaps Sheriff Charles Amundson provided the most interesting testimony in this case. While acknowledging that an inmate "should be placed on suicide watch if it was recommended by the hospital," he was not "critical of any (of the staff)….I think everybody did everything right."

Grossly Inadequate Policies and Practices

The Monroe County Sheriff's Department had grossly inadequate policies and practices in the area of suicide prevention (particularly levels of observation and safe housing) that were the proximate causes of Ms. Mombourquette's serious suicide attempt because it was reasonable to assume that the provision of grossly inadequate supervision for continuing suicidal behavior, as well as placement in a dangerous cell, would ultimately result in her suicide or serious suicide attempt. The one-page suicide prevention section of the county jail policy stated that "whenever available, suicidal inmates will be housed in the observation cell. If the observation cell is not available, a holding cell will be utilized with only a mattress, pillow and no uniform, in critical cases….Cell checks will be conducted at 15 to 30 minute intervals, wherein the cell checks will be logged." In contradiction to this observation level, another section of the jail policy stated that "an inmate who is classified suicidal or who had medical/alcohol problems should be monitored in five (5) to fifteen (15) minute intervals, depending on the individual's condition. Said inspection shall be recorded on all shifts."

The plaintiff expert in the case testified in deposition that the Monroe County Jail policies and procedures were grossly inadequate, and contrary to national standards established by both the American Correctional Association and the National Commission on Correctional Health Care. They also violated the Wisconsin Department of Corrections' county jail standards which requires county jails to maintain a suicide prevention program that contains the following components:

- Assessment of an inmate's suicide risk at booking and documentation of the results.
- Designation of person who may assess an inmate's level of suicide risk and who may authorize placement on and removal from a suicide watch status for inmates who are suicide risks.
- Identification of housing areas for inmates who are suicide risks.
- Referral of inmates who are suicide risks to mental health care providers or facilities.
- Supervision of inmates who are suicide risks, including frequency of observation and documentation of supervision.
- Communication between health care and jail personnel regarding the status of an inmate who is a suicide risk.
- Intervention of a suicide in progress, including first aid measures.
- List of persons to be notified in case of potential, attempted or completed suicides.
- Documentation of actions and decisions regarding inmates who are suicide risks.

In addition, the *Training Guide for Jail Officers — Supervise "Special" Inmates* from the Wisconsin Department of Justice, Law Enforcement Standards Board provided additional guidance to county jails regarding the development of suicide prevention policies that was seemingly ignored by Monroe County. For example, in the areas of levels of observation and safe housing, the following was offered in the *Training Guide*:

> In most jails, if an inmate is assessed as being suicidal, he or she is put into a classification known as "suicide watch" or "special watch," which will result in the following procedural actions being taken:
>
> - The inmate will be housed in a safe area where he or she can be closely and frequently checked;
> - Certain security precautions will be taken to try to prevent the inmate from harming him/herself; and
> - Other specific intervention, such as medical/mental health care, may be initiated.
>
> Within the general classification category of "suicide watch," different actions will be taken with different inmates. Some inmates in this general classification may be assessed as being lower or moderate risks, and will therefore require a certain level of suicide prevention response; while other inmates may be assessed as higher risks, and will therefore require a higher level of suicide prevention response.

According to the *Training Guide*, inmates who are higher risks or actively suicidal should be observed on a constant basis or at least every 4 to 5 minutes. Inmates who are a lower or moderate risk should be observed every 5 to 15 minutes. With regard to safe housing, the *Training Guide* states that "this may be in a receiving or holding cell which is close to the control room. Ideally, such a cell or room should be 'suicide-resistant' to the maximum extent. This means, among other things, that it should contain no means for an inmate to hang or otherwise harm himself or herself."

In sum, the plaintiff's expert testified that the Monroe County Sheriff's Department's suicide prevention policy was grossly inadequate in several ways. For example, it offered contradictory levels of supervision (5 to 15 minute intervals and 15 to 30 minute intervals). There were *no* provisions for constant observation of actively suicidal inmates. There were *no* provisions for qualified mental health professionals to assess inmates at risk for suicide, including seeking the assistance of crisis intervention services from the Monroe County Human Services Department. There were *no* provisions for classifying suicidal inmates by risk level, continuing assessment, and discharge. There were *no* provisions for safe or suicide-resistant housing of suicidal inmates. (Ironically, the Monroe County Sheriff's Department substantially revised its suicide prevention policy in April 2003, expanding it from 1 to 22 pages, several months after Ms. Mombourquette's serious suicide attempt. There was no reasonable explanation as to why this revised policy could not have been in place prior to the incident.)

Finally, evidence in the case was supplemented by the fact that the Monroe County Sheriff's Department was cited numerous times by the Wisconsin Department of Corrections (DOC) for areas related to suicide prevention. For example, in October 2002, one month prior to Ms. Mombourquette's serious suicide attempt, the state jail inspector stated in his report that "proper segregation is of special concern in regards to housing high-risk inmates including those with mental health issues, those considered suicide risk, violent and combative inmates, and those with significant medical issues." It was the *seventh* consecutive year that the Monroe County Sheriff's Department had been cited by the DOC. The October 2002 inspection report also found problems with intake screening (i.e., "First line supervisors are not reviewing reports for accuracy, legibility, and completeness. Many reports failed to contain information necessary for proper mental health or medical health decisions") and mental health referrals ("Staff members are not clear on procedural issues related to inmate mental health referrals. Documentation is an important component of this program. Currently there is no procedure in place for documenting mental health or crisis intervention visits within the jail or to outside vendors. Documentation is an important component for coordinating the appropriate level of classification, supervision, and continuity of care").

The Defense:
Denial of Risk, Manipulative Behavior, and Reasonable Care

Defense counsel essentially relied upon three theories as to why the defendants were not deliberately indifferent to Brenda Mombourquette. *First*, they argued that Ms. Mombourquette denied any suicidal ideation when she returned to the jail from the Gundersen Lutheran Medical Center on November 18. This argument, of course, ignores the fact that the hospital discharge instructions clearly included the recommendation for "suicide watch." The defendants argued that the term "suicide watch" was vague because it did not include a time interval or duration, and the form was not signed by a doctor. Defense counsel utilized a psychiatrist to defend their position. The defense expert offered the following incredible testimony:

> There was a note from the hospital that Ms. Reinart believed was written by a nurse that suggested she be placed on suicide watch. Ms. Reinart interviewed Ms. Mombourquette and....concluded it was in Ms. Mombourquette's best interest to be placed in the general population, with careful observation. Though Ms. Reinart believed this would lead to her being observed more than the routine hourly checks, that is apparently not how her suggestion was interpreted. Rather, it was interpreted that during checks she should be more carefully scrutinized. Given that there was much reason to believe that Ms. Mombourquette was not acutely suicidal, and there was concern that watching her too closely might increase rather than help with her safety risk, that was not an unreasonable conclusion….

On January 12, 2007, United States District Court Judge Barbara B. Crabb for the Western District of Wisconsin issued a pre-trial opinion in the case. In addressing the defense argument that Ms. Mombourquette denied suicidal ideation, Judge Crabb wrote that the Supreme Court has held explicitly that knowledge of a risk of harm need not come from the plaintiff herself. In *Farmer v. Brennan*, the Supreme Court held "that it would be error to absolve officials of liability simply because statements from the plaintiff did not indicate that she was in danger. In this case, there was questionable value in plaintiff's self reporting of her mental state when she was under severe stress, on multiple psychotropic medications and recovering from a drug addiction, suffering multiple mental health conditions and returning from an involuntary commitment to a hospital."

Second, the defense argued that Ms. Mombourquette displayed manipulative behavior during her confinement in the Monroe Couny Jail and hospitalization at the Gundersen Lutheran Medical Center. Another defense expert, a college professor, offered the following opinion:

> It does not appear that Gunderson Lutheran mental health personnel believed Mombourquette to be truly suicidal but rather believed she was attempting to manipulate the system in order to stay in the hospital rather than the jail. Her probation officer believed Mombourquette was manipulative, and Mombourquette told her psychologist Kimberly Buchanan that she wanted to return to Gunderson Lutheran so she could receive visits from her children and boyfriend. Brenda Mombourquette also told Nurse Reinart that she had simulated an attempt at Gunderson (when staff became inattentive). She said she did not really want to kill herself.

Of course, such an opinion ignores the fact that any inmate who would go to the extreme of engaging in self-injurious behavior is

suffering from at least an emotional imbalance that requires special attention. It also assumes that inmates who appear manipulative are not also suicidal, that is, believing they are members of mutually exclusive groups.

The Court was also not persuaded by this defense argument. Judge Crabb wrote that:

> ….whether plaintiff was being "manipulative" is close to irrelevant. The important question is this: did plaintiff pose a serious risk of harm to herself? Defendants point to nothing in the record suggesting that Reinart believed a person who harms herself for "manipulative" reasons is less likely to make another attempt. Defendants' own training materials confirm what common sense would already suggest: "The more attempts a person has made, the greater the likelihood that the person will eventually die from suicide. *This is true even of inmates who made several attempts that seem to be attempts at manipulation of jail staff*." (Emphasis added.) In this case, plaintiff had demonstrated that she was capable of hurting herself when she cut her wrists on November 13 and tried to hang herself with a sheet on November 14. It matters little *why* she did these things, that is, whether she actually wanted to kill herself or was just seeking to use these attempts to seek some secondary gain. If she did it twice before, she was likely to do it again.

Third, the defense simply argued that inmate suicides are difficult to prevent and Monroe County Jail personnel provided reasonable care to Brenda Mombourquette. One defense expert concluded that "this case further emphasizes what is already known to social and behavior scientists: imminent suicide is extremely difficult if not impossible to predict," while the defense psychiatrist opined, "I see no evidence to suggest that Ms. Mombourquette was treated by staff at the Monroe County Jail with deliberate indifference….To the contrary, it appears she was carefully evaluated and thoughtfully attended to."

The Court ruled that it was relatively easy to find deliberate indifference in this case and Monroe County Jail personnel were "running amok without any supervision" and direction from the sheriff in a facility that lacked adequate policies and procedures on managing suicidal inmates. Judge Crabb wrote that:

> It seems that no one at the jail wanted to take responsibility for dealing with plaintiff once she returned from the hospital. This began from the moment she reentered the jail. Despite defendants' knowledge that plaintiff had been hospitalized for a suicide attempt, they did not assess her mental health status or deliberate about her proper classification. Instead, defendants simply returned plaintiff without discussion to the south block in general population. It was not until plaintiff made a medical request that jail staff met with her.
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> Each of the defendants appears to believe that someone else should have taken charge. The officers argue in their briefs that defendant Reinart should have been responsible for determining whether plaintiff was a suicide risk. In her deposition, Reinart testified that "the lead officer" (presumably defendant Schaldach) should have determined what to do with plaintiff. In his deposition, defendant Schaldach testified that he did not know why plaintiff was not placed in observation, even though he was the shift supervisor on November 18. The likely reason that each party denies responsibility is that the jail's policy does not squarely place responsibility on anyone. Again, all jail staff are equally responsible under the policy, which not surprisingly means that all staff attempt to fix the blame on someone else.
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> Closely related, effective communication was also sorely lacking at the jail. Although many events were documented in various logs, there was no mechanism in place for determining what should be done about issues that were raised in these logs. This problem was demonstrated time and time again in plaintiff's case, most obviously when no one took action despite repeated statements in the logs that plaintiff had tried to hang herself while at the hospital. A reasonable jury could find that plaintiff's attempted suicide could have been prevented if defendant Amundson had in place a policy that more clearly delegated authority and established procedures for acting on information documented in the logs. In other words, the jury could find that "but for" defendant's Amundson's failures, the remaining defendants "would have taken reasonable steps to prevent [plaintiff] from [attempting to] tak[e] [her] own life." *Novack*, 226 F.3d at 532.

….whether plaintiff was being "manipulative" is close to irrelevant. The important question is this: did plaintiff pose a serious risk of harm to herself?

Conclusion

Judge Crabb's 69-page pretrial ruling in *Mombourquette v. Amundson* (reprinted below) was devastating to the defendants. All of the defense motions were denied. In February 2007, on the eve of trial's opening, defense counsel agreed to settle the lawsuit. Monroe County agreed to pay the estate of Brenda Mombourquette $6.1 million if she dies within 13 years and no more than $13.1 million over her lifetime. Now 46-years-old, Ms. Mombourquette continues to experience severe and permanent brain damage requiring 24-hour care. The settlement also includes funds to allow her two daughters to attend college. "No amount of money could ever fix her. But maybe it can stop it for other people," plaintiff attorney Michael Devanie told the *La Crosse Tribune*. "It doesn't take a lot to prevent a suicide. Over and over and over, you see it where the proper steps are taken (to prevent a suicide) — people walk out of jail and pass that bump in their life to correct their circumstances. This did not have to happen." Mr. Devanie has also called for an investigation into staff misconduct and other questionable practices within the Monroe County Sheriff's Department. "I hope there's an investigation into the circumstances that could lead a jail to be this dysfunctional," he said. "I hope there's some introspection there and changes made, because they need them desperately." ❑

MOMBOURQUETTE V. AMUNDSON

On January 12, 2007, United States District Court Judge Barbara B. Crabb for the Western District of Wisconsin ruled that summary judgment was not appropriate for any of the defendants in ***Mombourquette v. Amundson*** *(469 F. Supp. 2d 624) because a reasonable jury could find that each of them was deliberately indifferent to a substantial risk that Brenda Mombourquette would attempt to commit suicide in the Monroe County (Wisconsin) Jail. The defendants in the case were Sheriff Charles Amundson, nurses Jeanne Reinart and Candace Warner, Lieutenant David Schaldach, and officers Sandi Wegner, Anna Janusheske, Mike Wildes, Janita Leis, Sue Wieman, and Patricia Fish. Portions of the Court's 69-page opinion are reprinted below.*

Plaintiff Brenda Mombourquette attempted to commit suicide by hanging herself with a bed sheet while she was detained in the Monroe County jail. Although two previous attempts of self harm several days earlier did not cause long lasting injury, plaintiff was left seriously brain damaged after she made a third attempt. Plaintiff brought this suit under 42 U.S.C. §1983 through her sister and children against various jail staff members, who plaintiffs believe violated Brenda Mombourquette's constitutional rights when they failed to protect her from harming herself. (For the remainder of the opinion, I will refer to plaintiff Brenda Mombourquette simply as "plaintiff" because most facts relevant to summary judgment relate to her solely.) Each of the defendants moved for summary judgment in three different groups: (1) defendants Charles Amundson, Candace Warner, Sandi Wegner, Anna Janusheske, Mike Wildes, Janita Leis, Sue Wieman and Patricia Fish; (2) defendant Jeanne Reinart and (3) defendant David Schaldach, who adopted the briefs and proposed findings of fact submitted by the other parties.

As an initial matter, it is important to understand the scope of plaintiff's claims. Although plaintiff does not say explicitly, it is clear from a review of her complaint, her brief opposing defendants' motions for summary judgment and her proposed findings of fact that her claim is directed at defendant's failure to prevent her attempted suicide on November 22, 2002. I do not understand plaintiff to be asserting a separate claim for the failure to prevent her from cutting her wrists on November 13. Rather, I understand her to be relying on facts surrounding that incident as evidence of defendants' deliberate indifference to her suicide attempt on November 22.

In addition to defendants' motions for summary judgment, two other motions are before the court: (1) plaintiff's motion to supplement her summary judgment materials with a document she obtained after filing her opposition brief; and (2) defendant Schaldach's "motion in limine" to exclude evidence that he engaged in sexual activity with another female inmate while plaintiff was detained at the Monroe County jail.

Both motions will be denied. With respect to the motion to supplement the record, plaintiff seeks to add a 2004 resignation letter from the jail administrator to defendant Charles Amundson. However, the document adds no new evidence to the record, so it is unnecessary to consider its admissibility. For reasons discussed further below, defendant Schaldach's motion in limine must be denied because plaintiff's complaint about Schaldach's misconduct may be relevant to show that both defendants Schaldach and Amundson were deliberately indifferent to plaintiff's health and safety.

Cases involving an unfortunate event like a jail suicide attempt are difficult for all parties involved. They are difficult as well for a judge or juror, who must resolve disputed issues on the basis of the law and not on feelings of sympathy either for plaintiffs, who have suffered greatly, or for defendants, who have a difficult and often thankless job. As is usually the case, the facts are not one-sided. However, I conclude that summary judgment is not appropriate with respect to any of the defendants because a reasonable jury could find that each of them was deliberately indifferent to a substantial risk that plaintiff would attempt to harm herself.

Opinion

I. Motion in Limine

Because it affects plaintiff's claims against multiple defendants, I consider first defendant Schaldach's motion to exclude evidence of his sexual activity with other inmates. Before permitting this evidence to be introduced, I must find that it is relevant, admissible and not unfairly prejudicial. In her brief opposing defendant Schaldach's motion in limine, plaintiff identifies three purposes of the evidence: (1) to show defendant Schaldach's motivation for failing to protect her; (2) to show that defendant Amundson was deliberately indifferent in failing to supervise defendant Schaldach; (3) to show that defendant Schaldach was sexually harassing plaintiff.

With respect to the third purpose, evidence that defendant Schaldach was sexually harassing plaintiff would certainly be highly relevant to the question whether he was deliberately indifferent to her health and safety. However, plaintiff does not explain how evidence that Schaldach was engaging in sexual activity with someone else is admissible to show he was sexually harassing plaintiff, particularly when there is little to no other evidence that Schaldach was harassing plaintiff. Using the evidence for that purpose would be marginally relevant at best and would certainly be unfairly prejudicial.

Nevertheless, defendant Schaldach's motion in limine must be denied with respect to evidence that plaintiff *reported* Schaldach's misconduct because such evidence shows that Schaldach had a strong motive to withhold protection from plaintiff and is thus relevant to show that he intentionally disregarded a risk to plaintiff's safety. Although there is no evidence that Schaldach ever spoke to plaintiff about her complaint, the facts show that defendant Wieman told him about it. This is sufficient to establish Schaldach's intent. Although none of the defendants in this case acted to protect plaintiff, it is particularly puzzling why Schaldach, as the lead officer on November 18, failed to take any action once he learned that plaintiff tried to hang herself while she was at the hospital. Because plaintiff's accusation provides a possible motive for Schaldach's indifference, her reporting of it is relevant.

Although I agree with defendant Schaldach that the evidence is likely to be prejudicial, I cannot conclude that it is unfairly so.

In addition, evidence that defendant Amundson refused to investigate plaintiff's allegations of sexual misconduct is relevant to show his state of mind. In *Woodward v. Correctional Medical Services*, 368 F.3d 917, 930 (7th Cir. 2004), the court held in a jail suicide case that the defendants' refusal to correct or investigate staff misconduct that could affect the health and safety of inmates was relevant and admissible to show deliberate indifference, even when that misconduct was not related to suicide prevention directly. The court rejected arguments that such evidence was unfairly prejudicial or barred under Fed. R. Evid. 404. *Id*. Similarly, in this case, Amundson's dismissive attitude of a very serious complaint that could have a profound impact on the physical and psychological well-being of multiple inmates exhibits an attitude of deliberate indifference, both toward plaintiff's health and safety in particular and generally toward the health and safety of all the inmates at the jail. Although the relevance of this evidence is somewhat limited (this is not a case about sexual harassment after all), defendant Schaldach has not shown that any unfair prejudice to him or defendant Amundson substantially outweighs the probative value of the evidence. Fed. R. Civ. P. 403. The motion in limine will be denied.

II. Motions for Summary Judgment

The Constitution guarantees persons in state or local custody a limited right to be protected from harm. *Farmer v. Brennan*, 511 U.S. 825 (1994). In determining whether this right has been violated, the standard is the same, regardless whether the person is a convicted prisoner or detainee, a victim of violence at her own hand or the hands of others. The question is whether the defendants were deliberately indifferent to a substantial risk of serious harm. *Cavalieri v. Shepard*, 321 F.3d 616 (7th Cir. 2003). (The Supreme Court has noted, and the court of appeals has repeated on several occasions, that pretrial detainees are entitled to "at least" the same protection under the Fourteenth Amendment's due process clause as convicted prisoners are under the Eighth Amendment, suggesting that the standard of review could be different for pretrial detainees like plaintiff. See, e.g., *City of Revere v. Massachusetts General Hospital*, 463 U.S. 239, 244 (1983); *Henderson v. Sheahan*, 196 F.3d 839, 854 (7th Cir. 1999); *Payne v. Churchich*, 161 F.3d 1030, 1040 (7th Cir. 1998). Despite this observation, I am unaware of any case in which the Supreme Court or the court of appeals has applied a different standard of review in detainee cases. In any event, both sides assume that a "deliberate indifference" standard applies, so I will do the same.)

Not surprisingly, defendants do not argue that plaintiff's harm was insufficiently serious to trigger constitutional protections. Rather, as in other cases involving suicide or attempted suicide, the question is whether plaintiff has adduced sufficient evidence to allow a reasonable jury to find that each of the defendants was deliberately indifferent to plaintiff's health and safety. As is often repeated, the deliberate indifference standard requires more than a finding of negligence but less than a showing of intentional harm. *Gil v. Reed*, 381 F.3d 649, 664 (7th Cir. 2004). The standard has two main parts. First, was the defendant subjectively aware of a substantial risk of serious harm to the plaintiff? *Farmer*, 511 U.S. at 828. Second, if the defendant was aware of the risk, did he respond reasonably to the risk, even if the harm was not ultimately averted? *Id*. at 844.

Of course, this test does not resolve all questions regarding the meaning of "deliberate indifference." For example, how great must a risk be before it is deemed "substantial" for the purpose of constitutional protections? The court of appeals has said only that it is more than "a mere possibility," *Pinkston v. Madry*, 440 F.3d 879, 889 (7th Cir. 2006), but less than a certainty, *Collignon v. Milwaukee County*, 163 F.3d 982, 990 (7th Cir. 1998). The Supreme Court has provided little guidance on this question and in fact expressly declined to consider it in *Farmer*, 511 U.S. at 834 n.3. In another Eighth Amendment case, the Court defined an "unreasonable risk" in part as one that society would not tolerate. *Helling v. McKinney*, 509 U.S. 11, 26 (1993). This suggests a meaning that is neither static nor rigid, but instead depends on the nature of the potential harm. In other words, the more serious a possible injury, the lower the threshold for showing that the risk is substantial. Cf. *In re Forty-Eight Insulations, Inc*., 115 F.3d 1294, 1300 (7th Cir. 1997) (adopting "sliding scale" approach to granting preliminary injunctions, in which requisite likelihood of success is contingent on balance of harms). For example, it is reasonable to expect officials to be more sensitive to a risk of death than to a risk of unsanitary conditions. "[W]e cannot equate death with dirty cells." *Wever v. Lincoln County*, Nebraska, 388 F.3d 601, 607-08 (8th Cir. 2004) (holding that what constitutes adequate notice under deliberate indifference standard "must change depending on the seriousness of the incident").

With respect to the second part of the test, defendants suggest that they were not required to respond "reasonably" to known risks. They cite *Cavalieri*, 321 F.3d at 622, which includes the statement that, in a suicide case, the defendant "was not required to take perfect action or even reasonable action." But this statement is best interpreted as simply rejecting the proposition that the Constitution adopts a negligence standard, which imposes liability whenever a defendant fails to recognize a risk that a "reasonable" person would recognize. *Restatement (Second) of Torts* § 283 (1965). Any other reading would conflict with *Farmer*, in which the Court held explicitly that an official is deliberately indifferent "if he knows that inmates face a substantial risk of serious harm and disregards that risk by failing to take reasonable measures to abate it." 511 U.S. at 847 (emphasis added).

Generally, the court of appeals has reiterated the standard from *Farmer* that officials must take reasonable steps when they are aware of a substantial risk of harm. *Borello v. Allison*, 446 F.3d 742, 747 (7th Cir. 2006); *Woodward*, 386 F.3d at 928; *Peate v. McCann*, 294 F.3d 879, 882 (7th Cir. 2002); *Sanville v. McCaughtry*, 266 F.3d 724, 737 (7th Cir. 2001); *Estate of Novack v. County of Wood*, 226 F.3d 525, 529 (7th Cir. 2000); *Estate of Cole by Pardue v. Fromm*, 94 F.3d 254, 258 (7th Cir. 1996). Accordingly, I conclude that the Constitution imposes a duty on government officials to respond reasonably to known risks of harm.

A) Defendant Reinart

I begin with defendant Jeanne Reinart, who was the only defendant to review plaintiff's discharge instructions from the hospital and

the first person plaintiff identifies who made a choice not to place plaintiff on suicide watch after she returned to the jail on November 18. (Although someone made the initial decision to place plaintiff in general population when she returned to the jail on November 18, neither side identifies who that was.) Defendants argue both that Reinart was not aware of a substantial risk of serious harm and that, even if she were aware of the risk, she responded adequately. (I refer to defendants collectively rather than to defendant Reinart alone because although Reinart filed her own brief in support of her motion for summary judgment, the other defendants make arguments in her defense and most of the arguments overlap Reinart's.)

1. Awareness of Risk

Under *Farmer*, 511 U.S. at 837, a plaintiff must prove not only that the defendant knew facts that would allow the drawing of inference that the plaintiff was at a substantial risk of harm, but also that the defendant actually "dr[e]w the inference." Thus, no matter how apparent the risk would be to a reasonable person, a defendant may avoid liability if she was in fact ignorant. However, a defendant does not immunize herself from trial simply by averring that she was unaware of a risk. A plaintiff may use circumstantial evidence to persuade the finder of fact that the defendant was aware of the risk, despite her protestations to the contrary. Further, although a defendant is not liable for obvious risks of which she remained unaware, the obviousness of a risk may be used as evidence that the defendant was aware that danger was present. *Id*. at 842. ("a factfinder may conclude that a prison official knew of a substantial risk from the very fact that the risk was obvious").

Viewing the evidence in the light most favorable to plaintiff, *Lopez v. City of Chicago*, 464 F.3d 711, 715 (7th Cir. 2006), I conclude that a reasonable jury could find that defendant Reinart was aware of the risk that plaintiff would attempt to harm herself again. In reaching this conclusion, I find two facts to be the most striking: (1) plaintiff's two previous attempts to harm herself within the previous ten days; and (2) plaintiff's hospital discharge instructions that she should be placed on a suicide watch.

By themselves, plaintiff's two previous attempts of self harm would be sufficient to create a jury question. In all of the published appellate cases I have reviewed, the court found that, when the defendants were aware of recent suicide attempts, it would be improper to grant summary judgment or judgment as a matter of law on the question whether defendants were aware of a substantial risk of serious harm. *Woodward*, 368 F.3d at 924, 928; *Cavalieri*, 321 F.3d at 621-22; *Hall v. Ryan*, 957 F.2d 402, 405 (7th Cir. 1992); *Perez v. Oakland County*, 466 F.3d 416 (6th Cir. 2006) (Cudahy, J.) (suicide attempt one month earlier); *Snow ex rel. Snow v. City of Citronelle, AL*, 420 F.3d 1262, 1270 (11th Cir. 2005) (inmate attempted to cut wrist one month earlier); *Turney v. Waterbury*, 375 F.3d 756, 760 (8th Cir. 2004) (previous suicide attempt at another facility); *Colburn v. Upper Darby Township*, 838 F.2d 663, 669 (3d Cir.1988); *Cabrales v. County of Los Angeles*, 864 F.2d 1454 (9th Cir.1988); *Partridge v. Two Unknown Police Officers*, 791 F.2d 1182 (5th Cir.1986) (suicide attempt in previous confinement). See also *Bradich ex rel. Estate of Bradich v. City of Chicago*, 413 F.3d 688 (7th Cir. 2005) (concluding that defendants were not deliberately indifferent in failing to prevent suicide while noting that inmate had not tried to injure himself before); *Brown v. Harris*, 240 F.3d 383, 390 (4th Cir. 2001) (defendant knew of suicide attempt week earlier; court assumed that defendant was aware of substantial risk but held that he acted reasonably by placing inmate on constant video monitoring); *Robey v. Chester County*, 946 F. Supp.

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 1997 thru 2006 to:

Lindsay M. Hayes, Project Director
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Mansfield, MA 02048
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333, 337-38 (E.D. Pa. 1996). Although the court concluded that summary judgment was appropriate in *Matos ex rel. Matos v. O'Sullivan*, 335 F.3d 553, 554 (7th Cir. 2003), the inmate in that case had attempted suicide three years before his incarceration and, more important, the defendants were unaware of it. The only specific sign that he was currently at risk was his saying that he was depressed over the recent death of his father.

When knowledge of plaintiff's suicide attempts is combined with instructions from the hospital to place plaintiff on suicide watch, it is clear that summary judgment is not appropriate with respect to this element. Although it is unnecessary to consider them, other facts suggest defendant Reinart was aware of a risk: (1) plaintiff was on medication for both depression and anxiety; (2) plaintiff had made multiple statements just days earlier that she was thinking of killing herself; (3) plaintiff had just returned from an emergency detention; (4) plaintiff had been upset since September about the prospect of losing her children, to the point that she could not sleep and anti-anxiety medications were not effective; and (5) plaintiff continued to face all of the stressors that led to her previous acts of self harm: continued incarceration and possible loss of her children and business. Despite defendant Reinart's awareness of these facts, defendants advance several arguments why they believe Reinart is entitled to summary judgment.

a) Medical Judgment

Perhaps defendants' most vigorously asserted argument is that, despite defendant Reinart's knowledge of plaintiff's past acts of self harm, the discharge instructions and the other information Reinart knew about plaintiff, Reinart made a medical judgment that plaintiff would not attempt suicide. In other words, defendants argue that despite Reinart's awareness of these facts, she concluded that plaintiff did not have a "serious medical need" triggering a constitutional duty to act. *State Bank of St. Charles v. Camic*, 712 F.2d 1140, 1145 (1983) (analyzing failure to properly diagnose suicidal tendencies as question whether defendants were deliberately indifferent to serious medical need).

Defendants seek to take advantage of the court of appeals' holding that when "professionals such as physicians, psychiatrists, and nurses" make a decision "within their area of professional expertise," there can be no liability under the Constitution for failing to recognize a risk of suicide unless "the professional's subjective response was so inadequate that it demonstrated an absence of professional judgment." *Collignon v. Milwaukee County*, 163 F.3d 982, 989 (7th Cir. 1998) (citing *Youngberg v. Romeo*, 457 U.S. 307, 323 (1982)). In other words, the court of appeals has held that unless there is evidence that the defendant did not use professional judgment, it would be unreasonable for a jury to find that the defendant was aware of the risk.

Initially, there is a question whether defendant Reinart was qualified to make a determination that plaintiff was no longer at risk for harming herself. The cases on which defendants rely, *Collignon*, *Fromm* and *Sanville* involved decisions of psychiatrists, each of whom had conducted mental health examinations of the inmate. In fact, in *Fromm*, 94 F.3d at 263, the court concluded that a "risk classification is most appropriately made by a licensed psychiatrist" and that "it would have been inappropriate for any of the nurses to change [the psychiatrist's] classification for anything other than a temporary basis without consulting a physician." (Emphasis added). See also *Perez*, 466 F.3d at 425 (reasonable jury could find that caseworker was deliberately indifferent when she took inmate off suicide watch without consulting psychiatrist).

Further, to the extent that some nurses might be qualified to make assessments about suicide risks, defendant Reinart has not shown that she is one of them. She avers vaguely in her affidavit that she received instruction on this issue in nursing school, but she does not provide any evidence about what the instruction was or how she used it to assess plaintiff. *Lujan v. National Wildlife Federation*, 497 U.S. 871, 888 (1990) ("The object of [summary judgment] is not to replace conclusory allegations of the complaint or answer with conclusory allegations of an affidavit."); *Drake v. Minnesota Mining & Manufacturing Co.*, 134 F.3d 878, 887 (7th Cir. 1998). ("Rule 56 demands something more specific than the bald assertion of the general truth of a particular matter[;] rather it requires affidavits that cite specific concrete facts establishing the existence of the truth of the matter asserted.").

Reinart avers that she had experience making mental health assessments while working for the Monroe County jail, but again she provides no specifics. In any event, Reinart was not hired at the jail until 2000 and the parties have proposed facts about only one other suicide attempt between 2000 and 2002. Reinart does not allege that she was involved in assessing that inmate.

Thus, defendant Reinart points to no evidence from which I could conclude that she was qualified to make a determination that an instruction for a suicide watch should be disregarded. In fact, as far as I can tell from this record, it appears that the *officers* received more training about suicide prevention than did defendant Reinart.

Even if I could conclude that Reinart was qualified, there is a genuine dispute whether defendant Reinart was actually using medical judgment. Unlike the doctors in *Collignon*, *Fromm* and *Sanville*, Reinart did not prepare a written report or otherwise document the medical basis for her decision to keep plaintiff in general population. Even more important, Reinart did not explain at the time why she chose to disregard the discharge instructions. The only documentation of her thought process was one line in the staff log stating: "[plaintiff] denies ideas of self harm or suicidal thoughts—continue to observe closely."

I disagree with defendants that Reinart's refusal to follow the discharge instructions is like the situation in *Fromm*, 94 F.3d at 261, in which the court held that no genuine dispute was created by an opposing opinion of the plaintiff's expert. This is not a case about a mere difference of opinion between two doctors. *Snipes v. DeTella*, 95 F.3d 586, 592 (7th Cir. 1996). Rather, in this case, defendants had already "expressly noted" that plaintiff was at risk for harming herself when they hospitalized her. Farmer, 511 U.S. at 842 (knowledge of risk may be inferred if risk was "longstanding, pervasive, well-documented, or expressly noted by prison officials in the past"). Defendant Reinart disregarded instructions from the very psychiatrist to whom plaintiff was sent in order to make a mental health assessment after she threatened to kill herself. That is not sound medical judgment.

Accordingly, I conclude that a reasonable jury could find that Reinart was aware that plaintiff was a suicide risk, either because the risk would be obvious, even to a layperson, *Collignon*, 163 F.3d at 989 ("a trier of fact can conclude that the professional knew of the need from evidence that the serious medical need was obvious"), or because any medical judgment she says she made was a substantial departure from professional judgment. *Cole*, 94 F.3d at 261-62 ("[D]eliberate indifference may be inferred based upon a medical professional's erroneous treatment decision only when the medical professional's decision is such a substantial departure from accepted professional judgment, practice, or standards as to demonstrate that the person responsible did not base the decision on such a judgment.")

b) Discharge Instructions

Defendants make two sets of arguments related to the discharge instructions. First, defendants say that the discharge instructions did not provide notice of a risk of harm because they were not signed by the psychiatrist and they did not provide details for implementing the suicide watch. (Defendants also point to statements made by the psychiatrist in other medical records, but none of the defendants can rely on these because they did not see the records before November 22, 2002.) Defendant Reinart is free to make this argument to the jury, but it does not entitle her to summary judgment.

Again, the instructions came from the hospital that had been charged with assessing plaintiff's mental health. Although the psychiatrist did not sign the instructions, his name was listed at the top of sheet as the attending physician. It is undisputed that the general practice at the jail was to follow discharge instructions. Further, Reinart cannot argue plausibly that the words "suicide watch" have no meaning to her or that they do not connote an assessment that there is a substantial risk that plaintiff would attempt to harm herself. The jail's own policy outlines appropriate procedures for a suicide watch. Although it is certainly true that the instructions could be more detailed, a reasonable jury could find that defendant Reinart had at least enough notice to trigger a duty to investigate further by contacting the psychiatrist rather than simply failing to follow the instructions.

Second, defendants suggest that instructions for a suicide watch, no matter how clear, are never sufficient to provide a notice of a risk. Defendants cite *Collignon v. Milwaukee County*, 163 F.3d 982, 990 (7th Cir. 1998) and *Taylor v. Wausau Underwriters Insurance Co.*, 423 F. Supp. 2d 882 (E.D. Wis. 2006), for the proposition that "even if an inmate is on actual suicide watch, this does not demonstrate a substantial awareness of a substantial risk of imminent suicide." Defendants' reliance on these cases is misplaced.

First, with respect to *Collignon*, its facts are so inapposite that its instructiveness for this case is extremely limited. In *Collignon*, the decedent had killed himself after he was released from county custody; his family's claim was that the county was liable for releasing him without an adequate treatment plan. In that context, the court considered the question whether the defendants' decision to place the decedent on suicide watch demonstrated that they were aware their treatment plan was inadequate to prevent the post-release suicide attempt. The court held only: "Placing him on a high level of suicide watch does not automatically impose on those responsible for the precaution a constitutional obligation to devise a treatment plan premised on the probability that Jonathan was on the verge of suicide." *Id*. at 990.

The facts of this case bear almost no relation to *Collignon*. Aside from the vastly disparate obligations the government owes to those in custody versus those out of custody, compare *DeShaney v. Winnebago County Dept. of Social Services*, 489 U.S. 189 (1989) with *Estelle v. Gamble*, 429 U.S. 97 (1976), the most notable difference in this case is that, unlike the defendants in *Collignon*, defendant Reinart is not being called to task because she erred on the side of caution and placed plaintiff on suicide watch despite the lack of a clear need to do so. It is not Reinart's decision to place plaintiff in a particular status that shows her awareness of a risk, but her knowledge that the hospital from which plaintiff was just discharged believed that plaintiff should be placed on a suicide watch. If an official decides to place someone on closer observation as a matter of extreme caution or as a matter of routine (as defendants apparently did when plaintiff was initially detained), this does not necessarily communicate how great a risk the official perceived. See also *Taylor*, 423 F. Supp. 2d at 893 (placement on suicide watch without more does not show awareness of risk when inmate was placed in that status primarily as matter of routine rather than because of risks specific to inmate). But knowledge of a recommendation for a suicide watch issued by those to whom the inmate was sent to have a mental health assessment is certainly strong evidence that the official is subjectively aware of a risk of harm. Neither *Collignon* nor *Taylor* suggests otherwise.

Further, as noted above, the discharge instructions were not the only red flag for Reinart. They were simply a confirmation that the risk demonstrated by plaintiff's previous acts of self harm had not abated. Not surprisingly, defendants challenge the importance of those events as well.

c) Past Acts of Self Harm

It is undisputed that defendant Reinart was aware that plaintiff cut her wrists on November 13, requiring her to be hospitalized, and that she attempted to hang herself with a bed sheet on November 14. Defendants make two related arguments in attempt to undermine the effect of the notice provided by these acts of self harm: (1) Reinart believed they were not "serious" suicide attempts; and (2) Reinart believed plaintiff was being "manipulative."

Throughout their proposed findings of fact and briefs, defendants object vigorously to any characterization of plaintiff's attempt to cut her wrists and neck on November 13 and to hang her herself on November 14 as "suicide attempts." This seems to be an implied concession that if defendants had perceived plaintiff's first two attempts of self harm as "suicide attempts," they would be unable to say they lacked awareness of a substantial risk of serious harm. These objections are disingenuous, however, because defendants, including defendant Reinart, consistently referred to the November 13 incident as a "suicide attempt" in their own records. In any event, defendants' game of semantics is unavailing. Regardless of the degree to which plaintiff was physically harmed after her first two attempts, it is difficult to deny that cutting three lacerations

on both wrists and hanging oneself with a bed sheet are distressing behaviors that signal the likelihood of another attempt, particularly when both attempts occurred within the previous few days.

A similar conclusion follows from defendants' "manipulation" objection. Defendants cite *Riccardo v. Rausch*, 375 F.3d 521, 525 (7th Cir. 2004), for the proposition that a prison official "may be responsible without being credulous." This unremarkable statement provides no support to defendants. The question in *Riccardo* was whether the Eighth Amendment required prison officials to move a prisoner away from a cell mate he feared when the prisoner's word was the only evidence suggesting that he was in danger.

Riccardo is not instructive for at least two reasons. First, it was not plaintiff's unsubstantiated fears that triggered a constitutional duty to act in this case, but her demonstrated history of self harm. *Riccardo* would be on point only if the court had come to the same conclusion despite two past assaults by the same prisoner. Second, and more important, in a case such as this one, whether plaintiff was being "manipulative" is close to irrelevant. The important question is this: did plaintiff pose a serious risk of harm to herself? Defendants point to nothing in the record suggesting that Reinart believed a person who harms herself for "manipulative" reasons is less likely to make another attempt. Defendants' own training materials confirm what common sense would already suggest: "The more attempts a person has made, the greater the likelihood that the person will eventually die from suicide. *This is true even of inmates who made several attempts that seem to be attempts at manipulation of jail staff*." *Aff.* of Devanie, Exh. 63, dkt. #116 (emphasis added). In this case, plaintiff had demonstrated that she was capable of hurting herself when she cut her wrists on November 13 and tried to hang herself with a sheet on November 14. It matters little *why* she did these things, that is, whether she actually wanted to kill herself or was just seeking to use these attempts to seek some secondary gain. If she did it twice before, she was likely to do it again.

d) Plaintiff's Denial of Suicidal Thoughts

Defendants' records indicate that plaintiff denied she was suicidal when she returned from the hospital. Defendants rely heavily on this, but I cannot conclude that this notation shows, as a matter of law, that Reinart did not believe plaintiff to be in danger of harming herself again. The Supreme Court has held explicitly that knowledge of a risk of harm need not come from the plaintiff herself. In *Farmer*, 511 U.S. at 848, the Court held that it would be error to absolve officials of liability simply because statements from the plaintiff did not indicate that she was in danger. In this case, there was questionable value in plaintiff's self reporting of her mental state when she was under severe stress, on multiple psychotropic medications and recovering from a drug addiction, suffering multiple mental health conditions and returning from an involuntary commitment to a hospital.

It is true that there is case law in which the court of appeals has absolved prison officials of liability while noting a prisoner's statement to those officials that he did consider himself to be suicidal, *Collins v. Seeman*, 462 F.3d 757, 759 (7th Cir. 2006); *Estate of Novack ex rel. Turbin v. County of Wood*, 226 F.3d 525, 530 (7th Cir. 2000), but these cases are readily distinguishable. In *Collins*, 462 F.3d at 759, the only factor initially suggesting that the inmate was at risk was a statement from the inmate that he was "feeling suicidal." Thus, when the inmate told the defendant officer that "he was all right and could wait until the counselor arrived," the court held that liability could not be imposed simply because the officer left the inmate alone for fifteen minutes at a time. *Id*. Both *Collins* and *Novack* were missing two key facts present in this case: previous attempts of self harm and instructions from a psychiatrist to place the inmate on suicide watch.

In cases in which the inmate had already demonstrated a tendency to harm herself, courts have held uniformly that a genuine dispute remains whether the defendants were aware of substantial risk of serious harm, even when the inmate denies feelings of suicide. *Perez*, 466 F.3d at 416 (summary judgment not appropriate despite inmate's denial of suicidal ideations; inmate had attempted suicide one month earlier); *Cavalieri*, 321 F.3d at 619-20 (inmate's statement that he was "doing fine" not dispositive when inmate had made earlier statements that he was going to kill himself and had made previous attempt to kill himself); *Robey v. Chester County*, 946 F. Supp. 333, 337-38 (E.D. Pa. 1996) (denial of suicidal intentions not dispositive when inmate had been diagnosed with major depression and had attempted suicide in the past). See also *Wever*, 388 F.3d at 604-05 (jury question on deliberate indifference remained despite inmate's promise not to commit suicide when inmate had recently threatened suicide).

2. Reasonable Response

I likewise conclude that a reasonable jury could find that defendant Reinart did not respond reasonably to the risk. It is undisputed that Reinart took virtually no action to protect plaintiff after she

returned from the hospital. She failed to place plaintiff on a suicide watch, even though that was part of plaintiff's discharge instructions. She withheld the discharge instructions from other staff, even though this was contrary to both her own general practice and to jail policy, which required her to disseminate to other jail staff all information provided by health care providers. She did not order follow up care for plaintiff, consult with the hospital that discharged plaintiff regarding proper care or place plaintiff in the observation cell (which was also required by jail policy). She did not order more frequent cell checks on plaintiff or monitor plaintiff herself, even though plaintiff told Reinart that lack of monitoring contributed to one of her previous attempts of self harm. Reinart provided no specific instructions to other jail staff on special precautions to take. Finally, there is a dispute whether Reinart ignored medical requests that plaintiff made to her during this time period.

Most relevant to the events on November 22, defendant Reinart did not take away from plaintiff any objects she could use to hurt herself, including bed sheets, the very materials with which plaintiff had hung herself only a few days earlier. This is a common jail practice, noted in numerous cases considering whether a prison official responded reasonably to a risk of harm. *Cavalieri*, 321 F.3d at 621 ("prisons and jails have developed procedures for dealing with prisoners who display suicidal tendencies, such as removing items that could be used as a suicide weapon, like sheets or a sturdy telephone cord"); *Cagle v. Sutherland*, 334 F.3d 980, 989 (11th Cir. 2003) (noting that "cell had been stripped of implements that might assist suicide"); *Frake v. City of Chicago*, 210 F.3d 779, 780-81 (7th Cir. 2000) ("If it seems likely that a person is suicidal, other precautions are taken, such as placing the person in a cell which can be continuously observed and replacing the person's clothing with a paper suit."). It does not take an expert in mental health to realize that a person should not be left alone for any period of time with materials with which she had tried to kill herself only a few days earlier. *Coleman v. Parkman*, 349 F.3d 534, 540 (8th Cir. 2003) (noting testimony of jailer that placing suicidal inmate in cell without bed sheet "would come under the common sense rule"). Common sense is confirmed by the Monroe County jail's own policy, which states that dangerous objects should be taken from inmates who are at risk of harming themselves.

Defendant Reinart points to several actions that she identifies as reasonable responses, including the "observe closely" notation she put in the log and the promise she elicited from plaintiff to refrain from harming herself. I cannot conclude that these actions, either separately or together, are sufficient to show as a matter of law that Reinart responded reasonably. With respect to the log notation, Reinart did not explain to staff what she meant by "observe closely" and, as noted above, there is no indication that she did anything to confirm that plaintiff was being carefully monitored. With respect to plaintiff's promise, Reinart had ample reason not to rely on the verbal assurances on someone who has just attempted multiple acts of self harm. Reinart cites no authority holding that seeking such an assurance relieves the defendant of any further obligation. *Wever*, 388 F.3d at 604-05 (reasonable jury could find defendant deliberately indifferent when he gave blanket to prisoner shortly after inmate threatened suicide, despite inmate's promise not to harm himself).

The Constitution does not hold officials liable only when they do *nothing*. *Cavalieri*, 321 F.3d at 622 (jury could find that defendant failed to respond reasonably even though he spoke with inmate to "check on his welfare" and offered to help arrange for plaintiff to see counselor). The question is not whether defendants took any action at all, but whether, knowing what they did, they made a *reasonable* response. *Comstock v. McCrary*, 273 F.3d 693, 708 (6th Cir. 2001) (inadequate response "to an inmate's serious need may constitute deliberate indifference just as readily as the intentional denial or delay of treatment"). Given defendant Reinart's failure to take away dangerous objects from plaintiff in combination with her failure to take many other measures, I cannot conclude that summary judgment is appropriate. *Calvalieri*, 321 F.3d at 621 (affirming denial of summary judgment when defendants placed known suicidal inmate in holding cell with telephone cord he used to hang himself); *Coleman*, 349 F.3d at 539 ("The jury could reasonably deduce that appellants recklessly disregarded that risk when they issued Coleman a bed sheet and placed him in a cell where they could not easily observe him."); *Robey*, 946 F. Supp. at 337-38 (reasonable jury could find deliberate indifference when defendant took inmate off suicide watch despite recent suicide attempts).

B) Defendants Warner, Schaldach, Wegner, Janusheske, Wildes, Leis, Weiman and Fish

1. Awareness of Risk

The primary difference between defendant Reinart and these defendants is that they were not aware of the discharge instructions from the hospital because Reinart failed to communicate them to the rest of the jail staff. It is thus a closer question whether a reasonable jury could find that these defendants were aware of a substantial risk of serious harm. I conclude nevertheless that a reasonable jury could much such a finding, primarily because each of these defendants was aware by November 22, either through personal observation or by reading the staff logs, that plaintiff had been hospitalized for a suicide attempt only a few days earlier and had tried to hang herself while at the hospital. As noted above, courts have held consistently that knowledge of a recent suicide attempt creates at least a question for the jury whether the defendants were substantially aware of a risk. E.g., *Turney v. Waterbury*, 375 F.3d 756, 760 (8th Cir. 2004). Further, nearly all the defendants received training that inmates who have made previous suicide attempts are the highest risk for further attempts of self harm. *Woodward*, 368 F.3d at 921-22 (relying on training policies in affirming jury decision that defendants were deliberately indifferent to substantial risk of suicide). Each defendant was aware also that plaintiff had been making threats to kill herself only a few days earlier.

Most of the arguments defendants raise on this question I have considered in the context of the claim against defendant Reinart and it is unnecessary to cover the same ground again. However, I will address the several arguments that do not overlap.

Defendants' primary argument is that they "were absolutely entitled to rely on th[e] professional judgments" of Reinart and Buchanan. Dfts.' Br., dkt. #50, at 23. They cite *Davis v. Jones*, 936 F.2d 971 (7th Cir. 1991), for the proposition that determinations

whether a medical condition is serious are best left to medical professionals. *Davis* does not support defendants' position. To the extent defendants mean to argue that only medical staff may be liable for failing to prevent an inmate's suicide, this position is untenable, as demonstrated by the numerous cases cited throughout this opinion in which courts have found correctional officers to be potentially liable. In fact, in *Sanville*, 266 F.3d 724, the court concluded that the defendant psychiatrists were not deliberately indifferent, but that a reasonable jury could find that the correctional officers were. Davis actually cuts against the defendants' argument because the court held in that case that police officers are constitutionally required "to seek medical attention for medical care when the wound reasonably *appears* to be serious even if the risk turns out to have been small." 936 F.2d at 972 (emphasis added).

Of course, jail employees are entitled generally to rely on the opinions of those who are more knowledgeable than themselves. But, as noted above, it appears that the non-medical jail staff had at least as much training on suicide prevention as did defendant Reinart, if not more.

In any event, defendants point to no evidence that they did in fact rely on anything Reinart said or did. First, with respect to the decision Reinart made, it is not as if she instructed staff, "I do not consider Brenda Mombourquette to be a suicide risk. No special precautions are necessary." Reinart wrote only that plaintiff had denied feeling suicidal and that staff should "observe" plaintiff "closely," without explaining what this meant. Although Reinart's instructions are not clear, they provide defendants no basis to say they believed plaintiff was in no need of special care. Further, defendants mischaracterize the record in their brief when they say they knew that Reinart was "trusted to make suicide assessments." The proposed finding of fact cited shows only that the *jail administrator* (who is not a defendant) believed that Reinart was qualified to make mental health assessments. Dfts.' PFOF ¶135, dkt. #51. Defendants cite no evidence that they relied on Reinart's judgment in this or any other case, or even that they viewed her as competent to make judgments about suicide. *Sanville*, 266 F.3d at 739 (correctional officers may not rely on psychiatrist's determination when no evidence indicated that "any of the doctors actually determined that [inmate] was not suicidal, much less that they then informed the guards that [inmate] was not suicidal and that the guards then decided not to act based on that information").

As defendants themselves assert repeatedly throughout their briefs and proposed findings of fact, no one staff member was assigned the duty of determining whether an inmate posed a threat to herself. Rather, all staff members had this responsibility collectively and any one of them had the authority to initiate a suicide watch.

In their reply brief, defendants assert that they were not aware of a risk because "it was an open question as to whether Mombourquette had genuinely attempted to take her life in the hospital." Dfts.' Br. dkt. #142, at 5. For support, defendants point to the question mark that followed the entry in the staff log stating "ALSO WE LEARNED MOMBOURQUETTE TRIED TO HANG HERSELF WHILE AT [the hospital]?" Defendants are grasping at straws; an awareness of a risk is not contingent on the punctuation used. Again, defendants did not have to be absolutely certain that plaintiff was in danger before they were required to act. Even if the notation left some room for doubt, defendants may not avoid liability if they refused to investigate facts that they strongly suspected to be true. *Farmer*, 511 U.S. at 843.

2. Reasonable Response

Like defendant Reinart, the other defendants did almost nothing to protect plaintiff from harming herself again after she returned to the jail on November 18. Even after learning that plaintiff had hung herself at the hospital, they did not place her on suicide watch, put her in the observation cell or take away potential harmful objects. They did not seek further direction from defendant Amundson or from plaintiff's counselor when she visited the jail. Further, defendants proposed no facts showing that they carried out Reinart's instruction to observe plaintiff closely. Although the instruction was vague, defendants did not seek to clarify it or interpret it for themselves. It does not appear that any of defendants asked plaintiff even once whether she was feeling suicidal or depressed. With two minor exceptions by defendant Warner, defendants point to no evidence that they took any special precautions or treated plaintiff any differently from any other inmate. A reasonable jury could find that defendants should have learned both from their training and from plaintiff's earlier attempts that they could not simply wait for a fatal event to occur before taking action. *Helling*, 509 U.S. at 33.

Defendant Warner did refuse to give plaintiff an extra blanket, but this hurts more than helps Warner's case. In refusing to give plaintiff the blanket because of her "suicidal gestures," defendant Warner suggests strongly that she was aware both of the likelihood that plaintiff would harm herself again and that bedding was one of the materials she could use to do it. Although it certainly made sense to deny plaintiff an object she could use to hurt herself, if plaintiff could hang herself with a blanket, would it not be obvious that she could do the same with a bed sheet?

Warner also instructed to staff to make sure plaintiff was not stockpiling medication, but Warner admits that she made this decision because plaintiff had a history of drug abuse, not because she was trying to prevent plaintiff using medication to commit suicide. In any event, I cannot conclude as a matter of law that taking steps to prevent one method of self harm is sufficient to resolve a defendant of liability, particularly when plaintiff had used two other methods to hurt herself in the past.

Defendants also point to the cell checks they did between November 18 and November 22, emphasizing that they checked on plaintiff only minutes before she hung herself. (The parties dispute the length of time plaintiff was alone before she was discovered. Defendants say it was less than five minutes; plaintiff says that it is unknown how long it was, but it was much longer than five minutes.) Even if I assume that plaintiff was left unsupervised for less than five minutes, this would not require that defendants' motion for summary judgment be granted. It is undisputed that the short span of time between the last two checks on plaintiff was completely fortuitous. Defendants were not checking plaintiff consistently every five minutes, fifteen minutes or even every hour. According to defendants' own records, plaintiff was left unsupervised for intervals of more than three hours. (And

it could have been even longer. Plaintiff raised a legitimate question about the accuracy of defendants' records of cell checks. The jail administrator from 2002 testified that jail staff commonly recorded cell checks that were never actually conducted.)

Plaintiff argues that if defendants had checked on her more often or more carefully, they might have seen more signs that she was still feeling suicidal. Although defendants object to this argument as speculation, plaintiff cites testimony of other inmates housed near plaintiff that, even after November 18, plaintiff continued to be depressed and to talk about committing suicide. This testimony at least creates a genuine dispute whether the cell checks were a reasonable response. *Snow*, 420 F.3d at 1270 (although defendants checked inmate fewer than fifteen minutes before she committed suicide, reasonable jury could find that "more vigilant" observation would have prevented suicide).

Finally, defendants point to no authority suggesting that conducting frequent cell checks is sufficient as a matter of law when the inmate is nevertheless left unsupervised with the same materials she used to hang herself only days earlier. *Id*. (despite cell check fewer than fifteen minutes before suicide attempt, jury could find inmate would not have committed suicide if "items she could have used to harm herself [were] removed from her reach").

It is true that defendants did not evince a complete lack of concern for plaintiff. Defendants propose various facts about things they did for plaintiff, such as allowing her to talk to her children and making sure she received her medication. But these random acts of kindness have little relevance in determining whether defendants acted reasonably to prevent plaintiff from attempting suicide. An official who shows concern for an inmate by feeding him every day may still be held liable for denying him water; a doctor who examines a prisoner whenever requested may still be liable if he withholds necessary treatment. *Cavalieri*, 321 F.3d at 622, 625 (rejecting argument made by dissenting judge that defendant's "time, attention and concern" to inmate required a conclusion that defendant acted reasonably).

To prevail, it is not necessary for plaintiff to show that defendants were monsters or had no concern for her well being. The standard of deliberate indifference does not require a showing of malicious intent or ill will toward plaintiff. *Farmer*, 511 U.S. at 835 ("the cases are also clear that [the test for deliberate indifference] is satisfied by something less than acts or omissions for the very purpose of causing harm or with knowledge that harm will result"). Plaintiff has to show only that defendants knew of the risk and did not act reasonably to abate it. She has adduced sufficient evidence to allow a reasonable jury to make that conclusion.

C) Defendant Amundson

There are two ways that a government actor may be sued: in his official capacity or his individual (sometimes called "personal") capacity. Generally, an official capacity suit is a brought against a high-ranking official as a way of challenging an unconstitutional policy, practice or custom. *Hill v. Shelander*, 924 F.2d 1370, 1372 (7th Cir. 1991). Suing a government employee in his official capacity is akin to suing the entity that employs him and the standard for liability is the same. *Kentucky v. Graham*, 473 U.S. 159 (1985). In contrast, an individual capacity suit requires a showing a personal involvement. Although the test for personal involvement has been stated in different ways, a commonly cited understanding is set forth in *Gentry v. Duckworth*, 65 F.3d 555, 561 (7th Cir.1995):

An official satisfies the personal responsibility requirement of section 1983 . . . if the conduct causing the constitutional deprivation occurs at [his] direction or with [his] knowledge and consent. That is, he must know about the conduct and facilitate it, approve it, condone it, or turn a blind eye. In short, some causal connection or affirmative link between the action complained about and the official sued is necessary for § 1983 recovery. (Internal quotation marks and citations omitted).

Plaintiff does not state unambiguously that she is suing defendant Amundson in his individual or official capacity but rather that she is suing him "individually in his supervisory capacity." Plaintiff's lack of clarity is not entirely her fault. Courts have struggled with limited success in defining the contours of the liability of supervisors in § 1983 cases. The confusion began with *Rizzo v. Goode*, 423 U.S. 362 (1976), a case preceding *Monell v. Department of Social Services*, 436 U.S. 658 (1978), in which the Supreme Court considered the liability of a mayor and police commissioner under § 1983. Without discussing whether its analysis applied to individual or official capacity suits, the court concluded that there could be no liability because there "was no affirmative link between the occurrence of the various incidents of police misconduct and the adoption of any plan or policy by petitioners." *Id*. at 371. To this day, commentators continue to question whether *Rizzo* was about individual or official liability 1A Martin A. Schwartz, *Section 1983 Litigation*, § 7.19[C] (4th ed. 2006).

Since *Rizzo*, the Court has not revisited the question of supervisory liability under § 1983, leaving the various courts of appeal to establish their own divergent tests, often choosing with little or no explanation some amalgamation of the standards for individual and official (or municipal) liability. E.g., *Andrews v. Fowler*, 98 F.3d 1069, 1078 (8th Cir.1996) (knowledge of violation not required but only "that the supervisor had notice that the training procedures and supervision were inadequate and likely to result in a constitutional violation"); *Colon v. Coughlin*, 58 F.3d 865, 873 (2d Cir. 1995) (liability may be imposed on supervisor if he (1) participated directly in violation; (2) was aware of violation and failed to remedy it; (3) was responsible for a policy that caused the violation; and (4) was grossly negligent in supervising subordinates who committed violation); *Baker v. Monroe Township*, 50 F.3d 1186, 1194 (3d Cir. 1995) (supervisor must have "actual knowledge and acquiescence" in constitutional violation); *Greason v. Kemp*, 891 F.2d 829, 836-37 (11th Cir. 1990) (relying on standard for municipal liability and concluding that supervisors could be liable if they were deliberately indifferent in supervising subordinates).

In this circuit, the court of appeals has stated that the test for imposing liability on supervisors is the same as that for any other individual: whether the "conduct causing the constitutional deprivation occurs at the supervisor's direction or with the supervisor's knowledge and consent." *Nanda v. Moss*, 412 F.3d 836, 842 (7th Cir. 2005). "[S]upervisors must know about the conduct and facilitate it, approve it, condone it, or turn a blind eye for fear

of what they might see." *Jones v. City of Chicago*, 856 F.2d 985, 992-93 (7th Cir. 1988) (citations omitted).

Nevertheless, the court of appeals has held that liability is appropriate even if the supervisor was not aware of the particular constitutional violation at issue. For example, in *Kitzman-Kelley v. Warner*, 203 F.3d 454, 459 (7th Cir. 2002), the court recognized that a supervisor's personal liability could be predicated on "the failure to train adequately the government agent who is alleged to have committed the constitutional violation," citing the standard for municipal liability. And in *Butera v. Cottey*, 285 F.3d 601, 605 (7th Cir. 2002), the court again mirrored the standard for official or municipal liability suits in stating that a supervisor could be held personally liable if he was responsible for a policy, practice or custom that caused the constitutional violation. Accordingly, I conclude, as the parties appear to agree, that plaintiff may prove her claim against defendant Amundson so long as she establishes that there is an "affirmative link between the action complained about and the official sued," *Gentry*, 65 F.3d at 561, and she can otherwise satisfy the standard for deliberate indifference. *Farmer*, 511 U.S. at 843-44 (to establish deliberate indifference plaintiff need not show that defendant was aware of risk specific to plaintiff if "all prisoners in his situation face such a risk").

Plaintiff seeks to hold defendant Amundson liable both because his policies were severely inadequate and because he was deliberately indifferent to the consequences of his failing to properly train and supervise the other defendants. I have little difficulty in concluding that a reasonable jury could find that there is an "affirmative link" between Amundson's failings and the failure to prevent plaintiff from attempting to commit suicide. At least two related problems with the general operation of the jail contributed to defendants' failure to stop plaintiff's attempted suicide: (1) the lack of a clear delineation of authority with respect to assessing risks of suicide; and (2) inadequate means of staff communication.

It seems that no one at the jail wanted to take responsibility for dealing with plaintiff once she returned from the hospital. This began from the moment she reentered the jail. Despite defendants' knowledge that plaintiff had been hospitalized for a suicide attempt, they did not assess her mental health status or deliberate about her proper classification. Instead, defendants simply returned plaintiff without discussion to the south block in general population. It was not until plaintiff made a medical request that jail staff met with her.

Each of the defendants appears to believe that someone else should have taken charge. The officers argue in their briefs that defendant Reinart should have been responsible for determining whether plaintiff was a suicide risk. In her deposition, Reinart testified that "the lead officer" (presumably defendant Schaldach) should have determined what to do with plaintiff. In his deposition, defendant Schaldach testified that he did not know why plaintiff was not placed in observation, even though he was the shift supervisor on November 18. The likely reason that each party denies responsibility is that the jail's policy does not squarely place responsibility on anyone. Again, all jail staff are equally responsible under the policy, which not

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) 995-6423, or visit their website at: www.nicic.org

surprisingly means that all staff attempt to fix the blame on someone else.

Closely related, effective communication was also sorely lacking at the jail. Although many events were documented in various logs, there was no mechanism in place for determining what should be done about issues that were raised in these logs. This problem was demonstrated time and time again in plaintiff's case, most obviously when no one took action despite repeated statements in the logs that plaintiff had tried to hang herself while at the hospital. A reasonable jury could find that plaintiff's attempted suicide could have been prevented if defendant Amundson had in place a policy that more clearly delegated authority and established procedures for acting on information documented in the logs. In other words, the jury could find that "but for" defendant's Amundson's failures, the remaining defendants "would have taken reasonable steps to prevent [plaintiff] from [attempting to] tak[e] [her] own life." *Novack*, 226 F.3d at 532.

This is not enough, however. Plaintiff must show also that defendant Amundson's policies and practices (or lack of them) "towards the treatment of its mentally ill inmates [were] so inadequate that [he] was on notice at the time that [plaintiff] was incarcerated that there was a substantial risk that [s]he would be deprived of necessary care in violation of [her] [Fourteenth] Amendment rights." *Woodward*, 368 F.3d at 927.

A reasonable jury could find that defendant Amundson had such notice. First, courts have concluded that deliberate indifference to a risk of suicide may be established solely by knowledge that the defendant failed to properly delegate responsibility for suicide assessments. E.g., *Estate of Cills v. Kaftan*, 105 F. Supp. 2d 391, 402-03 (D.N.J. 2000) (failure to have suicide assessments conducted by someone with psychiatric training); *Estate of Abdollahi v. County of Sacramento*, 405 F. Supp. 2d 1194 (E.D. Cal. 2005) (failure to train employees in communicating suicide risks to mental health personnel). See also *Rhyne v. Henderson County*, 973 F.2d 386, 395-96 (5th Cir. 1992) (Goldberg, J., concurring) ("vesting discretion in untrained jail personnel to assess the need for, and administer, mental health care, will not be responsive to the medical needs of mentally ill detainees").

Further, as plaintiff points out, defendant Amunson's failure to designate responsibility for handling inmates who are potential suicide risks is a violation of state law. Wis. Admin. Code § DOC 350.19(2) (requiring "[d]esignation of person who may assess an inmate's level of suicide risk and who may authorize placement on and removal from a suicide watch status for inmates who are suicide risks") Although this is not dispositive, it is relevant evidence. *Boncher*, 272 F.3d at 487-88. See also *Robey*, 946 F. Supp. at 338 (denying summary judgment in jail suicide case against county because defendant failed to comply with "minimal practice in the field").

Defendant Amundson had notice not just from the law but also from those who were charged with evaluating his performance. Both Scott Morris, the jail inspector for the Wisconsin Department of Corrections, and Mark Pressler, the jail administrator, severely criticized Amundson's operation of the jail on issues that are highly relevant to this case. The jail inspector identified problems in 2002, such as failing to properly classify and house suicidal inmates (in violation of state law), failing to insure effective staff communication during crisis situations and failing to properly supervise and train officers such as defendant Schaldach, who was running the jail on a day-to-day basis. His general opinion was that the jail was "poorly run" and "poorly supervised."

Pressler's assessment of the jail under defendant Amundson's supervision paints an even starker picture. He reported problems to Amundson about staff failures to perform cell checks for up to six hours, threats by staff and staff sexual misconduct, among other things. Amundson did not investigate any of these problems. Pressler's overall view was that Amundson provided no supervision of the prison and failed to hold staff accountable for their actions. As noted in the context of defendant's motion in limine, evidence of defendant Amundson's general lack of concern about staff misconduct and the safety and health of inmates is relevant to show that he was deliberately indifferent toward plaintiff. *Woodward*, 368 F.3d at 922 (testimony that environment at jail was "very lax, unprofessional" and that supervisors disregarded complaints about staff misconduct toward inmates was relevant to show deliberate indifference).

If the jury believes plaintiff's assessment of the jail under defendant Amundson's tenure, with staff essentially running amok without any supervision from Amundson, it could find reasonably that he was deliberately indifferent to a risk that an inmate like plaintiff would seriously harm herself.

Order

IT IS ORDERED that

1. The motion filed by plaintiffs Brenda Mombourquette, Tammy Mombourquette, E.S. and C.S. to supplement their summary judgment materials is DENIED as unnecessary.

2. Defendant David Schaldach's motion in limine to exclude evidence of his sexual activity with other inmates is DENIED.

3. The motion for summary judgment filed by defendants Charles Amundson, Candace Warner, Sandi Wegner, Anna Janusheske, Mike Wildes, Janita Leis, Sue Weiman and Patricia Fish is DENIED.

4. Defendant Schaldach's motion for summary judgment is DENIED.

5. Defendant Jeanne Reinart's motion for summary judgment is DENIED.

Entered this 12th day of January, 2007.

BY THE COURT:
/s/
BARBARA B. CRABB
District Judge ❑

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.

California

Following a three-week trial in late March 2007, a Kings County jury in Hanford found Kings County and three Probation Department officials and staff negligent in the prevention of, and response to, Christian Rodriguez's suicide attempt in the county's juvenile boot camp program. The following week, the jury awarded Christian $4.6 million in compensatory and punitive damages. Of the amount, $160,000 was awarded in punitive damages, with the remainder given to offset medical bills and lost income.

On February 2, 2004, Christian Rodriguez, then 16-years-old, hung himself in the school bathroom of the Kings County Probation Department's Juvenile Boot Camp. He sustained severe and permanent brain damage, and currently is confined to a wheelchair and unable to care for himself. His father, Miguel Rodriguez, filed the lawsuit in 2005 claiming that Kings County and several defendants were negligent to his health care needs while confined in both the detention center and boot camp programs. The jury split the liability into three portions between the boot camp director (45%), probation department chief (20%), and an officer (35%).

One juror told the *Handford Sentinel* that it was not difficult for the jury to come up with the amount of money they felt was appropriate to award the young man. "It was pretty cut and dry," Shelly Dykes said. Jurors relied on several tools, Ms. Dykes said, including expert testimony, Christian's personal history, and projected medical needs.

During the damages phase of the trial, plaintiff attorney Robert Patch had petitioned the jury for $9.8 million to cover Christian's medical care and loss of potential income. Defense counsel argued that $3.5 million would suffice. Although the defendants may appeal the award, Lawrence C. Levine, a law professor at the University of the Pacific's McGeorge School of Law, said he did not think the county would appeal the damage decision. "The jury's figure is much closer to the defendant's (Kings County) figure, so it would be foolhardy for the defendant to appeal that figure."

Although evidence presented at the trial demonstrated that Kings County did not have an adequate suicide prevention policy, in fact, had no policy at all, County Administrative Officer Larry Spikes told the *Handford Sentinel* that there would be no changes to boot camp's policies. "Our defense is that we have adequate policies and procedures," Mr. Spikes said. "I don't really want to give any indication that we would do something that's not consistent with what our defense was."

Indiana

When 39-year-old Adekunle Adumabo committed suicide in the Lake County Jail in Crown Point on April 30, 2007, it marked the fifth such death in 950-bed facility in less than two years. Mr. Adumabo had been detained in the jail on charges of using fraudulent credit cards and fake identification to obtain cash advances from a local casino. At the conclusion of a court hearing on April 26, the inmate yelled out that he "was ready to give up (his) life." The judge ordered that Mr. Adumabo be immediately placed on suicide precautions and transported back to the Lake County Jail." But at the time of death four days later on April 30, he was not on precautions. A spokesperson for the Southlake Mental Health Center, which provides medical and mental health services to the facility, declined to comment on the case.

The rash of suicides in the Lake County Jail began in August 2005 when 29-year-old James Hunt was found hanging from a cell window by a bed sheet. Four months later on January 10 2006, convicted serial killer David Maust was found hanging from a clothing hook by a bed sheet shortly after being sentenced to three life sentences. Due to the nature of his crimes (the serial murders of three teenagers in 2003) and previous suicide threats, Mr. Maust's suicide should not have come as a surprise to either jail or mental health officials. On August 15, 2006, 31-year-old James Hutchinson was found hanging from a door hinge by a bed sheet. A little more than a month later on September 18, 2006, Andrew Lehman was found hanging from a bathroom stall by his t-shirt. Mr. Lehman had only been in the facility for approximately 30 minutes.

It was following the death of Mr. Lehman that Lake County Sheriff Roy Dominguez sought the technical assistance of the U.S. Justice Department's National Institute of Corrections (see page 16). A consultant team arrived on-site, reviewed policies and procedures, interviewed jail and mental health staff, and subsequently submitted a 20-page report of findings and recommendations. Among the recommendations were better intake screening procedures to help identify suicidal inmates, as well as better suicide prevention training for staff.

Texas

In December 2006, the Civil Rights Division (Special Litigation Section) of the U.S. Department of Justice released an investigative report regarding grossly inadequate medical and mental health care at the Dallas County Jail (DCJ). According to the report, "jail staff frequently mismanage inmates' acute medical needs, thereby significantly delaying appropriate medical care….Most seriously, we found numerous instances where DCJ's mismanagement contributed to preventable deaths, hospitalizations and unnecessary harm."

The report was based on on-site inspections at the jail in February and March 2006, as well as review of hundreds of documents (including policies and procedures, grievances, and medical and mental health files). Investigators found inadequate record keeping, staffing, training and supervision, and quality assurance.

With regard to mental health screening and assessment, DCJ staff utilized an intake screening form that was not incorporated into the medical record. Consequently, "we found that less than 20 percent of inmates referred for a mental health assessment were evaluated within seven days after intake. In addition, these mental health assessments are typically done by mental health liaisons who have no specialized training in mental health care and are inadequately supervised. We found that even for those inmates affirmatively identified with serious mental illness, the subsequent referral process to mental health is flawed." One inmate with a 20-year history of mental illness did not receive his psychotropic medication for five weeks.

Suicide prevention practices were found to be grossly inadequate. The report found that:

> DCJ's current practice of suicide prevention does not comport with generally accepted professional standards of correctional mental health care. The Jail's written policy on suicide prevention fails to ensure appropriate management of suicidal inmates and lacks major components of an adequate suicide prevention program. For example, DCJ's policy does not require that staff be trained on suicide recognition and intervention. The current intake screening/assessment process fails to assess adequately the suicide risk factors of inmates. The process is not under the direction of trained mental health staff. As a result, correctional staff inappropriately have the authority to place any inmate who they deem to be suicidal into a "suicide cell," which is a closed observation cell in which the inmate is under continuous lock down. There are two housing tiers designated as suicide tiers with eight cells in each tier that are classified as suicide cells. These cells are reportedly visually checked by an officer at regular intervals. However, because this check is not formally logged, monitoring is haphazard and places inmates in potential danger.
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> Moreover, placement in a suicide cell appeared to be arbitrary. The assessment is seldom performed by a mental health staff member so placement in a suicide cell is often inappropriate and utilized as a form of punishment. Mental health staff repeatedly reported that it is their perception that few of the persons placed in these cells are actually suicidal. In addition, mental health staff reported that they disagreed clinically with existing suicide practices, especially the stripping of inmates of all clothing and granting them only a paper gown.

The report cites three specific cases that were illustrative of poor suicide prevention practices:

- C.L., a 27-year-old inmate, died on October 10, 2005, of toxic effect of an overdose of Nortriptyline, an antidepressant medication that had not been prescribed to him. His suicide intake screening assessment had never been completed. C.L.'s problem list in his medical record included "mental health issues." A nursing clinical note, dated February 15, 2005, indicated that his sister had called concerned that C.L. had voiced suicidal thoughts. Yet, C.L. never received a mental health evaluation while he was incarcerated at DCJ.

- While on suicide watch, inmate K.B. hung himself in July 2003. The physician assistant subsequently reported that he had not been able to interview the inmate due to the lack of an available detention officer escort. As a result, K.B.'s transfer to a closed behavioral observation tank was delayed. This case highlights issues related to inadequate supervision, poor communication between custody and mental health staff, and the lack of adequate numbers of detention officers for escort/transfer purposes.

- Inmate M.K. hung herself on January 5, 2003 after having been admitted on December 4, 2002. Her record contained the following inmate request form dated two days before her death on January 3, 2003. The note indicated the following: "I need to see the doctor to get my medicine straightened out. I am not getting my meds that my doctor faxed prior orders for me, and I brought in the medication myself and paid for it. I cannot afford to be treated this way! Please help me! I need my medicine." There is no indication that M.K. received her medication before her death. The case reflects inadequate screening for mental illness, inadequate screening for suicide prevention purposes, lack of timely access to needed medications, and the lack of timely response to an inmate request form.

The Department of Justice's investigative findings letter regarding medical and mental health care within the Dallas County Jail can be found at: http://www.usdoj.gov/crt/split/documents/dallas_county_findlet_12-8-06.pdf

Colorado

Denver Police and Denver Sheriff Department officials say that jail staff and police officers need to fix communication gaps between themselves, with jailers saying they never learned from police that Shimondi Gebreselassie had previously attempted suicide before he hanged himself in his Denver County Jail cell on February 24, 2007. "This is an unfortunate incident that only demonstrates the need to improve communication," Virginia Quiñones, Denver Police Department spokeswoman told the *Denver Post* on March 2, 2007. "It's a safety issue for officers and inmates."

According to arrest records, Mr. Gebreselassie, 39-years-old, was so obsessed with a coffee-shop owner that when she rejected his romantic advances, he attempted suicide in September 2006 and, on December 2, 2006, allegedly fatally stabbed her in the neck. He then fled the state. When Mr. Gebreselassie was subsequently returned to Denver and booked into the Denver County Jail, no suicide precautions were taken because the police detectives did not inform jail intake staff of his suicide attempt, even though they mentioned that fact in an affidavit used to get a warrant signed by a judge, said William Lovingier, the jail's director of corrections. "The suspect had attempted to take his own life," homicide Detective David Neil wrote in a December 3 arrest-warrant affidavit. "The suspect stated to (a friend of the victim's) that he wanted to die since the victim would not have a relationship with him."

Detective Neil said he "probably did not" contact the jail about the suicide attempt because Mr. Gebreselassie was arrested in California and the Denver Sheriff Department brought him back when he was extradited. Sergeant Frank Gale, Denver County Jail spokesman, told the *Denver Post* jail staff did not get a copy of the affidavit.

The arrest form that police officers pass on to jail intake staff when an arrestee is booked into the jail does not contain a section where officers can warn jail staff when an inmate is suicidal, violent or mentally ill, Director Lovingier said. "It's an excellent example of the type of information that is pertinent to a person's incarceration," he said. "It would have been one more thing (psychiatric nurses) could have explored." Mr. Lovingier said that even before the suicide, jail officials had been meeting with police to try to establish a way to warn jail intake staff when a suspect shows signs of mental illness, including speaking incoherently. A psychiatric nurse interviews each new detainee to see if they had ever attempted suicide, the director said. Mr. Gebreselassie did not report the September 2006 suicide attempt to the nurse, he said.

On January 2, 2007, less than two months before his death, Mr. Gebreselassie wrote a note to medical staff at the jail that stated "If you keep me here I'll kill myself." He was briefly placed on suicide precautions and then released back to his housing unit when the psychiatrist felt that Mr. Gebreselassie's chief complaint was his diet.

Mississippi

In June 2007, Pascagoula Police Chief Mike Whitmore said his department did all it could to prevent the suicide of Robert James Smith in the Pascagoula City Jail. The 18-year-old young man, who was found hanging in his cell on May 18, had threatened suicide and self-reported mental illness to jail staff two days before this death. Although Chief Whitmore refused to provide many details, he told a local newspaper that his jail staff followed proper procedures in the case. "I'm confident that we did all we could do at the police department to monitor him and take care of his needs like we do anyone who is in our jail," the chief told *The Mississippi Press*.

The Smith family later held a press conference to complain that the police department had shared little information about the incident with them, and they had doubts Mr. Smith committed suicide. One family member complained that they were hearing conflicting facts about the death. The Mississippi American Civil Liberties Union and the Moss Point-Jackson County National Association for the Advancement of Colored People later announced that they were both investigating the death.

According to jail officials, Mr. Smith has been arrested on May 16 and charged with two counts of armed robbery. He subsequently threatened suicide after placed in a cell, claiming the room was too small and he was claustrophobic. Mr. Smith also complained he needed his psychotropic medication for a pre-existing mental health problem. Mr. Smith was allegedly told by jail staff to have his family fill the prescription. He was then placed in restraints in a holding cell for the remainder of the day due to his suicide threat. When he was apparently stabilized, Mr. Smith was returned to his cell, but remained on suicide precautions. Less than two days later, he was dead, found hanging from a strip of blanket tied to his bunk. ❑

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 1-15)

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

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