JAIL SUICIDE/MENTAL HEALTH UPDATE

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

Winter 2008 **Volume 16 • Number 3**

Special Issue: Preventing Suicides Through Prompt Emergency Response and Intervention

Two days before Matthew Mancl committed suicide in the Pepin County Jail in Durand, Wisconsin on October 20, 1999, a patrol sergeant from the local police department overheard a jail deputy tell a colleague: "There's a problem in the jail. Mancl thinks he wants to kill himself. If the f..... wants to kill himself, make sure he's dead before you cut him down." The deputy was not only sued as a result of Mr. Mancl suicide, but was criminally charged with obstruction of justice when he subsequently admitted to falsifying a jail log to reflect cell checks that never occurred.

As repugnant as this case may appear, it is not necessarily an aberration. Take the case of 27-year-old Terry Miller.[1] He entered the Concord County Jail on December 18, 2004 on charges of violation of probation/parole, theft, and receiving stolen property. A few days later at approximately 1:35pm on December 22, 2004, Officer Patrick Parker was conducting rounds and found Mr. Miller hanging from a sheet tied to the top bunk in his cell). Officer Parker called for back-up assistance, entered the cell, removed Mr. Miller from the ligature, and placed him on the floor. There was a factual dispute about what occurred next. According to Officer Parker, he immediately initiated cardiopulmonary resuscitation (CPR) until relieved by arriving correctional personnel. Other responding officers, however, stated that it did not appear that Officer Parker had started CPR and they initiated CPR upon arrival to the cell and continued life-saving measures until the arrival of medical staff. When medical personnel arrived approximately 10 minutes later, they reported that it did not appear that any correctional personnel had initiated CPR. Nurse Betty Wilcox then initiated CPR, but based upon the alleged condition of the victim's body upon discovery (including the onset of rigor mortis), life-saving measures were terminated and Mr. Miller was pronounced dead at the scene by an arriving physician.

Following the incident, an investigation was initiated and what follows is a summary of the interview with both Nurse Wilcox and Health Services Administrator David Clark:

"This investigator asked Betty if she was working on December 22, 2004 and did she respond to a stretcher call on B-2 Pod-1 at approximately 1:35pm and her answer was yes. I then asked her if she was the first medical person to arrive at cell 14 and she stated yes and David (the health services administrator) came right behind her. I then asked her when she arrived at cell 14 were there any officers in the cell doing CPR on the decedent and Betty stated no but she noticed one officer entering the cell when she came on the pod and when she got to the cell the officer was standing over the decedent and Betty was told the decedent had a pulse, but when Betty checked for a pulse she found none and the body was cold to the touch. I went on and asked Betty if there was a mouth protector in the decedent's mouth or did she remember seeing a mouth protector in the cell and she stated no. I then asked Betty what position was the decedent in and she stated decedent was lying on his back in the middle of the cell. Betty stated to me that when she started CPR on the decedent she noticed fluid coming out of the decedent's mouth and nose, which means that no CPR was performed on the decedent before she got there. This investigator then asked Betty and David if they were able to get a trachea tube into the decedent's mouth and they stated no, his mouth could not be opened and it appeared rigor mortis was setting in.

According to HSA David, they overheard an intercom call at 1:30pm calling for a stretcher on A-2 Pod-1. When we got to the A elevators, the A building center control told us to go to B-2 Pod-1 instead. When we got to the B elevators we met up with the medical inmate worker who had the medical stretcher. At no time did we have a security escort with us. The misdirected response cost us approximately 5 minutes. Upon arriving on B-2 we were directed to Pod-1 where the unit was locked down and the officers were screaming at us to hurry up, what took so long! We then arrived at the cell, initiated CPR, and no correctional staff assisted us."

Randy Buckley, 38-years-old, was arrested by state police on November 29, 2004 for leaving the scene of an accident and driving under the

[1]Due to pending litigation, certain identifying information regarding the facilities, staff names, and all suicide victims have been removed. No other modifications have been made.

Inside. . .

influence of alcohol, the result of which was the death of a pedestrian. He was booked into the Neville County Detention Center. Mr. Buckley remained in the facility until the early morning hours of December 7, 2004 when Officer Deborah Clancy found Mr. Buckley hanging from a ventilation grate above the sink/toilet in his cell by a sheet and laundry bag string. The officer exited the cell and informed Sergeant Charles Waters of the emergency. Sergeant Waters then entered the cell, observed Mr. Buckley hanging, and then exited the cell and told other officers *not* to enter the cell. Neither Sergeant Waters or any other officer attempted to take any vital signs, remove the ligature from around the victim's neck, or provide any life-saving measures to Mr. Buckley. Instead, the victim's body was left hanging and photographs of the scene were taken. During subsequent interviews with an investigator, both Officer Clancy and Sergeant Waters stated that they knew where the Automated External Defibrillator (AED) equipment was in the facility, but were not trained in its use. Even though they were both CPR-trained, Officer Clancy stated that she did not know where the CPR mask was located. Sergeant Waters failed to provide any reasonable explanation as to why he chose not to provide life-saving measures to Mr. Buckley other then to suggest that "It wasn't necessary to…He was deceased." Of course, Sergeant Waters was not licensed as a physician to determine death, had never examined the victim to determine if he had any vital signs, did not know how long Mr. Buckley had been hanging, and his CPR training gave him the knowledge that an absence of vital signs required the initiation of CPR. Sergeant Waters later admitted that he was more concerned about preservation of the emergency scene then with saving Mr. Buckley's life.

David Claybrook, 31-years-old, was arrested on Christmas Day in 2003 for failure to appear in court, and passing bad checks. He was booked into the Adams County Jail. Four days later on December 29, Officer Carolyn Dempsey was conducting rounds and found Mr. Claybrook hanging from the bunk ladder in his cell by a sheet. The officer exited the cell and informed Officer Barry Ramsey of the emergency. Officer Ramsey, who had conducted the previous housing unit round over an hour earlier, then entered the cell, observed Mr. Claybrook hanging and "checked for a pulse, there was none." He then exited the cell and went to the control room to call the jail administrator, sheriff, investigator, ambulance, and coroner. Neither Officers Dempsey or Ramsey attempted to remove the ligature from around the victim's neck, or provide any life-saving measures to Mr. Claybrook. Instead, the victim's body was left hanging and photographs of the scene were later taken by an investigator. The coroner subsequently arrived and pronounced Mr. Claybrook dead.

Nelson Garrison, 24-years-old, was arrested for burglary, criminal trespassing, and criminal mischief, and booked into the Monument County Jail on July 10, 2005. He was later placed in the infirmary on close observation status following complaints of extreme anxiety, paranoia, visual hallucinations, and withdrawal from Methadone. He also had a recent history of suicidal behavior. Several days later on July 15, Mr. Garrison was found hanging from an electric conduit by a shoelace. Officer Jack Poppy called an emergency code, entered the cell, and tried to lift Mr. Garrison's body up to relieve pressure from the ligature. Another correctional officer arrived and assisted in holding up the victim's body. Removal of the ligature was delayed because neither officer, nor any other responding officers, had an emergency rescue tool (to quickly cut through fibrous material). The shoelace was eventually cut away from Mr. Garrison's neck by another officer's key. Mr. Garrison was then placed on the floor. Nursing staff arrived, but according to various correctional personnel, were unresponsive to the emergency and failed to initiate CPR. Another officer (Matthew Bottoms) arrived and took Mr. Garrison's vital signs. A pulse was detected, but the victim was not breathing. Officer Bottoms then requested various breathing equipment, including an oxygen tank, Ambu bag, and pocket mask. Because arriving medical personnel were not initially informed as to the nature of the medical emergency, they did not initially respond with proper emergency equipment, including an oxygen tank. Either a correctional officer or nurse then went to the medical unit, grabbed an oxygen tank, and returned to Mr. Garrison's cell. According to Officer Bottoms, "I looked at the tank and there was no regulator, there was no mask, there was no nasal cannular, there was no wrench to open the top of the oxygen tank so I asked for the Ambu bag." One of the responding staff then stated that there was no Ambu bag available, and a pocket mask bag was tossed to him. Upon examination, the pocket mask bag was empty. At some point, another officer retrieved an Ambu bag from the medical unit and gave it to Officer Bottoms, who then initiated CPR with the assistance of another officer. Nursing staff at the scene were still unresponsive to the victim.

The chaotic and delayed emergency response to Mr. Garrison's suicide attempt can best be described by Officer Mary Bryson, who detailed her observations in the following incident report:

> I responded to a code 37 in the infirmary area. When I arrived on the scene there were several officers already there and at least three nurses. Approximately four to five officers in the cell, trying to remove the shoelace from the pole and inmate Garrison. Officers were yelling 'get some scissors, we need some scissors to cut him down.' The nurses were unresponsive at first, then both myself and someone else yelled 'get the scissors!' One nurse began walking in the direction of the medical department to get the scissors, seeing that she was walking, I was instantly agitated and began running behind her, towards the medical area. She then began to run. Once in the medical area, she yelled 'I can't get the scissors, they are locked up, I don't have the keys.' At that time I went to leave the medical area back to the infirmary to get someone with keys, and another nurse entered into the area and checked a med cart, looked in a small black pouch, but found no scissors. I then went into the infirmary area and yelled 'they need the keys.' Another nurse began to respond, but then the officers stated he was down, implying that the inmate was no longer hanging. I then looked into the cell and saw inmate Garrison on the floor in his own urine, with his jumper open and the nurse standing over him. Noticing that the nurse did not have any gloves on, I grabbed some gloves and passed them into the cell for the nurse. The nurse then said 'He's not breathing,' and she just stood there looking at inmate Garrison. I then yelled, 'give him CPR, help him breath, do something.' I then began yelling, get the bag, get the oxygen, get a mask, help him breath. The nurses looked confounded. I looked into the cell again

and the inmate was still in the same position. I turned and looked behind me (away from the cell) and the nurse was kneeling on the floor, digging through a red medical bag. She appeared to be picking through it as if she wasn't sure of what to do. A supervisor asked the nurse who should they call, first aid or the paramedics, and the nurse responded, whoever can get here first. Shortly thereafter, I was instructed by radio, being the response relief three officer, to 'strap up,' I would be following the ambulance to the hospital, which would transport inmate Garrison.

I was horrified by what I had witnessed in the infirmary. Unfortunately, I don't know which horrified me most, the sight of inmate Garrison on the floor or the appearance of incompetence, un-preparedness, and the unprofessional response of the nurses on duty. The incident in itself was traumatic.

Two weeks later on July 28, 2005, Nelson Garrison succumbed to the injuries from his suicide attempt and died in the hospital.

Chaos Within A County Detention Center

Although staff training and identification of suicide risk are critical areas of suicide prevention, following a suicide attempt, the degree and promptness of the staff's *emergency response and intervention* often foretells whether the victim will survive. Perhaps few cases symbolize the systemic ineptitude regarding proper intervention following a suicide attempt than that of Quincy Rice, as well as eight other recent suicides in the County Detention Center. Arrested for a violent offense, Mr. Rice was placed in administrative segregation shortly after his arrival. He suffered from depression and spent long hours sleeping or inactive in his cell. Mr. Rice's intake screening form had indicated prior suicide attempts by hanging, wrist cutting, and drug overdose. He was seen frequently by the jail's mental health staff, later assessed as suffering from a "psychiatric disorder," and prescribed medication for depression. Mr. Rice was eventually placed on suicide watch for verbalizing suicidal ideation, and released from the watch five days later after a psychiatrist determined that he was stable.

Mr. Rice approached a mental health worker the following day and requested protective custody because he had been threatened by another inmate. The request was granted and Mr. Rice was locked in his cell. He was found hanging by a sheet from the door of his cell by an officer 15 minutes later. Mr. Rice was taken down and placed on the floor. No effort was made to initiate CPR by any of the correctional staff. Instead, the jail's medical staff were summoned and arrived more than 10 minutes later, apparently because they did not hear the first page over the intercom system. Upon arrival, medical staff initiated CPR and continued resuscitation efforts until EMS personnel arrived more than 45 minutes after Mr. Rice was found hanging. Due to the prolonged delay in initiating CPR, medical personnel were never able to obtain a pulse or breathing on the victim. Records also indicated that the oxygen tank did not function properly and a device to monitor cardiac rhythm was missing from the crash cart.

The death of Quincy Rice was the last of *nine* suicides to occur in the County Detention Center (CDC) during a recent catastrophic 24-month period. Situated in a large metropolitan area, the CDC has approximately 1,700 inmates. On an average day, 80 to 90 inmates are processed through the jail, or approximately 30,000 inmates per year. Although the facility predominantly houses pretrial inmates, there are a significant number of sentenced prisoners convicted of both misdemeanor and felony offenses. On-site medical personnel were available 24 hours a day, with mental health services available on-site five days a week and on-call around the clock. The facility has 18 housing blocks, including a forensic unit with 75 beds. Detailed below are summaries of the remaining eight inmate suicide cases, all of which involved grossly inadequate delays in intervention.

Month 1

Larry Stearns was committed to the CDC as a pretrial inmate charged with a minor offense. Due to certain information that was self-reported during the intake process, Mr. Stearns was placed in protective custody and housed in general population. However, his jail records did not accompany him to the housing unit and many correctional staff were apparently unaware of Mr. Stearns' protective custody status. In early evening two days later, several inmates found Mr. Stearns hanging by a sheet from the light fixture in his cell. Although the last recorded security check was an hour earlier and a meal delivery was completed 30 minutes earlier, it was not known when he was last physically observed by staff because, contrary to jail policy, a blanket had been covering his cell door and obstructing visibility. The inmates who found Mr. Stearns yelled out for correctional staff who arrived at the cell and had difficulty opening the door. Only after medical staff arrived five minutes later was the cell door opened and the victim removed from the light fixture. Although medical staff promptly responded to the emergency, they initially failed to arrive with any emergency equipment. After several additional minutes of delay, the equipment arrived and CPR was initiated. Mr. Stearns was subsequently transported to the hospital where he died three days later.

Month 2

John Turner was committed to the CDC as a pretrial inmate charged with a violent offense. He was processed, housed in general population and, for reasons that were unknown, placed in protective custody. Mr. Turner attended a court hearing five months later in which he was found guilty. The following night an inmate delivering meals on the housing unit observed him hanging by a sheet from the air vent in his cell. (Although the last recorded security check was an hour earlier, it is not known when Mr. Turner was last physically observed by staff because a towel was covering his door.) The inmate who found Mr. Turner yelled for assistance and an officer responded to the cell and attempted to remove the sheet from the victim's neck. However, although the officer was able to remove the victim from the air vent, he was unable to remove the sheet from around his neck. When medical staff arrived more than five minutes later, Mr. Turner was lying on his bunk with the sheet still tightly wrapped around his neck. The sheet was eventually removed and CPR was initiated, although medical staff reported that the victim's body appeared "cold." After a short time, first aid efforts were discontinued and Mr. Turner was pronounced dead at the scene by a jail physician.

WHAT THE STANDARDS REQUIRE

Detailed below is a listing of the applicable national correctional standards relating to emergency response within correctional facilities. Unless otherwise indicated, these standards apply to all types of correctional facilities, including city/county jails, prisons, juvenile facilities, and police department lockups/holding facilities.

AMERICAN CORRECTIONAL ASSOCIATION

Performance-Based Standards for Adult Local Detention Facilities, 4th Edition, June 2004
Performance-Based Standards for Correctional Health Care in Adult Correctional Institutions, 1st Edition, January 2002

Emergency Response

Correctional and health care personnel are trained to respond to health-related situations within a *four-minute response time* (emphasize added). The training program is conducted on an annual basis and is established by the responsible health authority in cooperation with the facility or program administrator and includes instruction on the following:

- recognition of signs and symptoms, and knowledge of action that is required in potential emergency situations
- administration of basic first aid
- certification in cardiopulmonary resuscitation (CPR) in accordance with the recommendations of the certifying health organization
- methods of obtaining assistance
- signs and symptoms of mental illness, violent behavior, and acute chemical intoxication and withdrawal
- procedures for patient transfers to appropriate medical facilities or health care providers
- suicide intervention

Comment: The facility administrator and the health care authority may designate those correctional officers who have responsibility for responding to health care emergencies. Staff not physically able to perform CPR are exempt from the expected practice.

NATIONAL COMMISSION ON CORRECTIONAL HEALTH CARE

Standards for Health Services in Jails, 7th Edition, 2003
Standards for Health Services in Prisons, 5th Edition, 2003

Training for Correctional Officers

A training program, established or approved by the responsible health authority in cooperation with the facility administrator, guides the health-related training of all correctional officers who work with inmates.

Compliance Indicators

1. All aspects of the standard are addressed by written policy and defined procedures.

2. Correctional officers who work with inmates receive health-related training at least every 2 years, which includes a minimum:

    a) administration of first aid;
    b) recognizing the need for emergency care and intervention in life-threatening situations (e.g., heart attack);
    c) recognizing acute manifestations of certain chronic illnesses (e.g., asthmas, seizures), intoxication and withdrawal, and adverse reaction to medication);
    d) recognizing signs and symptoms of mental illness;
    e) procedures for suicide prevention;
    f) procedures for appropriate referral of inmates with health complaints to health staff;
    g) precautions and procedures with respect to infectious and communicable diseases; and
    h) cardiopulmonary resuscitation.

3. The appropriateness of the health-related training is verified by an outline of the course content and the length of the course.

4. A certificate or other evidence of attendance is kept on site for each employee.

5. While it is expected that 100% of the correctional staff who work with inmates are trained in all of these areas, compliance with the standard requires that at least 75% of the staff present on each shift are current in their health-related training.

Discussion: This standard intends to promote the training of correctional officers to recognize when the need to refer an inmate to a qualified health care professional occurs and to provide emergency care until he or she arrives.

Because correctional personnel are often the first to respond to problems, they must be aware of the potential for emergencies that may arise, know the proper response to life-threatening situations, and understand their part in the early detection of illness and injury.

Emergency Services

The facility provides 24-hour emergency medical, mental health, and dental services

Compliance Indicators

1. A written plan includes arrangements for the following, which are carried out when necessary:

    a) emergency transport of the patient from the facility;
    b) use of an emergency medical vehicle;
    c) use of one or more designated hospital emergency departments or other appropriate facilities;
    d) emergency on-call physician, mental health, and dentist services when the emergency health care facility is not located nearby;
    e) security procedures for the immediate transfer of patients for emergency medical care; and
    f) notification to the person legally responsible for the facility.

2. Emergency drugs, supplies, and medical equipment are regularly maintained.

Discussion: This standard intends that sufficient emergency health planning occurs and is put into effect when necessary. Planning ahead for emergencies can help minimize bad outcomes. Policy and procedures address, for example, which facility on-call staff need to be notified, arranging for an ambulance, and alerting the community emergency room.

The choice of basic emergency equipment depends on the size of the facility, its distance from the nearest emergency department, and the level of staff training.

Suicide Prevention: Intervention

There are procedures addressing how to handle a suicide attempt in progress, including appropriate first-aid measures.

COMMISSION ON ACCREDITATION FOR LAW ENFORCEMENT AGENCIES

Standards for Law Enforcement Agencies, 5th Edition, 2006

Medical and Health Care Services

A written directive, approved by a licensed physician, identifies the policies and procedures to be followed when a detainee is in need of medical assistance.

Commentary: Arrangements for detainee emergency health care should be made with a local medical facility. If possible, a licensed health care professional should be identified as the emergency health care contact person. At least one on-duty person should be certified in first-aid. The intent of this standard is to ensure that staff recognize, take immediate action on, and report all detainee medical emergencies.

Month 4

Edward Booth was committed to the CDC as a pretrial inmate charged with a minor property offense. He was processed and housed in general population. On the morning of his third day of confinement, an inmate found Mr. Booth hanging by a sheet from the light fixture in his cell. (He had last been seen alive by staff approximately 30 minutes earlier while returning from the infirmary.) When correctional staff were alerted to the emergency, officers arrived at the cell and removed Mr. Booth from the light fixture, placed him in a chair and moved him into the corridor. Despite the presence of at least three correctional officers, CPR was not initiated until medical staff arrived approximately five minutes later. Mr. Booth was subsequently transported to the hospital where he died two days later.

Month 6

Fred Payton was committed to the CDC as a pretrial inmate charged with various property offenses. He requested and was approved for protective custody based upon a concern for his personal safety. Mr. Payton was assigned to the facility's forensic unit because of an extensive psychiatric history which included a diagnosis of chronic schizophrenia and depression. He also had a history of multiple suicide attempts and/or gestures that resulted in his placement on suicide watch in the CDC the previous year. During his most recent stay on the forensic unit, Mr. Payton was seen regularly by mental health staff, including a unit psychiatrist who prescribed psychotropic medication to control his depression and auditory hallucinations. The inmate's weekly progress notes by the psychiatrist often included the impression that Mr. Payton was calm and denied suicide ideation.

Mr. Payton was sentenced four months later and had a release date listed as the following month. However, one day prior to his release, Mr. Payton was informed that a parole board warrant had been issued that would continue his incarceration pending a revocation hearing. Shortly thereafter, a mental health worker passed Mr. Payton's cell and noticed that a blanket hanging on his door was obstructing visibility into the cell. She called out to the inmate who responded that he was using the toilet. She departed without further inquiry. Less than 30 minutes later an inmate walking down the corridor found Mr. Payton hanging by a sheet from the cell door. Correctional officers responded, removed the victim from the door, and placed him on the floor. Several mental heath staff responded to the scene and initiated CPR with the assistance of a correctional officer. Medical staff was notified, arrived five minutes later and continued resuscitative efforts until EMS personnel arrived more than 35 minutes after the incident was first discovered. In addition to the delayed medical response, there were again problems with the facility's medical equipment.

Month 9

Raymond Middleton was committed to the CDC as a sentenced inmate awaiting transfer to the state prison system to serve a term for a property offense. Due to an extensive psychiatric history, which included extended stays at a psychiatric hospital, Mr. Middleton was housed in the facility's forensic unit. He was considered a quiet inmate who preferred to be alone, and was in protective custody because he feared being housed in general population. Mr. Middleton was not considered suicidal. His medical file revealed that, although considered schizophrenic and delusional, a recent psychiatric consultation showed that his psychosis was in remission.

Following several months of uneventful confinement, Mr. Middleton was found hanging by a sheet from the air vent in his cell by an inmate picking up meal trays very early one morning. (Although the last recorded security check was 45 minutes earlier and the meal delivery to his cell was completed 15 minutes earlier, it is not known when Mr. Middleton was last physically observed by staff because the meal tray was still undisturbed at the cell opening and a blanket was covering his door.) The inmate who found Mr. Middleton yelled for assistance, and two correctional officers responded to the cell. Although officers cut the sheet off the victim's neck, CPR was not initiated until medical staff arrived approximately five minutes later. Medical staff later reported that Mr. Middleton's body appeared "cold" when they arrived, and had apparently been hanging for a prolonged period of time. Medical staff also had difficulty utilizing the oxygen tank, either because of faulty equipment or lack of oxygen in the tank. Mr. Middleton was subsequently transported to the hospital where he was pronounced dead.

Month 12

Darryl Dawson was committed to the CDC as a pretrial inmate charged with a violent offense. He was processed and housed in the forensic unit due to a psychiatric history that included at least three prior suicide attempts by hanging several years earlier and a threat of self-injury during his most recent prior incarceration. For reasons that are unknown, Mr. Dawson was placed in protective custody. Although he could not attend his initial appointment with the jail psychiatrist because he was at a court hearing, Mr. Dawson's mental health records nonetheless noted that he was "stable" and a follow-up assessment was recommended in four weeks. During the morning hours a few weeks later, several inmates found Mr. Dawson hanging by a sheet from the door of his cell. (He had last been seen by a nurse approximately 30 minutes earlier.) Several correctional staff responded to the cell and, with the assistance from other inmates, removed the victim from the door. After several minutes of waiting for medical staff to arrive, one officer and an inmate initiated CPR on the victim. The officer later stated that she only initiated CPR because medical staff took so long in responding to the emergency. Following two separate calls from the facility's Central Control station, medical staff arrived 15 minutes later and Mr. Dawson was pronounced dead.

Month 15

Johnny Whitley was committed to the CDC as a pretrial inmate charged with a violent offense. Although he was recommended for a mental health evaluation by the committing judge after the defendant stated his life was in danger, CDC medical staff was not notified of this referral and the inmate was cleared for general population housing. Mr. Whitley was placed under protective custody and transferred to another housing unit two days later after notifying correctional staff that: "I fear for my safety." In fact, Mr. Whitley was verbally harassed by other inmates during the transfer and correctional staff admitted that he was "genuinely

scared." Several hours later an inmate found Mr. Whitley hanging by a sheet from the bunk in his cell. Correctional officers responded, removed the victim from the bunk, and placed him on the floor of the cell. However, no effort was made to remove the tightly wrapped noose from his neck, nor was CPR initiated by any of the officers. Instead, medical staff arrived approximately five minutes later and determined that CPR would be fruitless because Mr. Whitley had been dead for a prolonged period of time.

Month 18

Wayne Scott was committed to the CDC as a pretrial inmate charged with a minor offense. Due to an extensive psychiatric history, which included two threats at self-injury while in the facility the previous year, Mr. Scott was housed in the forensic unit. While in the unit, the inmate asked to be placed under "protective custody" because he wanted "to be alone." Mr. Scott was initially diagnosed by a unit psychiatrist as suffering from an organic mental disorder. A progress note written by a psychiatric nurse during a screening clinic stated that the psychiatrist found him having trouble adjusting to incarceration, suffering from insomnia, situational depression, visual hallucinations, and recent paranoia. A progress note written a week later by a mental health worker indicated that Mr. Scott requested a cell change and removal from protective custody. A similar progress note was written two months later.

In the morning of the following day a correctional officer observed Mr. Scott crying, complaining that he was depressed and tired of being locked down. Approximately 30 minutes later, he asked to speak with a mental health worker regarding his protective custody status, but the worker refused to talk with him. A few minutes later Mr. Scott asked to speak to a physician's assistant who was on the unit conducting sick call, but was informed that he would have to wait until sick call was completed. Mr. Scott returned to his cell and several inmates observed him hanging by a sheet from the cell door 20 minutes later. Correctional staff rushed to the cell but had difficulty opening the door and removing the sheet. They eventually were able to remove the sheet and open the door, but not before Mr. Scott's body fell to the floor. The victim was placed on his bed and CPR was initiated by the physician's assistant who had been on the unit at the time. Additional medical staff arrived shortly thereafter, but had difficulty using the oxygen equipment (the tank was either empty or the value and/or tubing were non-functional). Mr. Scott was subsequently transported to the hospital where he was pronounced dead.

From Chaos to Calm

Aside from the above described features common in many of these suicides, it will appear obvious to our readers that there were several systemic deficiencies within the County Detention Center that resulted in these nine deaths. First, staff supervision of these inmates was grossly inadequate. With one exception, all of the victims were discovered hanging, not by correctional staff, but by other inmates. The victims were either found during the delivery of meals or by inmates simply walking by their cells. In three of the cases, it was not known when the victims were last physically observed by staff because either blankets or towels obstructed a view of the cell interior. In addition, the majority (five of nine) of the suicides occurred during daytime hours, ironically when staffing levels were the highest. In fact, five suicides occurred in the forensic unit, a housing location that boasted the highest staff complement. In addition, although the jail policy in effect at the time required that each inmate housed in the forensic unit be observed at intervals that did not exceed every 15 minutes, these cell checks were not consistently made or not made at all.

Second, despite the fact that the infirmary was in close proximity to all housing units, medical staff arrived five minutes or more from the time that eight of nine victims were discovered (10 minutes or more in two cases). In seven cases, medical personnel either failed to initially bring emergency rescue equipment or the equipment they brought was faulty. More importantly, with the exception of two cases, correctional staff failed to initiate CPR anytime during the critical period prior to the arrival of medical staff.

To correct the glaring deficiencies associated with intervention following these suicide attempts, the County Detention Center (with assistance from a suicide prevention consultant and federal court monitor) embarked upon the development of comprehensive intervention procedures that would be incorporated into their suicide prevention policy. CDC officials first looked to national correctional standards for guidance. As shown on pages 4 and 5, however, although both American Correctional Association (ACA) and National Commission on Correctional Health Care (NCCHC) standards address the issue of intervention, neither are elaborative in offering specific protocols. The ACA standards require that "personnel are trained to respond to health-related situations within a four-minute response time. The training program...includes the following: recognition of signs and symptoms, and knowledge of action required in potential emergency situations…administration of first aid and cardiopulmonary resuscitation (CPR)...suicide intervention," while NCCHC standards require that the "intervention" section of a facility's suicide prevention policy address "how to handle a suicide in progress, including appropriate first-aid measures."

CDC's intervention procedures were ultimately framed within three guiding principles: 1) All staff who come into contact with inmates will be trained in standard first aid and cardiopulmonary resuscitation (CPR); 2) Any staff member who discovers an inmate attempting suicide will immediately respond, survey the scene to ensure the emergency is genuine, alert other staff to call for medical personnel, and begin standard first aid and/or CPR; and 3) Staff will never presume that the inmate is dead, but rather initiate and continue appropriate life-saving measures until relieved by arriving medical personnel. With this framework, the following procedures were developed:

Suicide Intervention Procedures

1) All staff who come into contact with inmates will be trained in standard first aid and cardiopulmonary resuscitation (CPR). All staff who come into contact with inmates will participate in annual "mock drill" training to ensure a prompt emergency response to all suicide attempts.

2) All housing units will contain an emergency response bag that includes a first aid kit, pocket mask, microshield or face

shield, latex gloves, and emergency rescue tool. All staff who come into regular contact with inmates will know the location of this emergency response bag and be trained in its use. The emergency response bag will be inspected by correctional staff each shift to ensure all equipment is accounted for and in proper working order.

3) Any staff member who discovers an inmate attempting suicide will immediately respond, survey the scene to ensure the emergency is genuine, alert other staff to call for the facility's medical personnel, and bring the emergency response bag to the cell. If the suicide attempt is life-threatening, Central Control personnel will be instructed to immediately notify outside ("911") Emergency Medical Services (EMS). The exact nature (e.g., "hanging attempt") and location of the emergency will be communicated to both facility medical staff and EMS personnel.

4) The first responding officer will use their professional discretion in regard to entering the cell without waiting for backup staff to arrive. With no exceptions, if cell entry is not immediate, it will occur no later than four minutes from initial notification of the emergency. (Should the emergency take place within the Special Housing Unit and require use of the Cell Entry Team, the Team will be assembled, equipped and enter the cell as soon as possible, and no later than four minutes from initial notification of the emergency.) Correctional staff will *never* wait for medical personnel to arrive before entering a cell or before initiating appropriate life-saving measures (e.g., first aid and CPR).

5) Upon entering the cell, correctional staff will *never* presume that the victim is dead, rather life-saving measures will be initiated immediately. In hanging attempts, the victim will first be released from the ligature (using the emergency rescue tool if necessary). Staff will assume a neck/spinal cord injury and carefully place the victim on the floor (not mattress or other soft surface). Should the victim lack vital signs, CPR will be initiated immediately. All life-saving measures will be continued by correctional staff until relieved by medical personnel. If cell space is limited for CPR initiation, the victim may be carefully carried out onto the tier, ensuring protection of both the neck and spinal cord. The victim should *not* be carried to the infirmary or satellite nursing station.

6) The shift supervisor will ensure that both arriving facility medical staff and EMS personnel have unimpeded access to the scene in order to provide prompt medical services to, and evacuation of, the victim.

7) Although the scene of the emergency will be preserved as much as possible, the first priority will always be to provide immediate life-saving measures to the victim. Scene preservation will receive secondary priority.

8) An Automated External Defibrillator (AED) is located in the Special Housing Unit. All medical staff, as well as designated correctional personnel, will be trained (both initial and annual instruction) in its use. The facility medical director

EMERGENCY RESCUE TOOLS

Approximately 95 percent of all suicides occur by hanging. Prompt emergency response is often interrupted when correctional staff have difficulty loosening or removing the ligature from the victim's neck. Precious minutes are lost trying to locate a knife or other sharp object that can be utilized to cut the victim down without causing further injury. But conventional. straight-edge knifes, as well as medical shears or scissors, are often unable to cut through blankets or heavy cloth. There is also the obvious concern for safety and safely storing a knife or scissors within a correctional facility.

In recent years, specially designed knifes (often referred to as 911 rescue tools) have become available as safe and efficient devices in cutting a variety of fibrous materials found in correctional facilities. With its hooked shape, the rescue tool allows for rapid insertion between the ligature and the skin, with no risk of cutting the victim. (In fact, paramedics and fire fighters have historically utilized these knifes to cut seatbelts away from automobile accident victims, while mountain climbers utilize the knifes for clearing lines and outdoorsmen use them for cleaning fish and deer.) Several models, such as the Addis Wonder Knife shown above, are preferable because they contain a replaceable stainless steel blade that can quickly cut through all fibrous material found in a cell — including blankets, sheets, clothing, belts, and shoelaces. And because the blade is located inside the frame of the tool, it can not be utilized as a life-threatening weapon in the hands of an inmate.

Emergency rescue tools have become a standard piece of the equipment for responding to a hanging attempt. The tools are commonly utilized in all types of correctional facilities, including city/county jails, prisons, juvenile facilities, and police department lockups/holding facilities. Because a suicide attempt can occur within any inmate housing unit, it is strongly recommended that one rescue tool should be securely placed with other emergency response equipment in an easily accessible location in each housing unit of the facility.

will provide direct oversight of AED use and maintenance. (See also policy on "Automated External Defibrillator Use.")

9) The facility medical director will ensure that all equipment utilized in the response to medical emergencies (e.g., crash cart, oxygen tank, AED, etc.) is inspected and in proper working order on a daily basis.

10) All staff and inmates involved in the incident will be offered critical incident stress debriefing. (See policy on "Critical Incident Stress Debriefing.")

Conclusion

Many correctional officials cling to the misguided belief that suicide prevention and the collateral issues of liability begin and end at the point of intake when the detainee is assessed for the risk of self-harm. It has become well established, however, that suicide prevention is a multidimensional issue and includes a prompt emergency response and intervention following self-injury. As shown below, federal courts have ruled that correctional officials and their staff can be held liable for delaying and/or failing to provide prompt emergency medical services to inmates.

In conclusion, any inmate death that results from unclear or confusing procedures, inadequately trained, callous or simply unwilling participants, and faulty (or non-existent) equipment is inexcusable. As reflected by both their written policy and actions, correctional facilities that fail to adequately address the issue of prompt intervention following a suicide attempt will substantially increase the likelihood of preventable deaths and subsequent litigation. ❑

What do the Courts Say?

In ***Heflin v. Stewart County*** [958 F.2d 709 (6th Cir. 1992)], a deputy went to the decedent's cell on September 3, 1987 and saw a sheet tied to the cell bars. The deputy immediately went to the dispatcher's office, told the dispatcher to call the sheriff and ambulance service, picked up the cell block keys, and returned to open the cell. When the deputy entered the cell, he observed the decedent "hanging by the neck on the far side of the shower stall." The decedent's hands and feet were tied together, a rag was stuffed in his mouth, and his feet were touching the floor. With the body still hanging, the deputy checked for a pulse and signs of respiration, but found none though the body was still warm. He also opened the decedent's eyes and found the pupils were dilated. From these observations the deputy concluded that the decedent was dead. While the deputy was still alone in the cell with the hanging body, a jail trusty arrived with a knife he had picked up in the kitchen. Rather than utilize the knife to cut the decedent down, the deputy ordered the trusty out of the area. The sheriff arrived shortly thereafter and directed the deputy to take pictures of the decedent before he was taken down.

At trial, the plaintiffs introduced evidence that the county maintained a policy of leaving victims as discovered, despite the ability to resuscitate victims. They ultimately prevailed and a jury awarded damages to the decedent's family based upon proof that the defendants' acted with deliberate indifference after discovering the decedent hanging. The defendants appealed and argued that the decedent was already dead and their action or inaction could not have been the proximate cause of his death. The appeals court ruled that "there clearly was evidence from which the jury could find that Heflin died as the proximate result of the failure of Sheriff Hicks and Deputy Crutcher to take steps to save his life. They left Heflin hanging for 20 minutes or more after discovering him even though the body was warm and his feet were touching the floor...The unlawfulness of doing nothing to attempt to save Heflin's life would have been apparent to a reasonable official in Crutcher or Hick's position in 'light of pre-existing law'..." The court also affirmed the award of damages in the amount of $154,000 as well as approximately $133,999.50 in attorney fees.

In ***Tlamka v. Serrell*** [244 F.3d 628 (8th Cir. 2001)], the appeals court ruled that three correctional officers could be sued for allegedly ordering inmates to stop giving CPR to an inmate who collapsed in a prison yard following a heart attack. The court stated that:

> Based on the obvious and serious nature of Tlamka's condition, the corrections officers' alleged failure to even approach Tlamka during the maximum 10-minute period would rise to a showing of deliberate indifference. None of the parties dispute that Tlamka's medical condition was objectively serious nor that it was obvious to those present at the scene that his condition was life threatening. Nevertheless, according to the plaintiff's witnesses, the corrections officers failed to provide CPR or approach Tlamka for a period of 10 minutes (albeit that time estimate is provided by only one inmate) even though all three officers were trained to provide CPR. The officers' alleged inaction occurred even though they were presumably aware that Tlamka had been responding favorably to the CPR provided by the inmates, and an inmate told them that it was essential that CPR be continued under the circumstances. This alleged failure to act given the patent nature of Tlamka's condition, considering the corrections officers' ability to provide CPR, is conduct sufficiently severe to evidence an Eighth Amendment violation.

In ***Bradich v. City of Chicago*** [413 F.3d 688 (7th Cir. 2005)], the appeals court ruled that deliberate indifference could occur if correctional staff unnecessarily delayed (up to 10 minutes) the emergency medical response, including CPR:

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

The Estate's preferred answer is that the three officers are dissembling about their activities during the critical ten minutes. As the Estate sees things, delay in calling for outside assistance was a deliberate choice, not a side effect of devoted rescue attempts….Protecting one's employment interests while an inmate chokes to death would exemplify deliberate indifference to serious medical needs....If the Estate is right about what happened during the ten minutes, the lockup keepers are not entitled to qualified immunity: no reasonable officer could think that the Constitution allowed him to cover up his own misconduct at the expense of a prisoner's life. ❑

USE OF AUTOMATED EXTERNAL DEFIBRILLATORS IN CORRECTIONAL SETTINGS

(A Position Statement of the National Commission on Correctional Health Care)[1]

Background

Approximately 360,000 Americans experience sudden cardiac arrest annually. Ventricular fibrillation (VF) is the most common cause of sudden cardiac arrest with pulseless ventricular tachycardia (VT) as another leading cause. The standard therapeutic response to ventricular fibrillation and pulseless ventricular tachycardia is defibrillation. Sudden cardiac arrest is survivable. The sooner defibrillation is provided after onset, the greater the likelihood that the patient will survive a VF or VT event. It has been demonstrated that within the first ten minutes of a sudden cardiac arrest, a patient's survival rate improves 10 percent for every minute that is saved by getting the defibrillator to the patient (Eisenberg, Horwood & Cummins, 1990). Technological innovations in Automated External Defibrillators (AEDs) have made early defibrillation programs possible in many public places, such as airplanes, restaurants, and sport facilities. The American Heart Association (AHA) has recommended that all communities implement a principle of early defibrillation with use of AEDs, strengthen their access to the emergency dispatch system, promote cardiopulmonary training and response, and coordinate first response units with advanced life support units (American Heart Association, 1990).

An AED is an electronic device, first introduced in 1979, that interprets cardiac rhythms, makes a "shock" or "no shock" decision, and, if appropriate, delivers an electrical shock to the patient. An AED can be applied by non-physician medical personnel and lay persons with minimal training. The simplicity of an AED makes training and application easy. Studies have shown that volunteer first responders can remain effective past six months of a brief two-hour training in applying an AED (Walters, Glucksman & Evans, 1994).

AEDs have been found to be very effective. Studies on AED use have shown they can be instrumental in successful out-of-hospital cardiac resuscitation in adults (Stapczynski, Burklow, Calhoun & Svenson, 1995). Children and young adolescents have also benefited by the early application of AEDs (Atkins, Hartley & York, 1998). Typically, AED units cost a few thousand dollars, have few maintenance costs, and are lightweight and durable. Studies have found AEDs to be reliable, and experts have called for increased federal and state support for AED utilization (Smith & Hamburg, 1998). Safeguards in the equipment prevent accidental defibrillating shocks.

AEDs have become the standard of care for sudden cardiac arrest (Cummins, 1993). Training in the application and use of AEDs has become standardized in the AHA's Advanced Cardiac Life Support (ACLS) curriculum. The success of AEDs in improving cardiac survival from a sudden arrest, its ease of use, and a fail safe technology has led the AHA to call for its use even by non-medical, minimally trained personnel (e.g., security guards and spouses of cardiac patients). The American College of Emergency Physicians (ACEP) endorses the use of AEDs when integrated into the emergency medical system (American College of Emergency Physicians, 1991 and 1993). The question facing correctional facilities is, should they incorporate AEDs into their medical systems, and if so, how?

Most correctional facilities are not practically able to maintain ACLS capability in the institution on a 24-hour a day (or even part-time) basis. Most rely on the local EMS system to bring ACLS into the institution when it is required. AEDs used in the institution can provide the early defibrillation needed prior to ACLS arrival.

The implementation of an early defibrillation program requires careful study and analysis. Correctional administrators and medical directors considering the use of AEDs, should identify when AEDs should be used, who should be trained in their use, and where AEDs should be kept.

Position Statement

Institutions considering the implementation of an early defibrillation program and the use of AEDs should do so only after a thorough needs analysis with input from physicians who are experienced in implementing such programs. Correctional institutions should refer to the Commission's Standards for Health Services in Prisons, the Standards for Health Services in Jails, and Standards for Health Services in Juvenile Detention and Confinement Facilities for further guidance. The standards on Emergency Plan, Communication on Special Needs Patients, Continuing Education for Qualified Health Care Professionals, Training for Correctional Officers, Position Descriptions, Assessment Protocols, and Emergency Services may be of assistance to correctional administrators.

Correctional institutions differ in size, type, population, and staffing. The decision as to who should be trained in the use of

[1]Reprinted with the permission of the National Commission on Correctional Health Care, Chicago, Illinois.

AEDs in a correctional facility should be made by the medical director in collaboration with the correctional authority. Correctional officers are generally the first responders to any situation in a jail, prison, or juvenile facility, and as such should be given appropriate training and permitted to use AEDs. When a facility is staffed 24 hours with health care staff, it may not be necessary to train correctional officers in the application of AEDs. In prisons, jails, and juvenile detention and confinement facilities that do not have health staff on a 24-hour basis, correctional officers are an essential element of an early defibrillation program and should be trained accordingly.

AEDs should be located were there will be quick and easy access by individuals who are trained in their use. The decision of where to place an AED in a correctional facility must be determined by the medical director working in conjunction with the facility administrator, taking into account the staffing and facility design. The following recommendations provide guidelines for instituting AEDs in a correctional setting:

1) The use of AEDs should be approved, planned, and implemented under the direction of the responsible physician in collaboration with the facility authority.

2) An early defibrillation program includes a training program to designated staff who would be authorized to use AEDs. This includes both initial and periodic in-services as appropriate.

3) The location of AEDs should be approved by facility administrators and the responsible physician, taking into account the staffing and design of the facility.

Adopted by the National Commission on Correctional Health Care, Board of Directors: November 1, 1998.

References

American College of Emergency Physicians (1991). Statement on early defibrillation. *Circulation*, 83: 2233.

American College of Emergency Physicians (1993). ACEP policy statement on implementation of early defibrillation/ automated external defibrillator programs. *Annals of Emergency Medicine*, 22: 768.

Atkins, D. L. Hartley, L. L. & York, D. K. (1998). Accurate recognition and effective treatment of ventricular fibrillation by automated external defibrillators in adolescents. *Pediatrics*, 101 (3 Part 1): 393-397.

Cummins, R. O. (1993). Emergency medical services and sudden cardiac arrest: The 'chain of survival' concept. *Annual Review of Public Health*, 14: 313-333.

Eisenberg, M. S., Horwood, B. T., Cummins, R. O. (1990). Cardiac arrest and resuscitation: A tale of 29 cities. *Annals of Emergency Medicine*, 19: 179-186.

Smith, S. C., & Hamburg, R. S. (1998). Automated external defibrillators: Time for federal and state advocacy and broader utilization. *Circulation*, 13: 1321-1324.

Stapczynski, J. S., Burklow, M. Calhoun, R. P. & Svenson, J. E. (1995). Automated external defibrillators used by emergency medical technicians: Report of the 1992 experience in Kentucky. *Journal of Kentucky Medical Association*, 93(4); 137-141.

Walters, G., Glucksman, E., & Evans, T. R. (1994). Training St. John ambulance volunteers to use an automated external defibrillator. *Resuscitation*, 27(1): 39-45.

UPDATE
ON THE INTERNET

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

www.ncianet.org/suicideprevention

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

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

www.hhpub.com/journals/crisis/1997
www.nicic.org
www.ncjrs.org/html/ojjdp/jjjnl_2000_4/sui.html
www.cimh.org/publications/publications.cfm
www.omh.state.ny.us/omhweb/forensic/suicide.htm
www.pbstandards.org/ResourceSection.aspx?id=4

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.

Ohio

Seven of every 10 youths sent to Ohio's juvenile prisons have been diagnosed with a mental illness and are supposed to get treatment while they're locked up. But for many, help never comes. With too many troubled young adults and not enough professionals to treat them, only those with the most severe problems get much therapy. For the rest, one-on-one counseling is rare except when youths are in danger of hurting themselves or others.

All inmates attend group meetings to discuss how to change their attitudes and behavior. Although each inmate is assigned to a social worker, only about half of those who hold that job title are licensed to offer therapy. "If we're going to rehabilitate kids, we're going to have to get them treatment," said Cheri Walter, chief executive officer of the Ohio Association of County Behavioral Health Authorities. "Not all the kids who need treatment are getting it." Walter pointed to state statistics as proof of gaps. Although mental illness has been diagnosed in 70 percent of juvenile-prison inmates, only about one-third of them are scheduled to see a psychiatrist or psychologist regularly.

Federal investigators agree that more needs to be done. A two-year probe of the Scioto prison in Delaware County found that "a number of obvious candidates for psychiatric care were not referred for psychiatric assessment." The U.S. Department of Justice discovered "significant deficiencies in almost every aspect of mental-health care" in the Delaware County prison, where all convicted girls are housed and where all boys are evaluated before they are sent to other prisons. The investigation, which began in 2005 and ended in May, also included the prison in Marion County. Young felons with significant mental-health problems received only "superficial treatment" at both prisons, investigators found. Parents and defense attorneys told *The Dispatch* that some youths have been taken off medications, or their illnesses incorrectly diagnosed.

Differing Diagnoses

Vincent Walker was one of them, said his attorney, Linda Julian. Walker arrived at the Delaware County prison in November 2005 with a document detailing a diagnosis of bipolar disorder. A psychologist at Case Western Reserve University Hospital had evaluated Walker a week earlier, Julian said. Employees at the prison instead diagnosed oppositional defiant disorder and wrote that Walker, then 16, didn't need follow-up appointments with the mental-health staff, prison records show. While in juvenile prison, Walker repeatedly attacked inmates and employees. He was locked in solitary confinement on three occasions, each time for two weeks. There, he sat alone in a 9-by-8-foot cell with no television or radio.

Walker, now 18, was sent to juvenile prison for stealing a man's car and threatening him with a gun. He was sentenced to at least a year. But months were continually added to his sentence because he kept getting into fights. He now sits in an adult prison, where he was transferred in July after attacking a juvenile-prison employee. "Of course, you're having kids with behavior problems in there because their mental-health problems aren't being addressed," Julian said. "It's scary to take a kid that's mentally ill and not give him medication."

John F. Bradley, medical director of the juvenile-prison system, said the symptoms of bipolar disorder and oppositional defiant disorder are similar. Oppositional defiant disorder typically is not treated with medication, he said. With every case, there "should be an ongoing evaluation" of whether the diagnosis and the treatment plan are right, Bradley said. Whether that happened with Walker, prison officials would not say, citing privacy laws. But Julian said that did not happen. "There are times we will not recognize each and every kid that is suffering from a mental illness," said Monique Marrow, who manages treatment and rehabilitation for the juvenile-prison system. It's not common, she said, although she couldn't say how often it happens. "If a kid comes in and we believe there's a significant mental-health issue, we would make a referral for them to be seen by a psychologist," Marrow said.

The juvenile-prison system has 31 psychologists and assistants for about 1,800 inmates. The Marion prison, which typically gets the most violent, troubled felons, has three psychologists for 280 inmates. That prison's mental-health unit might be shut down because of low staffing and other conditions federal investigators found. Even adolescents without a severe mental illness can get help, Marrow said. "Therapy happens at all different levels," she said. "Every kid has a social worker. Sometimes, our kids just need someone to talk to."

Lawyers with the Children's Law Center, a Kentucky-based nonprofit, have challenged state officials who say youths are getting enough help. They are suing the state to try to get regular mental-health treatment for locked-up adolescents. A committee of child advocates and mental-health professionals agreed with the nonprofit group after checking out the prison system last winter for then-incoming Gov. Ted Strickland. The panel recommended that more youths go to smaller centers that focus on helping them resolve what's causing them to break the law.

Alternative Treatment

Every year, 15 percent to 20 percent of the adolescents found guilty of felonies in Ohio's juvenile courts go to juvenile prison. The rest are put on probation or sent to alternative programs to teach them how to behave. Franklin County sent the second-highest number of youths to juvenile prison in the 2006-07 fiscal year: 205, an increase of about 20 percent over the previous year. Although the county is trying to send more young felons to alternative programs, less state money is coming in to pay for them. This year, Franklin County will receive $2.5 million, 22 percent less than last year and 37 percent less than in 2005. This is because the county is sending more youths to juvenile prison and they are staying longer. The state maintains that youths convicted of less-violent crimes should be dealt with in the community.

Judges set the minimum time youths will stay in prison, but the prison system can give them more time. And it often does. Most inmates in Ohio's juvenile prisons are staying locked up past their expected release date in part because of glitches in the prison system, said Larry Travis, a University of Cincinnati professor the prison system hired as a consultant. Some youths have had to wait to get into prison treatment programs, Travis said. Sometimes, prison employees are late in conducting required reviews to see if inmates are ready to get out. Youths who don't complete some group-therapy programs must repeat them, but openings might be unavailable for months. Every day a youth is in prison costs taxpayers an average of $219. "I

think (prison administration officials) are aware of the problems and they're trying to fix them," Travis said. But "It's a very entrenched bureaucracy, as is in any large organization."

Sex offenders and juveniles hooked on drugs or alcohol have had some of the longest waits. For example, a 16-year-old was ordered to serve at least 100 days and complete a four-month substance-abuse program at the Freedom Center, a juvenile prison in Delaware County. She entered the prison in August 2006 but wasn't taken to the treatment center until January. The prison system extended her stay to July. Last week, she was still there.

She is one of six plaintiffs in the lawsuit filed by the Children's Law Center in March. The suit faults the prison system for keeping youths in longer because of bureaucratic foul-ups and not enough therapy programs. "It's disturbing," said Franklin County Juvenile Court Judge Dana Suzanne Preisse. "We shouldn't be having them languish."

A fix is said to be in the works. By January, Franklin County's Juvenile Court staff will determine which treatment programs youths need before they arrive in prison. That's expected to eliminate a lot of the time spent in the prison-system's reception center, where youths are evaluated to see where they will serve their sentences.

A handful of juvenile courts across the state already are doing that. One of them is in Stark County, where the average stay for youths in the prison reception center dropped from two months to two weeks. Juvenile Court staff members also are looking into how Franklin County can offer more programs in the community so inmates can get out of prison early and get outside treatment.

The above article, "Most Inmates Mentally Ill, But Treatment Can Be Sparse," was written by Alayna DeMartini, a staff writer for ***The Columbus Dispatch****, and appeared in the September 9, 2007edition of the newspaper. Copyright 2007,* ***The Columbus Dispatch****. All rights reserved. Used with permission.*

Editor's Note*: On April 3, 2008, a comprehensive class-action settlement which outlines reforms for the Ohio Department of Youth Services (DYS) was filed in the United States District Court for the Southern District of Ohio, Eastern Division. According to the joint press release from DYS and Al Gerhardstein, Esq., plaintiffs' counsel with Gerhardstein and Branch, the system-wide scope of* ***S.H. v. Stickrath*** *(Case No. 2:04-CV-1206) creates a long-term investment in Ohio youth by infusing new resources into DYS operations, overseeing reform in the process for determining when youth should be released from DYS custody, and supporting evidence-based community programs for low-risk offenders.*

Changes include hiring up to 115 juvenile correctional officers, as well as other staff in various areas of expertise, increasing training, and revising use of force, seclusion and discipline policies. The agreement also supports improved mental health services, enhanced educational, medical and dental services, and a capacity goal on the youth population. Although the final cost of implementing the agreement is still to be determined, it is estimated to annually increase the DYS budget between $20 to $30 million.

"The agreement turns a new corner in DYS history, and allows us to continue to aggressively move DYS forward in a meaningful way," Tom Stickrath, DYS Director, stated in the release. "This settlement builds on the dedication and professionalism of our current workforce and provides them with additional tools to increase rehabilitation opportunities and safety within our facilities."

The settlement agreement resolves a class-action lawsuit that originated in December 2004 and was followed by a January 2008 consultant fact-finding report. Attorneys for the youth, and state officials, worked collaboratively to negotiate the comprehensive settlement in order to respond promptly to the problems identified in the report and to avoid costly litigation. Joining Gerhardstein and Branch as plaintiffs' counsel in the lawsuit were the Children's Law Center; Ohio Justice and Policy Center; Sirkin, Pinales, and Schwartz; and Youth Law Center. Mr. Gerhardstein stated, "I commend the State for joining in this comprehensive remedy. Not only does this plan

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.

Phase 1 surveys were distributed in 2007. Phase 2 surveys were distributed in early 2008. 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

outline action to reduce violence and make programming more appropriate, it also will ensure DYS is holding youth for an appropriate length of time. In addition, the plan safeguards public safety while working toward more youth being served in smaller, more appropriate, community-based facilities. In this way we are following the lead of other states, using proven strategies."

The settlement will not become effective until it is approved by the federal court. Once approved, consultant Fred Cohen will monitor the compliance of the agreement. A full copy of the draft settlement agreement and the fact-finding report are available online at www.dys.ohio.gov.

Pennsylvania

A man who hanged himself in a police department lockup on Thanksgiving morning, November 22, 2007, had tried to hang himself twice earlier in his cell, but police personnel were unaware of the suicide attempts because no one was monitoring the closed circuit television (CCTV) cameras. William Hazen, Jr., 30-years-old, was arrested for public intoxication and placed in a holding cell of the Jeannette Police Department. According to Police Chief Jeff Stahl, there were two officers on duty on the overnight shift and both were on patrol at the time of the death. The police department has 14 full-time officers and at least two staff every shift. Officers on patrol are required to return to the station every 30 minutes to check on detainees. But that apparently did not happen.

Mr. Hazen was arrested at 2:00am and last seen alive at 3:30am on November 22. He was discovered hanging from the cell bars by a sweatshirt when one of the patrol officers returned to the station at the end of his shift at 5:00am. CCTV cameras are located in each of the police department's four holding cells, with monitors located in the squad room and secretary's office. With no other personnel in the building at the time, Mr. Hazen was left unobserved. The detainee's other suicide attempts were discovered when investigating detectives reviewed the videotape from the camera in his cell.

Mr. Hazen's stepmother did not blame anyone for his death, but questioned police department policy. "I'm not asking for a baby sitter," Alicia Hazen told the *Pittsburgh Tribune-Review*. "He was 30 years old. The boy tried to hang himself twice with his Steelers sweatshirt, they told me. Where were they between 3:30 and 5:00am, and why didn't they see the camera?" Chief Stahl said William Hazen's suicide would force him to consider revisions to the department's policy. "We're going to review our policy," he told the newspaper. "We're going to present some things to council. I have some ideas that I'm discussing. If we had three guys working, we could keep one guy here. We need to implement a new policy."

Illinois

Sometime before the sun came up, Charles Slaughter Jr. wedged a sheet into a smoke detector in his cell at the Rock Island County Jail and slipped the fabric around his neck. The Colona, Ill., man had been declared unfit to stand trial on theft charges two weeks earlier. The 43-year-old father of two was waiting to be taken to a mental-health hospital where he could be treated for his bipolar disorder and drug abuse.

But he had already spent five unmedicated months behind bars by the time he took the sheet off his bunk on July 16, 2006. The wait was too long. When Ray Conklin, a judge with less than two years on the bench, read about Slaughter's jailhouse suicide in the newspaper the next morning, he became sick to his stomach. "Honestly, I thought I was going to throw up," he said. "I knew what had happened. I knew we had to do something."

He also knew it wouldn't be easy. Even if the county had mental-health support money to burn, how would the judicial system burn it? How would mentally ill inmates be moved through a system that is not equipped for their brand of troubles? What about the culture that treats the mentally ill? Would they be ready to play ball? Would the state's attorney even listen to Conklin's idea that maybe it was time for Rock Island County to have a separate mental health court?

To the judge's surprise, people listened. In fact, everyone seemed to agree: There is struggle enough in being labeled mentally ill. Maybe the label of criminal could be avoided if, for instance, medications could be court-ordered. Conklin had all sorts of ideas for keeping the mentally ill out of his criminal court where, as he saw it, they didn't belong. And now his ideas are coming to life in a tiny courtroom beneath the row of cells where Charles Slaughter Jr. took his own life.

An Open Book

Three of the most important women in Charles Slaughter's life — his two sisters and a daughter — use the same words to describe him: "The most loving person I ever knew." But they also knew the hardworking welder had a dark side. He simply never brought it home. Diagnosed with bipolar disorder in about 2002, Slaughter did not want to take medication that might have helped with his depression and mood swings. He was afraid of the side effects. So he did what many others with his diagnosis do. He turned to illegal drugs as a way of medicating himself. To get money for the drugs, he turned to crime. But he wasn't very good at it. The last bad move to land him in jail was an attempt to walk out of a big-box store with a TV.

"It was stuff like that," said one of his daughters, Kayla Hollars of Moline. "He did some bad things, but it was all tied to the mental illness. He never used drugs when he was around us. He never physically hurt anyone. He couldn't. He wasn't made that way."

Slaughter could more reliably be counted on to protect his family, play on the floor with the children, show off another big fish he pulled out of the river and infect everyone around him with his laugh. When the bipolar disorder came to call, he often took off, shielding his family from the behavioral fallout of the illness. The depression was impossible to hide. "He was pretty much an open book about who he was," Hollars said. "His one fear was being alone," added his sister, Kassandra Walters of Colona.

But the fear and depression seemed to be on the shelf in July 2006. In fact, the last letter his mother received from him from the jail was "really high-spirited," his sisters said. "He was asking for regular clothes that he could wear at the hospital when they came to get him," said his other sister, Kim Bowden, also of Colona. "He was looking forward to getting some help." The next day, he killed himself.

Five Long Months

Slaughter had tried suicide at least twice before. He had been an off-and-on patient at Robert Young Mental Health Center, family members said. Despite his history with Robert Young, the bipolar diagnosis and the previous suicide attempts, he spent months in the Rock Island County Jail with no medication, no treatment and no mental health evaluation. He was not put on suicide watch. After more than three months in jail, one of his public defenders asked for a psychiatric evaluation, which concluded Slaughter was unfit to stand trial.

All those months in jail were more than he could take. "The Department of Human Services coming to get him a lot faster is what would have helped him," Rock Island County State's Attorney Jeff Terronez said. "Judge (Ray) Conklin has developed a hell of a relationship with DHS since we started the mental health court. Things would be different today."

Ironically, Slaughter's suicide had a lot to do with Conklin's relationship with DHS. And it was largely Slaughter's death that cinched the judge's resolve to get help for mentally ill inmates who were left to languish in the county jail. "He (Slaughter) would be handled completely differently now," Conklin said. "He'd have come to somebody's attention. He would've been evaluated."

About seven months before Slaughter's death, at least two other county officials were pushing to get something done about prisoners like him — people with mental-health issues who would not be committing crimes if not for their other problems.

Sheriff's Capt. Steve Dean was the jail administrator in December 2005 and sent a memo to Court Administrator Vicki Bluedorn, who Dean said shared his frustrations over the treatment of mentally ill inmates. "It frustrated me greatly," he said. "We were getting all these people who were not criminals but are mentally ill. They weren't medicated. They were drinking their own urine and eating their own feces. There were assaults on correctional officers. "It was inhumane, all the way around."

Sixteen months after Dean wrote his memo and nine months after Slaughter's suicide, the Rock Island County Mental Health Court opened for business for the first time. Today, there are at least 20 people with diagnosed mental illnesses who appear there — sometimes every week. Some still land back in jail, sometimes for failing a drug test or missing a dose of court-ordered medication.

The system is imperfect, say the people who are creating it, but it is better than what came before, which, too often, was nothing. A person still has the right to refuse to take medication, and no one can be forced to admit they need it. Slaughter never did. "My dad would be really happy that people are getting the help they need, but he didn't see himself as having a mental illness," Hollars said. "He thought his problem was drugs."

Contributors to Criminal Behavior

Charles Slaughter Jr., 43, of Colona, Ill., was diagnosed with bipolar disorder several years before he hanged himself in the Rock Island County Jail in July 2006. The disorder is one of the most commonly diagnosed mental illnesses in the United States. Schizophrenia and major depressive disorder are the other most commonly diagnosed mental illnesses and frequently contribute, authorities say, to criminal behavior and, consequently, imprisonment.

- Bipolar disorder, or manic depression, is a medical illness that causes extreme shifts in mood, energy and functioning. These changes may be subtle or dramatic and typically vary greatly over the course of a person's life as well as among individuals. More than 10 million people in America have bipolar disorder, and the illness affects men and women equally.

- Major depression is a serious medical illness affecting 15 million American adults, or approximately 5 to 8 percent of the adult population. Unlike normal emotional experiences of sadness, loss or passing mood states, major depression is persistent and can significantly interfere with an individual's thoughts, behavior, mood, activity and physical health. Among all medical illnesses, major depression is the leading cause of disability in the U.S. and many other developed countries.

- Schizophrenia is a serious and challenging medical illness, an illness that affects more than 2 million American adults, which is about 1 percent of the population age 18 and older. Although it is often feared and misunderstood, schizophrenia is a treatable medical condition. Schizophrenia often interferes with a person's ability to think clearly, distinguish reality from fantasy, manage emotions, make decisions and relate to others.

The above article, "Jail Suicide Inspires RI Judge to Start Mental Health Court," was written by Barb Ickes, a staff writer for the ***Quad-City Times****, and appeared in the January 13, 2008 edition of the newspaper. Copyright 2008,* ***Quad-City Times****. All rights reserved. Used with permission.*

New Mexico

In November 2007, the American Civil Liberties Union (ACLU) of New Mexico filed suit against the state Children, Youth, and Families Department (CYFD) for failing to ensure safe living conditions and essential rehabilitation services for youth adjudicated delinquent and confined in the state's juvenile facilities. The lawsuit, entitled *ACLU of New Mexico v. New Mexico*

Children, Youth and Families Department, et al, charged that CYFD breached terms of a settlement agreement that it signed with the ACLU in February 2006 requiring the agency to establish minimally adequate mental health services and protect youth from physical assaults and threats of violence. "This lawsuit seeks to make sure that youth in our juvenile justice system get a fair shot at redirecting their lives and overcoming mistakes they made in their past," ACLU Executive Director Peter Simonson said in a statement. "New Mexico puts its most troubled kids in prison because we don't have adequate mental health services. Kids are unnecessarily incarcerated and our juvenile detention facilities become training grounds for lifelong criminals instead of centers of genuine rehabilitation."

Filed in state court (First Judicial District, County of Santa Fe), the lawsuit seeks two basic reforms: 1) establish minimally adequate community mental health services for the 3,000 children and youth on probation or parole due to delinquent acts, in order to avoid the unnecessary incarceration of youth due to their mental illness; and 2) fundamentally improve the safety, medical care and mental health care provided to the approximately 300 children and youth held in the facilities.

The civil complaint cites several instances of officer-on-youth violence, including a March 2007 incident in which staff at the Santa Fe County Juvenile Detention Center, CYFD-contract facility, assaulted a 17-year old resident who was developmentally delayed and suffered from auditory hallucinations. The officers allegedly picked the youth up by his armpits and repeatedly slammed his head into a metal classroom door. CYFD rejected a complaint that the ACLU filed on the resident's behalf, except to criticize staff for failing to videotape the 'take down.'

Mr. Simonson said, "Hopefully your children don't wind up in one of these facilities. But if they do, you want to know that the staff is going to protect them, not brutalize them. You want to know that they're going to get the tools they need to address emotional problems and make productive behavioral adjustments."

A complete copy of the compliant in *ACLU of New Mexico v. New Mexico Children, Youth and Families Department, et al* can be found at: www.aclu-nm.org

Texas

In January 2008, the county medical examiner found that an inmate who died in Collin County Detention Center in McKinney after he was caught trying to commit suicide did not die as a result of suicide. Instead, 22-year-old Marcus Elliott died during a struggle with correctional officers at the facility on July 1, 2007. Jail staff discovered Mr. Elliott at approximately 11:00pm lying on his bunk with a thread tied around his neck. They attempted to remove the thread and check the inmate's condition when he began kicking and swinging at the officers. Jail staff then restrained Mr. Elliott, but a nurse determined he was not breathing. Mr. Elloitt was transported to a local hospital and later pronounced dead.

Dr. William Rohr, Collin County medical examiner, told the *McKinney Courier-Gazette* that he listed the manner of the death as "homicide" and the cause of death as "sudden death after struggle and restraint" on the death certificate. The medical examiner stated that Mr. Elliott "suddenly became unresponsive after his struggle while he was being restrained by law enforcement, which consists of nothing more than being placed on a restraint bed." Dr. Rohr said the most likely cause of Mr. Elliott's death was an extreme resistance to the restraints, which sparked an "acute psychosis." The medical examiner further reiterated to the newspaper that "it's a phenomenon of sudden death following the restraint after a struggle with law enforcement or healthcare personnel and it's well documented in literature." According to the National Institute of Health, the condition is also known as "excited delirium syndrome," a mental chemical imbalance that can cause death during encounters or struggles with law enforcement officials.

The Plano Police Department picked up Mr. Elliott on June 28, 2007 on several robbery and escape warrants. He was transported to the Collin County Detention Center and placed on a "special watch" due to statements he made after his arrest. Jail officials would not elaborate on the statements Mr. Elliott made to justify the special precautions.

CRAZY IN AMERICA: The Hidden Tragedy of Our Criminalized Mentally Ill

The American prison system today contains an estimated quarter of a million people who suffer from mental illness. In this searing critique, *Crazy in America* (Carroll & Graf, May 2007) examines a national scandal of staggering proportions. Author Mary Beth Pfeiffer, a 25-year veteran of investigative journalism who spent a decade at the *Poughkeepsie Journal*, shows how people suffering from schizophrenia, bipolar disorder, clinical depression and other serious psychological illnesses are regularly incarcerated simply because alternative care is not available, and how once behind bars, they are punished with placement in segregation for behavior that is psychotic, not criminal.

Drawing on six case studies — ranging from the story of a 56-year-old killer who thought he was Jesus Christ, to a 41-year-old woman who tore out her eyes while in prison, and a 18-year-old youth who hanged himself in a state juvenile correctional facility — Ms. Pfeiffer brings to light the wider failures behind a burgeoning crisis. The growing lack of proper help for persons with mental illness in society at large has led to the wrongful imprisonment of unprecedented numbers of people whose crimes were the result of psychosis. The author also lays bare, the woeful absence of proper psychiatric care within the prison system.

Florida

In December 2007, drawstring cords were removed from all inmate laundry bags in the Polk County Jail in Bartow following an inmate suicide by hanging in the special needs unit. "It's one issue after another in the county jail," Polk County Sheriff Grady Judd told *The Ledger* of Lakeland. "We have about 2,400 criminals in jail who have nothing better to do everyday other than to frustrate our attempts to protect them."

James Mark Garry, 39-years-old, hanged himself with the drawstring cord from a mesh laundry bag on December 24, 2007. The bag, as well as items such as bed sheets and shoelaces, had not been given to inmates on suicide watch, but were previously available to inmates in the special needs unit, the sheriff said.

According to jail officials, the special needs unit is reserved for inmates identified as mentally ill and/or suffering from substance abuse. Mr. Garry had been the first inmate to commit suicide in the facility since 2003, although the jail sustained another death by hanging a month later in January 2008.

An apparently frustrated Sheriff Judd further told *The Ledger* that his staff books approximately 31,000 inmates through the jail each year and occasionally "one of those 31,000 people are going to do absolutely irrational acts. People have free will. If we could take all the strings and bed sheets away, what's to keep them from jumping off the second-floor balcony and taking a head dive onto the concrete floor below? You can't make a jail suicide-proof."

Meanwhile, friends of Mr. Garry questioned why he was placed in the special needs unit but not on suicide precautions after detectives were told prior to his death that he was potentially suicidal. According to his girlfriend, Migdalia Denizard, Mr. Garry had written a note addressed to her and her daughter stating he would "see you in heaven" the night he was arrested at her house and charged with two counts of arson and four counts of attempted murder for setting fire to his ex-wife's apartment. Ms. Denizard told *The Ledger* that she gave a taped statement to a detective the night of Mr. Garry's arrest stating that she thought he intended to kill himself. According to jail records, Mr. Garry then denied any suicidal ideation during the jail's booking process and when asked specifically about the suicide note to Mr. Denizard, he claimed to "upset and angry, but not suicidal." Following the booking process, however, Mr. Garry was placed in the special needs unit, in part because of a self-reported mental illness and because of the suicide note.

Mr. Denizard also complained that Mr. Garry was supposed to be on medication for bipolar disorder and that he took other medications including a painkiller for a back injury, as well as for anxiety and depression. According to his arrest report, Mr. Garry said he could not control what "the voices in his mind tell him to do." Jail officials said that Mr. Garry had not yet received a psychiatric assessment to determine the need for psychotropic medication.

Sheriff Judd deflected any blame by his staff by stating that James Garry "had all the opportunity in the world to say, 'I'm suicidal.' Had it been communicated that he was suicidal, he would have

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

been put on suicide watch. Just because someone else claims he's suicidal….I'm not sure that's enough to get him on suicide watch."

California

In January 2008, a federal civil rights lawsuit was filed charging that failure to provide psychiatric and medical care to an inmate with mental illness caused him to become paralyzed during a psychotic episode in the Glenn County Jail in Willows.

It all began the year before in early January 2007, when 24-year-old Reynaldo Cabral crashed his car through a fence and was found naked in a park in Chico, wrapped in cellophane doused with kerosene. Mr. Cabral told responding police officers he wanted to set himself on fire to cleanse himself. Although he was admitted into the Butte County Behavioral Health psychiatric unit for up to a 72-hour observation period, Mr. Cabral was released less than 10 hours later after assuring family members he would not kill himself. When his bizarre behavior continued the following day, the psychiatric facility allegedly refused family requests to recommit him upon their learning that Mr. Cabral began hearing voices from God telling him to "sacrifice" his girlfriend.

On January 6, 2007, in the midst of a psychotic episode, Mr. Cabral attempted to strangle his girlfriend. He was arrested, charged with attempted murder, and booked into the Glenn County Jail in Willows. When informed by a family doctor as to his psychiatric condition and need for medication after Mr. Cabral was booked into the jail, a jail sergeant allegedly replied that the inmate was "not mentally ill, but rather was arrested due to a lover's quarrel." Although the Glenn County Mental Health Department was contacted by the jail that morning and had been informed by the Chico Police Department about Mr. Cabral's bizarre actions in the park, no mental health services were apparently provided by the agency. While in the holding cell, Mr. Cabral experienced another psychotic episode and began vomiting and throwing feces inside the cell. Shortly thereafter, jail staff and police officers from the booking area entered the cell and subdued Mr. Cabral with pepper spray and a Taser gun. He was then placed naked into a safety cell.

Still disoriented from the pepper spray, Mr. Cabral broke his neck when he slammed his head hard into the cell wall during a subsequent psychotic episode at approximately 4:45am on January 8. According to the lawsuit, jail records showed that the inmate was then observed every 15 minutes lying on his stomach on the floor of his cell. Although Mr. Cabral was examined at approximately 7:00am by a jail employee who reported him to be "prone on the floor and moaning," the inmate was allegedly not given any medical assistance, even though he continued to complain that his neck was broken and "promised to be good" if staff helped him. It was not until several hours later that a jail nurse confirmed the inmate was paralyzed and Mr. Cabral was transported to the hospital.

The lawsuit quotes the Glenn County Sheriff's Office as reporting it was told that county mental health officials refused to provide any mental health services to Mr. Cabral because "they had no contract with the jail to do so." Scott Gruendl, the county's mental health director, told the *Chico Enterprise-Record* that, while he would not comment on the lawsuit, "in a general sense," the psychiatric and medical care of inmates is the responsibility of the jail, which has a contract with Glenn Medical Center, and not his department. "That said, we're always ready and willing to assist…. and I don't feel that contractual red tape is a reason" for denying an inmate care," he added.

In March 2008, Mr. Cabral's criminal charges were reduced and he was expected to be placed on probation for the serious attack on his girlfriend. "We don't expect any trouble from him, Glenn County District Attorney Robert Holzapfel told the *Willows Journal*. "The poor fellow is in terrible condition. There is no way the state could take care of him in prison." Reynaldo Cabral remains paralyzed and confined to a wheelchair while living in his parent's home.

Ohio

In February 2008, the state Ohio Department of Rehabilitation and Correction fired a correctional officer following a finding of dereliction of duty in the suicide of an inmate at the Grafton Correctional Institution last year. Jorge Ruiz, a 10-year veteran of the prison system, lost his job after prison officials completed their review of his actions while 37-year-old Earl Elswick hanged himself on December 30, 2007. Mr. Ruiz had been on paid administrative leave during the investigation. He was then arrested and charged with a felony of tampering with records. In early February Mr. Ruiz entered a no contest plea to the misdemeanor charge of dereliction of duty. He had entered the no contest plea as part of an agreement that led to prosecutors to drop the felony charge. Mr. Ruiz was sentenced to either five days in jail or 50 hours of community service, and fined $250.

Warden Margaret Bradshaw said the investigation showed that Mr. Ruiz had failed to follow proper procedures, falsified records and that his actions threatened the safety of the prison. "(Termination is) what the charges he was charged with at the administrative level called for," the warden told *The Chronicle-Telegram*. An investigation by the state Highway Patrol determined that the officer failed to perform required prisoner checks and then falsified log books to suggest that the checks were made.

Missouri

In January 2008, St. Louis city jail officials were investigating why the system twice failed Joshua Turner, an 18-year-old inmate who managed to find a bed sheet to hang himself despite being on suicide watch at the St. Louis Medium Corrections Facility. In addition, the young inmate's court-ordered psychiatric evaluation, that had been required seven months earlier in May 2007, had apparently stalled. Charles Bryson, the city's public safety director, told the *St. Louis Post-Dispatch* that "It's a horrible situation. The system broke down" in Joshua's case. The director stated that an investigation will focus on "what happened that night and what kept him from going into a psychiatric facility or getting treatment?"

Joshua Turner was being held at the jail facility, commonly referred to as the "Workhouse," on a charge of property damage. The youth had been dual-diagnosed with mild developmental disabilities and mental illness, including hallucinations. According to his court file, Joshua had pled guilty in May 2007, but his lawyer

had asked the judge to continue the case for a psychiatric evaluation. The case was stalled until it could be determined whether Joshua was capable of understanding the charges. A psychiatrist finally began the assessment process on December 7, 2007. "They've been trying to wait for a bed (to become available) to get him in a psychiatric facility," Director Bryson told the newspaper. "I don't think the judge really wanted to send him to prison."

Patrick Schommer, assistant to the city's commissioner of corrections, told the *St. Louis Post-Dispatch* that Joshua "started decomposing," refused to take his psychotropic medication, and was locked down almost 24 hours a day. He only left his cell so that staff could clean up the feces." Joshua had a habit of throwing feces under his cell door, and someone apparently stuffed a bed sheet under the door to curtail the problem. On January 21, he used the sheet to hang himself. He was found sometime between 4:20pm and 5:30pm. It remained unclear when Joshua was last observed by staff. Two correctional officers were placed on administrative leave.

California

In March 2008, county officials tentatively agreed to a $3 million settlement with the family of a man who died in Santa Cruz County Jail in September 2005. The agreement would also require the county to revise the death certificate of David Anthony Cross, and send a written apology to his family, said Andrew Schwartz, one of the attorneys representing the family. "I think both sides realized it was in their best interest" to end the case, Mr. Schwartz told the *Santa Cruz Sentinel*. "Everybody involved in this incident feels terrible about it, both sides. The litigation was difficult because of the subject matter. Somebody died." The sheriff's office declined to comment on the case.

David Cross, 44-years-old and suffering with bipolar disorder, lost consciousness during a struggle with jail officers on September 17, 2005. The officers were trying to restrain him after he began banging his head on his cell door and thrashing on the floor. Court documents indicated that Mr. Cross repeatedly screamed "I can't breathe" and "I'm going to die" during the altercation. He stopped breathing while being restrained and was pronounced dead at a local hospital the following day. The County Coroner ruled his death accidental and a subsequent investigation by the District Attorney's Office concluded that correctional officers did not commit any criminal acts.

According to court documents, Mr. Cross was described as a habitual drug and alcohol user, and his mother had described him as being on "a self-destruct mission for many years." Mr. Cross had been arrested numerous times between 1993 and 2005 for alcohol and methamphetamine abuse, and theft. His most recent arrest involved charges of domestic violence and vandalism.

The Cross family had filed a wrongful death suit against the county, sheriff, and several correctional officers and medical personnel alleging their conduct was "malicious, wanton and oppressive." The suit questioned how much awareness the correctional officers had of his medical state as they restrained him, if their use of force contributed to his death, and if they were negligent in summoning medical help. The suit also alleged that correctional officers used a Taser gun on Mr. Cross, sat on him, and allowed him to sit in a restraint chair with his head pressed tightly against his chest for several minutes. At that point, Mr. Cross stopped resisting – and while jail officials argued that it was not unusual for inmates to switch from active to passive resistance, the family alleged his lack of resistance should have signaled a problem and triggered an immediate medical assessment.

A jail nurse checked Mr. Cross' pulse more than 16 minutes following initiation of the restraint procedure. Resuscitation efforts started approximately minute after a pulse could not be found. The autopsy report later indicated that Mr. Cross suffocated due to pressure correctional officers applied to his upper torso. The county, however, later retained two experts (a forensic pathologist and a pulmonologist) during the civil action to rebut the coroner's findings. The experts opined that Mr. Cross died from cardiopulmonary arrest due to a methamphetamine overdose. Other medical issues including an enlarged heart, his size (6 feet, 1 inch tall and 260 pounds), bipolar disorder, and extreme agitation contributed to his death, the experts stated.

Neither side disclosed how the $3 million settlement was determined. According to the tentative agreement, the sheriff will write a letter of apology to the family and the wording "out of control" will be deleted from Mr. Cross' death certificate. "I think it was important because we're of the opinion that 'out of control' doesn't accurately describe the condition of David at the time he died," Mr. Schwartz told the *Santa Cruz Sentinel*. According to the Santa Cruz County Sheriff's Office, some restraint and emergency response policies have been revised since the incident, including creation of a "safety officer" position.

Tennessee

In March 2008, state officials were investigating why an inmate with mental illness was allegedly isolated in his cell for nine months. He had not showered and received limited medical care. According to the Nashville *Tennessean*, Frank Horton, 23-years-old, refused to leave his cell for the allotted 60 minutes per day for a shower and recreation. Mr. Horton's grandmother, Mary Braswell, who reportedly raised him, told the newspaper that there is no excuse for what happened. "It's ridiculous to have anybody live like that," Ms. Braswell said. "To me, that's not even human."

Mr. Horton is confined in the Metro-Davidson County Detention Facility in Nashville. The 1,200 jail is operated by Corrections Corporation of America (CCA) through a contract with Davidson County. The *Tennessean* reported that county officials disagree on whose responsibility it is to enforce hygiene standards. According to the newspaper, Mr. Horton's living conditions changed only after a CCA employee complained to the Metro Public Health Department on January 31 and he was forcibly removed from his cell for a shower and a mental health evaluation. Once out of his cell, Mr. Horton seemed cooperative but was incoherent, according to a nurse.

CCA spokesman Steve Owen told the newspaper that he could not respond directly to any questions about Mr. Horton "as that may violate federal privacy protections for medical/mental health information." He did say that the facility had policies on enforcing

minimal showering for hygienic and health reasons. Both the health department and the Davidson County Sheriff's Office have contractual authority to oversee operations at the Metro-Davidson County Detention Facility, but they disagree about whose responsibility it is to ensure that basic hygiene is enforced.

None of this makes sense or even matters to Ms. Braswell, who raised her grandson until he was too hard to handle. When she heard that Mr. Horton had not bathed in nine months, she fought off tears like a woman who has spent years perfecting the art of being strong. When Ms. Braswell last called the facility several months earlier, she was told that he was fine. She told the *Tennessean* that was the most information she had received in nearly a year, since the last time anyone in her family heard from him. Ms. Braswell had tried to see her grandson, but she has never been added to his visitor list. She asked her pastor to visit him, but she, too, was denied.

Mr. Horton's arrest sheet had been full of non-violent offenses for trespassing, drug possession, driving without a license, and vandalism. In 2006, however, he was twice charged with assault while in the Metro Davidson County Detention Facility. One incident allegedly involved throwing feces at an officer.

Health department officials confirmed to the *Tennessean* that they received a complaint about the treatment of an inmate on January 31, but they declined to confirm the inmate's name. That same day, health officials visited the facility, and Mr. Horton was given a shower and his cell was cleaned. "We asked that he have an assessment from the mental health coordinator and a physician," said Cathy Seigenthaler, director of correctional health. "Both of those things occurred. There is no corrective action plan warranted on a medical end." Although health officials responded to the complaint about Mr. Horton and took action, they said they did not believe the showers were related to health care. "Facility-wise, anything regarding the cleanliness or segregation unit falls under the sheriff's department," Ms. Seigenthaler told the newspaper. "That's something they monitor."

Davidson County Sheriff Daron Hall disagreed. The sheriff said that, while he thinks the lack of showers is an obvious issue, his first reaction to Mr. Horton's prolonged isolation in his cell points to a serious question: "Has his mental health been adequately addressed?" In 2004, Sheriff Hall said the CCA contract was rewritten so that inmate health care would be monitored on-site by the Metro Public Health Department. Both the sheriff's office and the health department have a staff member on-site at the facility.

Health officials said their primary duty is monitoring medical records, and they are permitted to merely recommend a fix with no enforcement power to back it up. "We go in as we do in other facilities and look at various aspects of medical care, and if we find issues, then we ask that facility to come up with corrective action," Margaret Holleman, the health department's director of policy development, told the *Tennessean*.

Hedy Weinberg, executive director of the state branch of the American Civil Liberties Union, said that if true, Mr. Horton's treatment was "unforgivable." She told the newspaper that "The idea that both the government and the private contractor agree to provide service and are now tossing the ball, saying, 'We're not responsible,' raises serious constitutional questions and concerns." ❑

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.

This publication is supported by Cooperative Agreement Award Number 07HI05GJTO from the National Institute of Corrections (NIC), U.S. Department of Justice. Points of view or opinions stated in this document do not necessarily represent the official position or policies of the U.S. Department of Justice.

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:

Lindsay M. Hayes, Editor/Project Director
National Center on Institutions and Alternatives
40 Lantern Lane
Mansfield, Massachusetts 02048
(508) 337-8806 • (508) 337-3083 (fax)
Web Site: www.ncianet.org/suicideprevention
E-Mail: Lhayesta@msn.com

or

NIC Information Center
791 North Chambers Road
Aurora, Colorado 80011
(800) 877-1461 • (303) 682-0558 (fax)
Web Site: www.nicic.org