

UNITED STATES DISTRICT COURT

DISTRICT OF MAINE

LYNN MULKERN, et al.,)
)
 Plaintiffs)
)
 v.) **Civil No. 00-382-P-C**
)
 CUMBERLAND COUNTY, et al.,)
)
 Defendants)

**RECOMMENDED DECISION ON DEFENDANTS’
MOTIONS FOR SUMMARY JUDGMENT AND
MEMORANDUM DECISION ON DEFENDANTS’
MOTION TO STRIKE**

All defendants in this action arising from the suicide of Cumberland County Jail inmate Robert Hale in December 1998 move for summary judgment as to the four-count amended complaint of plaintiffs Lynn Mulkern and Sheryl Ann Hale, the duly appointed personal representatives of Hale’s estate. Defendant[s] Harold Gillman, William Lawson and Jean McNamara’s Motion for Summary Judgment, etc. (“Guard Defendants’ Motion”) (Docket No. 26); Motion for Summary Judgment of Defendants Prison Health Services, Inc. [(“PHS”)], Phebe Dixon, Susan Accardi, Sherry Littlefield and Patricia Rinehart (“PHS Defendants’ Motion”) (Docket No. 28); Defendants’ Motion for Summary Judgment (“County Defendants’ Motion”) (Docket No. 33); Second Amended Complaint (“Complaint”) (Docket No. 17).¹

¹ The Complaint was further amended to correct the spelling of the name of defendant Susan Accardi, who mistakenly was referred to as “Susan Giralrdi.” Motion To Amend Complaint (Docket No. 22) & endorsement thereto. As so corrected, the Complaint names the following: Cumberland County (“County”), former Cumberland County Sheriff Wesley Ridlon, Cumberland County Jail (continued on next page)

The Guard Defendants, joined by the County Defendants, file a related motion to strike portions of the testimony of the plaintiffs' experts. Defendants Gillman, Lawson and McNamara's Motion To Strike and/or Exclude the Testimony of Plaintiffs' Experts ("Motion To Strike") (Docket No. 25); Motion To Adopt Co-Defendants' Motion To Strike and/or Exclude the Testimony of Plaintiffs' Experts (Docket No. 42) and endorsement thereon. For the reasons that follow, I address the Motion To Strike only to the extent necessary in the context of the summary judgment motions, granting it in part, and recommend that the PHS Defendants' Motion be granted; the Guard Defendants' Motion and the County Defendants' Motion be granted as to Counts I, II and a portion of Count IV, and that the court decline to exercise supplemental jurisdiction as to the remaining state-law claims, which I recommend be remanded to the Maine Superior Court (Cumberland County), from which this action was removed on November 30, 2000. *See* Notice of Removal (Docket No. 1) & attachments thereto.

I. Summary Judgment Standards

Summary judgment is appropriate only if the record shows "that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." Fed. R. Civ. P. 56(c). "In this regard, 'material' means that a contested fact has the potential to change the outcome of the suit under the governing law if the dispute over it is resolved favorably to the nonmovant By like token, 'genuine' means that 'the evidence about the fact is such that a reasonable jury could resolve the point in favor of the nonmoving party'" *McCarthy v. Northwest Airlines, Inc.*, 56 F.3d 313, 315 (1st Cir. 1995) (citations omitted). The party moving for summary judgment must demonstrate an absence of evidence to support the nonmoving party's case. *Celotex Corp. v. Catrett*, 477 U.S. 317, 325 (1986).

Administrator Jeffrey [sic] Newton, Sergeant Sean Brown, Commander Michael B. Vitiello, Captain Francine Breton, Captain [Wayne] Pike and corrections officers Anne Marie Morin and J. F. Fallon (the "County Defendants"); corrections officers Lawson, McNamara and Gillman (the "Guard Defendants"); and PHS and its employees Accardi, Littlefield, Rinehart and Dixon (the "PHS (continued on next page)

In determining whether this burden is met, the court must view the record in the light most favorable to the nonmoving party and give that party the benefit of all reasonable inferences in its favor. *Cadle Co. v. Hayes*, 116 F.3d 957, 959 (1st Cir. 1997). Once the moving party has made a preliminary showing that no genuine issue of material fact exists, “the nonmovant must contradict the showing by pointing to specific facts demonstrating that there is, indeed, a trialworthy issue.” *National Amusements, Inc. v. Town of Dedham*, 43 F.3d 731, 735 (1st Cir. 1995) (citing *Celotex*, 477 U.S. at 324); Fed. R. Civ. P. 56(e). “This is especially true in respect to claims or issues on which the nonmovant bears the burden of proof.” *International Ass’n of Machinists & Aerospace Workers v. Winship Green Nursing Ctr.*, 103 F.3d 196, 200 (1st Cir. 1996) (citations omitted).

II. Factual Context

The parties’ statements of material facts, credited to the extent either admitted or supported by record citations in accordance with Loc. R. 56, reveal the following relevant to this recommended decision:²

A. Facts Relating To All Defendants

Robert Hale, who had a long history of incarceration, was last admitted to the Cumberland County Jail (“Jail”) on July 24, 1998. Plaintiffs’ Additional Facts in Support of Their Omnibus Objection to Defendants’ Motions for Summary Judgment (“Plaintiffs’ Additional SMF”) (Docket No. 54) ¶ 1; Reply of Defendants Prison Health Services, Inc., Phebe Dixon, Susan Accardi, Sherry Littlefield and Patricia Rinehart to Plaintiffs’ Additional Statement of Material Facts (“PHS Defendants’ Reply SMF”) (Docket No. 64) ¶ 1; Defendants’ [sic] Gillman, Lawson and McNamara’s Response to Plaintiff’s [sic] Additional Facts in Support of Their Omnibus Objection to Defendants’

Defendants”). Complaint ¶¶ 2-7.

² To the extent any statement is neither admitted nor fully supported by the citation given, if any, I have disregarded it. To the extent that any statement is admitted by fewer than all three of the defendant groups but not fully supported by the citation given, if any, I have (continued on next page)

Motion for Summary Judgment (“Guard Defendants’ Reply SMF”) (Docket No. 63) ¶ 1; Rule 30(b)(6) Deposition of Cumberland County Jail through its designee Jeffery L. Newton (“Newton Dep.”), filed by Plaintiffs, at 97; Robert Hale Dates of Incarceration, Exh. 11 to Newton Dep., attached as Exh. 1 to Plaintiffs’ Additional SMF; Cumberland County Sheriff’s Department Arrest Information, attached as Exh. 1 to Defendant’s [sic] Statement of Uncontested Material Facts (“Guard Defendants’ SMF”) (Docket No. 27).³

Intake information noted that Hale had been diagnosed as bipolar and was taking both Klonopin and Zoloft to address his condition. Plaintiffs’ Additional SMF ¶ 2; PHS Defendants’ Reply SMF ¶ 2; Guard Defendants’ Reply SMF ¶ 2; County Defendants’ Reply to Plaintiffs’ Additional Facts (“County Defendants’ Reply SMF”) (Docket No. 59) ¶ 2. As a result of a point system used to classify inmates, Hale was placed in the maximum-security pod. *Id.* Maximum security is the most secure status at the Jail, with inmates allowed out of their cells only four hours per day and given only limited access to the commissary, the Jail canteen. *Id.* ¶ 3. Even within the maximum-security housing unit there is a “high max” area with three cells, A105, A106 and A107. *Id.* Persons in “high max” must be visually observed every fifteen minutes, exactly as if they were on suicide watch. *Id.*

Within days of Hale’s admission, his Zoloft and Klonopin prescriptions were discontinued and Xanax was prescribed. *Id.* ¶ 4. He complained of both auditory and visual hallucinations. *Id.*⁴ On August 5, 1998 Hale applied to be reclassified to medium security. *Id.* ¶ 5. The request was denied. *Id.* On August 10 Thorazine was added to Hale’s medications to help control his hallucinations. *Id.* ¶

noted that it is admitted only by certain defendant groups.

³ The plaintiffs point out that the “Dates of Incarceration” summary incorrectly states that Hale last entered Cumberland County Jail on August 24, 1998. Plaintiffs’ Additional SMF ¶ 1 n.3. The plaintiffs’ assertion that Hale’s file folder included forms from prior incarcerations indicating “threats of suicide,” *id.* ¶ 1, is admitted only by the Guard Defendants.

⁴ PHS adds that the medical record referred to in the testimony cited indicates that Hale was experiencing no homicidal or suicidal ideation. Statement of Material Facts of Defendants Prison Health Services, Inc., Phebe Dixon, Susan Accardi, Sherry Littlefield, and Patricia Rinehart (“PHS Defendants’ SMF”) (Docket No. 29) ¶ 4; Rule 30(b)(6) Deposition of PHS through its designee Phebe J. Dixon (“Dixon Dep.”), filed by Plaintiffs, at 61.

6. On August 11 Hale again asked for reclassification, explaining, “I’m having a real rough time w/ my anxiety. I think it has a lot to do w/being locked down all the time.” *Id.* ¶ 7. On August 17 Hale again applied for reclassification, politely explaining that he had “major problems with being locked down for so long, because of my anxiety, which I am taking medicine for. I am on disability (S.S.D.I.) 100%.” *Id.* ¶ 8. On August 19 Hale’s reclassification to medium security was approved. *Id.* ¶ 9. On September 9 Hale was moved to another pod in the medium-security area. *Id.* ¶ 10. On September 29 Hale was considered for the minimum-security pod if he could “go 30 days without writeup” for misconduct. *Id.* ¶ 11.

On September 30, told that he would be starting a period of disciplinary segregation, Hale became “rageful and violent” and had to be placed in leather restraints and a “pro-restraint” chair for his own safety, according to a report filed by defendant Commander Vitiello. Plaintiffs’ Additional SMF ¶ 12; Guard Defendants’ Reply SMF ¶ 12; Cumberland County Sheriff’s Office Use of Force and Incident reports dated Sept. 30, 1998, attached as Exh. 8 to Guard Defendants’ SMF, at 636, 638.⁵ Inmates in disciplinary segregation are allowed out of their cells only one hour per day, with no access to the commissary. Plaintiffs’ Additional SMF ¶ 12; Guard Defendants’ Reply SMF ¶ 12; Newton Dep. at 19. County officers continued to use disciplinary segregation to address Hale’s outbursts all fall. Plaintiffs’ Additional SMF ¶ 13; PHS Defendants’ Reply SMF ¶ 13; Guard Defendants’ Reply SMF ¶ 13; County Defendants’ Reply SMF ¶ 13.

On November 1 officers were called because Hale and others were creating a “disturbance” by banging on the door, table and bunk of his cell. *Id.* Vitiello again directed that Hale’s arms and legs be placed in leather restraints “for the subject’s safety.” *Id.* Hale asked the officers several times to tighten the restraints, drag him out of the cell and spray him with mace. *Id.* Defendant

⁵ The plaintiffs’ further assertion that, in conjunction with Hale’s placement in restraints, he was evaluated by a PHS nurse per policy (continued on next page)

corrections officer Fallon was one of those involved in the effort, supervised by Corporal Brown. *Id.*⁶ On November 11 Dixon noted that she thought Hale had the potential to harm himself. *Id.*⁷ On that day Hale refused to take the Thorazine. Plaintiffs' Additional SMF ¶ 14; Guard Defendants' Reply SMF ¶ 14; County Defendants' Reply SMF ¶ 14; Dixon Dep. at 67. On November 17, without seeing Hale, Dr. Steven Katz, the psychiatrist who consulted to the Jail, discontinued the Thorazine and ordered Vistaril up to three times a day. Plaintiffs' Additional SMF ¶ 14; PHS Defendants' Reply SMF ¶ 14; Guard Defendants' Reply SMF ¶ 14; County Defendants' Reply SMF ¶ 14; *see also* PHS Defendants' SMF ¶ 5; Plaintiffs' Responsive Statement of Material Facts in Support of Its [sic] Objection to [PHS Defendants'] Motion for Summary Judgment ("Plaintiffs' Opposing SMF/PHS") (Docket No. 52) ¶ 5. On November 24 the Vistaril was ordered discontinued. Plaintiffs' Additional SMF ¶ 14; PHS Defendants' Reply SMF ¶ 14; Guard Defendants' Reply SMF ¶ 14; County Defendants' Reply SMF ¶ 14.

On November 24, suspicious that Hale may have concealed contraband on his person (*i.e.*, cigarettes) and because Hale "would not cooperate in the recovery," Corporal Brown ordered Hale removed to administrative segregation (similar to disciplinary segregation except that no fact-finding has been held). Plaintiffs' Additional SMF ¶ 15; PHS Defendants' Reply SMF ¶ 15; Guard Defendants' Reply SMF ¶ 15; Cumberland County Sheriff's Office Jail Services Bureau Incident reports dated Nov. 24, 1998 ("11/24 Incident Reports"), attached as Exh. 10 to Guard Defendants' SMF, at 596, 602-03; Newton Dep. at 19.⁸ Restraints again were used "for the subject's safety." Plaintiffs' Additional SMF ¶ 15; PHS Defendants' Reply SMF ¶ 15; Guard Defendants' Reply SMF ¶

before being returned to the maximum-security area, Plaintiffs' Additional SMF ¶ 12, is admitted only by the Guard Defendants.

⁶ "Corporal" Brown apparently is not the same person as defendant "Sergeant" Brown.

⁷ PHS adds that Dixon testified that "potential for self-harm" is not "suicidal ideation." PHS Defendants' Reply SMF ¶ 13; Dixon Dep. at 63.

⁸ The plaintiffs' statement that Corporal Brown was "irked" because Hale would not cooperate, Plaintiffs' Additional SMF ¶ 15, is (*continued on next page*)

15; 11/24 Incident Reports at 592, 596. Eventually, the officers, including Brown, carried Hale to maximum security and then to a room in the intake area. Plaintiffs' Additional SMF ¶ 15; PHS Defendants' Reply SMF ¶ 15; Guard Defendants' Reply SMF ¶ 15; 11/24 Incident Reports at 597.⁹ Medical was notified in order for the nurse to do an assessment on Robert Hale at his request. *Id.*

Hale remained agitated and violent. Plaintiffs' Additional SMF ¶ 16; PHS Defendants' Reply SMF ¶ 16; Guard Defendants' Reply SMF ¶ 16; 11/24 Incident Reports at 609. He stated that he needed his medication and that he was not responsible for his actions without it. *Id.* Upon inquiry, the nurse informed a corrections officer that the drugs Hale was asking for had been discontinued but she did not know why. *Id.* She stated to the corrections officer that she had already informed Hale that he was not going to get his medications. *Id.* When the officer again informed Hale that he would not be receiving any of his medication, Hale became more out of control. *Id.* He started banging his head on the cell window with enough force to injure himself. *Id.* He started banging his head so hard that there was blood coming from his forehead. Plaintiffs' Additional SMF ¶ 16; PHS Defendants' Reply SMF ¶ 16; Guard Defendants' Reply SMF ¶ 16; 11/24 Incident Reports at 612.

The officer's attempt to "rationalize" with Hale had no effect. Plaintiffs' Additional SMF ¶ 16; PHS Defendants' Reply SMF ¶ 16; Guard Defendants' Reply SMF ¶ 16; 11/24 Incident Reports at 610. Advising Hale that the officer would not allow him to harm himself, the officer maced Hale to secure him in the pro-restraint chair for his own safety. *Id.*¹⁰ Hale immediately became incapacitated. *Id.* Eventually, the nurse provided Hale with some Xanax. *Id.* After remaining in the pro-restraint chair for two more hours, Hale was cleared to return to maximum security as he was no longer a threat

admitted only by the PHS and Guard defendants.

⁹ The plaintiffs' further assertions that Hale again became violent after being handcuffed and leaving his cell, that the officers carried him still fighting, kicking and screaming to maximum security, and that after being placed in the intake area Hale continued to make threats, Plaintiffs' Additional SMF ¶ 15, are admitted only by the PHS and Guard defendants.

¹⁰ The PHS and County defendants add that Hale was maced for the officers' safety as well as his own. PHS Defendants' Reply SMF (continued on next page)

to staff members or himself. Plaintiffs' Additional SMF ¶ 16; PHS Defendants' Reply SMF ¶ 16; Guard Defendants' Reply SMF ¶ 16; 11/24 Incident Reports at 615; Cumberland County Sheriff's Department Jail Log, attached as Exh. 11 to Guard Defendants' SMF.¹¹

Two days later, on November 27, Hale was again found by Corporal Brown and others "violent and highly agitated" and threatening the officers. Plaintiffs' Additional SMF ¶ 18; PHS Defendants' Reply SMF ¶ 18; Guard Defendants' Reply SMF ¶ 18; Cumberland County Sheriff's Office Jail Services Division Incident reports dated Nov. 27, 1998 ("11/27 Incident Reports"), attached as Exh. 12 to Guard Defendants' SMF, at 821-22.¹² Fallon and others placed Hale's legs, arms and waist in leather restraints and put a foam helmet on his head so that he would not harm himself when he banged his head against the door. *Id.* After the officers left the cell, Hale came up to his cell door and started banging his head against the window, yelling, "I'm a Pittsburgh Steeler." Plaintiffs' Additional SMF ¶ 18; PHS Defendants' Reply SMF ¶ 18; Guard Defendants' Reply SMF ¶ 18; Cumberland County Sheriff's Department Jail Log, attached as Exh. 12 to Guard Defendants' SMF, at 1378.¹³ Fallon, who was involved in subduing Hale, had never seen any other inmate chew himself out of a restraint helmet. Plaintiffs' Additional SMF ¶ 18; PHS Defendants' Reply SMF ¶ 18; Guard Defendants' Reply SMF ¶ 18; Deposition of Joseph Fallon ("Fallon Dep."), filed with Defendants' Statement of Material Facts (DSMF) ("County Defendants' SMF") (Docket No. 34), at 9-10, 15.

¶ 16; County Defendants' Reply SMF ¶ 16; 11/24 Incident Reports at 610.

¹¹ A grievance filed by Hale as a result of this treatment was dismissed on December 7, 1998 with a notation that his allegation that a conspiracy existed against him was "ludicrous." Plaintiffs' Additional SMF ¶ 17; PHS Defendants' Reply SMF ¶ 17; Guard Defendants' Reply SMF ¶ 17; County Defendants' Reply SMF ¶ 17; Memorandum dated Dec. 7, 1998 from Commander Michael B. Vitiello to Major Newton, Exh. 23 to Newton Dep., attached as Exh. 1 to Plaintiffs' Additional SMF, at 1336.

¹² The plaintiffs' further statements that Hale was "screaming" and "kicking his door and banging his head against the door and wall," Plaintiffs' Additional SMF ¶ 18, are admitted only by the PHS and Guard defendants.

¹³ The plaintiffs' further assertion that "[w]ithin two hours, Hale had broken the leather restraints and shredded the foam helmet" and that he was still highly agitated and therefore placed in segregation in the pro-restraint chair, Plaintiffs' Additional SMF ¶ 18, is admitted only by the PHS and Guard defendants.

Officer Jessica Brown noted her “professional opinion” that Hale posed a threat to himself, “but more importantly to members of the correction staff. It is my recommendation that he be reclassified to High Maximum security and to continue to serve out his disciplinary segregation time.” Plaintiffs’ Additional SMF ¶ 19; PHS Defendants’ Reply SMF ¶ 19; Guard Defendants’ Reply SMF ¶ 19; 11/27 Incident Reports at 823. Defendant Sergeant Brown agreed. Plaintiffs’ Additional SMF ¶ 19; PHS Defendants’ Reply SMF ¶ 19; Guard Defendants’ Reply SMF ¶ 19; Memorandum dated Nov. 27, 1998 from Sgt. Sean Brown to Captain Breton, Exh. 29 to Newton Dep., attached as Exh. 1 to Plaintiffs’ Additional SMF.

On November 30 Breton requested that Hale see Dr. Katz. Plaintiffs’ Additional SMF ¶ 20; PHS Defendants’ Reply SMF ¶ 20; Guard Defendants’ Reply SMF ¶ 20; Dixon Dep. at 74.¹⁴ Although it was clear from his reports that Hale was having problems with anxiety from at least November 11 through December 2, Hale did not see any doctor in that period. Plaintiffs’ Additional SMF ¶ 20; Guard Defendants’ Reply SMF ¶ 20; Dixon Dep. at 75.¹⁵ Both staff and inmates were aware that Hale complained that the medical department was not medicating him correctly. Plaintiffs’ Additional SMF ¶ 21; Guard Defendants’ Reply SMF ¶ 21; Memorandum dated Jan. 13, 1999 from Wes Andrenyak to Ralph Nichols, Exh. 15 to Newton Dep. (“Andrenyak Memo”), attached as Exh. 1 to Plaintiffs’ Additional SMF, at 4.¹⁶ On one occasion a nurse told corrections officer Charles Ryder, “It’s just behavioral. Spray him if you have to.” Plaintiffs’ Additional SMF ¶ 21; Memorandum dated Jan. 4,

¹⁴ The plaintiffs’ further statement that “a report was made that Hale was continuing to have difficulties with anxiety,” Plaintiffs’ Additional SMF ¶ 20, is admitted only by the PHS and Guard defendants.

¹⁵ The plaintiffs’ further assertion that it was clear from Hale’s behavior (in addition to his reports) that he was having “increased” problems with anxiety, Plaintiffs’ Additional SMF ¶ 20, is admitted only by the PHS and Guard defendants. An assertion that Hale “was not doing well on Xanax alone,” *id.*, is admitted only by the Guard Defendants.

¹⁶ PHS qualifies this statement, noting that the complete sentence referred to is as follows: “Though both staff and inmates have stated Mr. Hale complained the medical department was not medicating him properly for his anxiety disorder and panic attacks, there is documentation of at least seven (7) different medications having been ordered at different times to treat his anxiety and panic between the time of his arrival and the suicide attempt.” PHS Defendants’ Reply SMF ¶ 21; Andrenyak Memo at 4.

1999 from Lorraine Spiller, PA-C to Ralph Nichols, Exh. 18 to Newton Dep., attached as Exh. 1 to Plaintiffs' Additional SMF.¹⁷

On December 2 Hale was reclassified as a maximum-security risk "as soon as D-Seg time is completed." Plaintiffs' Additional SMF ¶ 26; PHS Defendants' Reply SMF ¶ 26; Guard Defendants' Reply SMF ¶ 26; County Defendants' Reply SMF ¶ 26. The same day Dr. Katz finally saw Hale, ordering the Xanax discontinued and Hale returned to a Klonopin regime. *Id.* The order specifically said, "Do not stop xanax til Klonopin in." *Id.* However, Hale last received Xanax on the morning of December 4. *Id.*

Within forty-eight hours of December 5 Herbert Haase, the father of Hale's girlfriend Angela Haase, telephoned the Jail, advising the person who took the information that he was calling on behalf of his daughter and that he had received information that Hale was threatening to kill himself. Plaintiffs' Additional SMF ¶ 23; Affidavit [of Herbert H. Haase] ("Haase Aff."), attached as Exh. 6 to Plaintiffs' Additional SMF, ¶¶ 1-2, 4. Haase told this individual that he wanted to know what was going on with Hale, whether he was being evaluated and what the Jail was doing about Hale's emotional state. Plaintiffs' Additional SMF ¶ 23; Haase Aff. ¶ 4. Haase gave the individual a phone number and was told that he would be called back. *Id.*¹⁸

¹⁷ This statement is objected to by the PHS Defendants as inadmissible hearsay to the extent offered to prove PHS's policy or practice, PHS Defendants' Reply SMF ¶ 21; objected to by the Guard Defendants on the basis that the plaintiffs failed to identify whether the party who made the alleged statement was the agent or employee of a party-opponent and the statement therefore is inadmissible hearsay, Guard Defendants' Reply SMF ¶ 21; and denied by the County Defendants, County Defendants' Reply SMF ¶ 21. Inasmuch as there is evidence that the nurse in question was an employee or agent of PHS, *see* PHS Defendants' SMF ¶¶ 19-21, the statement is admissible as the admission of a party-opponent, *see* Fed. R. Evid. 801(d)(2)(D) (statement not hearsay if it "is offered against a party and is . . . a statement by the party's agent or servant concerning a matter within the scope of the agency or employment, made during the existence of the relationship."). The plaintiffs' further assertion that Ryder reported to an investigator that he personally had reported to nurses at PHS on a number of occasions that Hale was in distress, anxious, heavily agitated and needing medication, Plaintiffs' Additional SMF ¶ 21, is admitted by the Guard Defendants but objected to by the PHS Defendants, and properly excluded, on the basis that it is inadmissible hearsay. *See* PHS Defendants' Reply SMF ¶ 21. Although denied by the County Defendants, *see* County Defendants' Reply SMF ¶ 21, the statement is supported by the citation given save for the allegation that Ryder made these reports "on a number of occasions."

¹⁸ The PHS and County defendants jointly object to these statements on the ground that this information was not made part of the plaintiffs' discovery responses, their designation of experts or experts' opinions and is not the basis for any argument in their opposing (*continued on next page*)

On December 3 inmate David Mitchell was found hanging in his cell (A144) from the handicap bars. Plaintiffs' Additional SMF ¶ 27; PHS Defendants' Reply SMF ¶ 27; Guard Defendants' Reply SMF ¶ 27; County Defendants' Reply SMF ¶ 27. Mitchell and Hale were close friends, and Mitchell's death was very upsetting to Hale. *Id.* Medication administration records show that Mitchell was given his bedtime medications on December 3 at a time when he already was at Maine Medical Center. *Id.* ¶ 28. On December 4 Newton ordered Breton to issue instructions to remove all non-handicapped inmates from cells containing handicapped-accessible facilities. *Id.* ¶ 29. McNamara, Gillman and Lawson attended the briefing and have admitted that they heard these instructions. Plaintiffs' Additional SMF ¶ 30; Guard Defendants' Reply SMF ¶ 30; Memorandum dated Dec. 21, 1998 from Major Jeffery L. Newton to Sheriff Wesley W. Ridlon, Exh. 19 to Newton Dep., attached as Exh. 1 to Plaintiffs' Additional SMF, at 1. However, no entry was made in the Maximum Security Logbook concerning the instructions, and the inmates in that pod were not moved. *Id.*

Not all handicapped-accessible cells have placards. Plaintiffs' Additional SMF ¶ 31; Newton Dep. at 38.¹⁹ There is no difference between such cells, with or without placards. *Id.* The toilet area

memorandum. County Defendants' Reply SMF ¶ 23; PHS Defendants' Reply SMF ¶ 23. The Guard Defendants object on the basis that Haase's lack of specificity as to the date, time and identity of the person with whom he spoke fails to show he is competent to testify in the matter and that the plaintiffs failed to disclose the witness in response to interrogatories or identify him as a basis for any of the experts' opinions. Guard Defendants' Reply SMF ¶ 23. While exclusion of testimony is an appropriate sanction for failure to disclose a witness, *see, e.g., Ortiz-Lopez v. Sociedad Espanola de Auxilio Mutuo Y Beneficiencia de Puerto Rico*, 248 F.3d 29, 33 (1st Cir. 2001), the PHS and County defendants fail to cite to any material buttressing the allegation of omission, and the Guard Defendants merely cite unidentified "Exhibits." I thus decline to disregard this portion of paragraph 23. The plaintiffs' remaining assertion in paragraph 23, that Angela Haase told her father that Hale was despondent and threatening suicide, as well as an allegation in the preceding paragraph that someone reported to the medical examiner that Hale had been increasingly depressed in the week before December 5 because his girlfriend preferred not to bring their children to visit, and that he had packaged and mailed back all photos and memorabilia of the children, Plaintiffs' Additional SMF ¶ 22, are objected to by all defendants on hearsay grounds, PHS Defendants' Reply SMF ¶¶ 22-23; Guard Defendants' Reply SMF ¶¶ 22-23; County Defendants' Reply SMF ¶¶ 22-23, and are properly excluded on that basis.

¹⁹ The Guard Defendants deny this assertion to the extent it implies that there were cells other than A107 that were handicapped-equipped and did not have a handicap placard, noting that Newton testified that A107 did not have a handicap placard; that the jail floor plans did not indicate that it was a handicapped-accessible cell; and to his knowledge there were no other handicapped-accessible cells that were not marked on the floor plan as such. Guard Defendants' Reply SMF ¶ 31; Newton Dep. at 183-84.

in all cells equipped with handicap bars was visible through the windows in the cell doors. *Id.*²⁰ On December 7, 1998 McNamara admitted having known on December 4 that A107 was a handicapped-equipped cell. Plaintiffs' Additional SMF ¶ 31; Langella's Report dated Dec. 7, 1998 ("Langella's Report"), Exh. 19 to Newton Dep., attached as Exh. 1 to Plaintiffs' Additional SMF, at 1.²¹ McNamara was aware of the risk of suicide increasing when another inmate has committed suicide a short time before. Plaintiffs' Additional SMF ¶ 32; PHS Defendants' Reply SMF ¶ 32; Guard Defendants' Reply SMF ¶ 32; County Defendants' Reply SMF ¶ 32. She also was aware that Hale was in maximum security because he was having behavioral problems. *Id.* Lawson was aware that Hale again was having problems getting his medications. *Id.* Hale did not receive his bedtime medications on December 4, 1998. *Id.* On December 4 Hale had at least three interactions at different times of the day with medical staff because of his complaints of anxiety. PHS Defendants' Reply SMF ¶ 33; Andrenyak Memo at 4.

Hale received his regular anti-anxiety medicine at noon on December 5. Plaintiffs' Additional SMF ¶ 34; PHS Defendants' Reply SMF ¶ 34; Guard Defendants' Reply SMF ¶ 34; County Defendants' Reply SMF ¶ 34. At that time, he also requested his "as needed" medication, Xanax. *Id.* Accardi, the nurse, said she had to recheck the order because she thought the Xanax had been discontinued. *Id.* Hale lost the only hour he had out of his cell that day after responding angrily to the nurse. *Id.*²² Accardi never returned either to reassess Hale or to inform him of the results of her

²⁰ The Guard Defendants deny this sentence to the extent applicable to cell A107, asserting that paragraph 39 of the Plaintiffs' Additional SMF accurately describes what was, and was not, visible through the window and tray slot. Guard Defendants' Reply SMF ¶ 31.

²¹ The Guard Defendants deny this assertion and the PHS and County defendants qualify it on the basis, *inter alia*, of McNamara's deposition testimony that she could not authenticate the accuracy of the information in Langella's Report, that the conversation was not taped or taken down by a stenographer, that her answers appeared to be garbled and it was clear she was upset, and that she denied knowing as of the time of the Hale suicide that cell A107 was equipped with a handicap bar. PHS Defendants' Reply SMF ¶ 31; Guard Defendants' Reply SMF ¶ 31; County Defendants' Reply SMF ¶ 31; Deposition of Jean McNamara ("McNamara Dep."), filed by Plaintiffs, at 15-17, 24.

²² PHS denies that it was aware Hale lost one hour of time. PHS Defendants' Reply SMF ¶ 34; Dixon Dep. at 90.

inquiry. *Id.* Nurse Plummer, who replaced Accardi, also did not give Hale the Xanax he had requested. *Id.*

Hale reported to the staff on the late afternoon of December 5 that he needed medication and was afraid he was going to “go off.” Plaintiffs’ Additional SMF ¶ 35; Guard Defendants’ Reply SMF ¶ 35; Deposition of Anne-Marie Morin (“Morin Dep.”), filed with County Defendants’ SMF, at 25.²³ The last time the prison log books show that Hale was checked by staff was at 5:15 p.m. on December 5. Plaintiffs’ Additional SMF ¶ 36; Guard Defendants’ Reply SMF ¶ 36; Andrenyak Memo at 2. The next log entry was a Code White called at 5:42 p.m. *Id.*

Morin was aware that other suicides in a jail raised the risk factors for the other inmates still incarcerated. Plaintiffs’ Additional SMF ¶ 37; PHS Defendants’ Reply SMF ¶ 37; Guard Defendants’ Reply SMF ¶ 37; County Defendants’ Reply SMF ¶ 37. She testified that she helped Fallon pass out food trays to the inmates on maximum security and finished at about 5:30 p.m. *Id.* ¶ 38. Fallon left for a supper break, and Morin began collecting trays. *Id.* She stated that she “heard two of the inmates in A103 Dayroom yelling stuff to Bobby Hale. I thought it odd because I didn’t hear Bobby yell a response. I decided for some unknown reason to get the trays from Dayroom A103 [and then] collected the first two trays.” *Id.*

When Morin reached Hale’s cell, A107, she looked in but saw only his shoes sticking up out of the end of his blankets. *Id.* ¶ 39. She called to him, and when she did not get a response she opened his food-tray slot and looked in. *Id.* She saw Hale’s feet by the toilet. *Id.* When she opened the door, she saw Hale sitting on the floor directly below the handicap bar, with a plastic bag over his head and a white sheet tied around his neck. *Id.* He was completely limp. *Id.* She called a Code White

²³ The PHS and County defendants qualify this statement by noting that Morin testified specifically that Hale said “Nurse Sue had screwed up his meds” and that he was afraid he was going to “go off,” and that “going off” meant that Hale would “start yelling and screaming and hitting things and yelling at the officers, calling them every name in the book, trashing his cell, that was going off for (*continued on next page*)

(suicide) before entering the cell, where she slipped on soap that had been spread over the floor. *Id.* Plastic bags are contraband. *Id.* ¶ 40.

Hale was transported to Maine Medical Center and placed on life support. *Id.* ¶ 42. He died on December 11, 1998. *Id.* As a result of an investigation into Hale's suicide, McNamara, Gillman and Lawson were charged with failure to follow an order. Guard Defendants' Reply SMF ¶ 43; County Defendants' Reply SMF ¶ 43; Newton Dep. at 134-35.

Cumberland County Jail Policy F321 requires that "emergency mental health services" be provided to inmates who appear to be "seriously depressed or having suicidal thoughts/actions." Plaintiffs' Additional SMF ¶ 24; PHS Defendants' Reply SMF ¶ 24; Guard Defendants' Reply SMF ¶ 24; County Defendants' Reply SMF ¶ 24. It is the corrections officers' responsibility to contact a mental-health counselor when an inmate has been identified as at increased risk for suicide. *Id.*

Each housing unit or pod also maintains both "hot books" and log or pod books. Plaintiffs' Additional SMF ¶ 25; PHS Defendants' Reply SMF ¶ 25; Guard Defendants' Reply SMF ¶ 25; Newton Dep. at 39, 42-43. The former is used to note particular issues that officers pass from one shift to the next; the latter is a daily journal of activity on that pod. *Id.* In addition, the officers go through "pass downs" at shift changes, where troubled inmates are discussed. Plaintiffs' Additional SMF ¶ 25; PHS Defendants' Reply SMF ¶ 25; Guard Defendants' Reply SMF ¶ 25; Fallon Dep. at 13-14. Hale was one of the inmates discussed at these meetings. *Id.* Officers not only read recent entries in the hot book every shift but also go as far back as they feel necessary to find out what is happening on the housing unit. Plaintiffs' Additional SMF ¶ 25; PHS Defendants' Reply SMF ¶ 25; Guard Defendants' Reply SMF ¶ 25; Deposition of William G. Lawson ("Lawson Dep."), filed by Plaintiffs, at 9.

Bobby." PHS Defendants' Reply SMF ¶ 35; County Defendants' Reply SMF ¶ 35; Morin Dep. at 25.

According to Department of Corrections Standard B.12, training in suicide prevention is supposed to occur once a year. Plaintiffs' Additional SMF ¶ 44; Andrenyak Memo at 1. At the time of the Mitchell and Hale suicides, no training had been provided in 1998, and the training staff was unaware that training had to be provided. *Id.*²⁴ Corrections Standard E.12.c requires that residents in maximum-security and special-management status be personally supervised by a corrections officer every fifteen minutes. Plaintiffs' Additional SMF ¶ 46; PHS Defendants' Reply SMF ¶ 46; Guard Defendants' Reply SMF ¶ 46; County Defendants' Reply SMF ¶ 46. There were three hangings in the Jail in 1998, all involving inmates hanging themselves from handicap bars in the cells. *Id.* ¶ 47.²⁵

PHS arranged for care to be given by Dr. Katz. *Id.* ¶ 50. There was no provision that PHS be compensated beyond the normal contract rate if it was required to provide physician services beyond the contracted allotment. Plaintiffs' Additional SMF ¶ 49; Newton Dep. at 87. Likewise, PHS included the cost of medication it provided to inmates in its total contract price. Plaintiffs' Additional SMF ¶ 49; Newton Dep. at 99. Consequently, the more medication PHS dispensed the more money it had to expend. Plaintiffs' Additional SMF ¶ 49; Newton Dep. at 100.

The third 1998 hanging – actually the first in time – occurred on May 3, 1998, when inmate Paul Beaton hanged himself in his cell. Plaintiffs' Additional SMF ¶ 53; Letter dated May 8, 1998 from Jeffery L. Newton to Ralph Nichols, Exh. 13 to Newton Dep., attached as Exh. 1 to Plaintiffs'

²⁴ The defendants qualify these statements on the basis that Standard B.12 states that training in suicide prevention is to occur “on an annual basis.” PHS Defendants' Reply SMF ¶ 44; Guard Defendants' Reply SMF ¶ 44; County Defendants' Reply SMF ¶ 44; standards attached as Exh. 1 to County Defendants' Reply SMF. The plaintiffs' additional statements that training in calendar-year 1998 did not occur until the end of December, some eighteen months after the training in 1997, and that no training in recognizing mental health problems or deterioration was provided, Plaintiffs' Additional SMF ¶ 45, which are not admitted by any of the defendants, do not conform with the requirement of Loc. R. 56(e) that an assertion of fact “be followed by a citation to the specific page or paragraph of identified record material supporting the assertion.” The plaintiffs instead cite a thick stack of training materials that I decline to parse through.

²⁵ The plaintiffs also state that, currently, to comply with standards of the American Correctional Association, any amount of time in disciplinary segregation over thirty days requires the approval of the Jail Administrator. Plaintiffs' Additional SMF ¶ 48. All of the defendants object that this statement is inadmissible. PHS Defendants' Reply SMF ¶ 48; Guard Defendants' Reply SMF ¶ 48; County Defendants' Reply SMF ¶ 48. Inasmuch as one cannot reasonably infer from the statement that Jail policy at the relevant time (continued on next page)

Additional SMF.²⁶ He had informed the staff that he was suicidal on April 30 and was visited by a nurse who pronounced him “no immediate threat.” *Id.* Medications had not been given as ordered. Plaintiffs’ Additional SMF ¶ 53; Memorandum dated Oct. 13, 1998 from Wes Andrenyak to Ralph Nichols, Exh. 14 to Newton Dep. (“Second Andrenyak Memo”), attached as Exh. 1 to Plaintiffs’ Additional SMF, at 2. As a result of Beaton’s suicide Cumberland County modified the PHS intake screening form. Plaintiffs’ Additional SMF ¶ 53; Newton Dep. at 110.

Complaints were made by inmates in addition to Hale in the fall and winter of 1998 that they were not receiving their medications. Plaintiffs’ Additional SMF ¶ 54; Newton Dep. at 76-77. A consultant hired to review the PHS contract concluded that the medical care was “adequate” but that record keeping was “not as good as it should have been.” Plaintiffs’ Additional SMF ¶ 54; Newton Dep. at 81.²⁷

According to plaintiffs’ expert Dr. Linda Peterson, a psychiatrist whose specialty is post-traumatic stress disorder and anxiety conditions, Hale clearly suffered from an anxiety disorder, although in her opinion a diagnosis of bipolar disorder is less clear. Plaintiffs’ Additional SMF ¶¶ 56-57; PHS Defendants’ Reply SMF ¶ 56; Guard Defendants’ Reply SMF ¶¶ 56-57; County Defendants’ Reply SMF ¶ 57; Deposition of Linda G. Peterson, M.D. (“Peterson Dep.”), filed with PHS Defendants’ SMF, at 9-10, 24.²⁸ He also suffered from panic disorder and claustrophobia. Plaintiffs’ Additional SMF ¶ 57; Guard Defendants’ Reply SMF ¶ 57; County Defendants’ Reply SMF

violated correctional standards, it is immaterial.

²⁶ The defendants object to paragraph 53 of the Plaintiffs’ Additional SMF on relevance grounds. PHS Defendants’ Reply SMF ¶ 53; *see also* Guard Defendants’ Reply SMF ¶ 53; County Defendants’ Reply SMF ¶ 53. However, the occurrence of two previous suicides at the Jail, committed within a short space of time in the same manner, is potentially relevant.

²⁷ The plaintiffs further assert that, according to Newton, PHS terminated its contract in the fall of 2000 primarily for “financial” reasons but that a *Maine Times* newspaper story indicated that Cumberland County terminated the contract after PHS repeatedly violated contractual standards. Plaintiffs’ Additional SMF ¶ 55. The defendants object on both relevance and hearsay grounds. PHS Defendants’ Reply SMF ¶ 55; Guard Defendants’ Reply SMF ¶ 55; County Defendants’ Reply SMF ¶ 55. I agree and accordingly disregard the statements in paragraph 55 on those bases.

²⁸ The PHS Defendants deny this statement, asserting that Hale did suffer from bipolar disorder. PHS Defendants’ Reply SMF ¶ 57; (*continued on next page*)

¶ 57; Peterson Dep. at 29.²⁹ Persons suffering from bipolar and anxiety disorders have a high rate of suicide. Plaintiffs' Additional SMF ¶ 58; Guard Defendants' Reply SMF ¶ 58; County Defendants' Reply SMF ¶ 58; Loboizzo Dep. at 53-54.³⁰ Hale had been provided with prescriptions for both Klonopin and Xanax, both anxiety-reducing medications, both requiring close monitoring to make sure that the dosage does not cause disinhibition and increased violence. Plaintiffs' Additional SMF ¶ 59; Guard Defendants' Reply SMF ¶ 59; County Defendants' Reply SMF ¶ 59; Peterson Dep. at 30.³¹ Xanax is short-acting, and Klonopin requires seventy-two hours or more to reach a steady state. Plaintiffs' Additional SMF ¶ 59; Guard Defendants' Reply SMF ¶ 59; County Defendants' Reply SMF ¶ 59; Peterson Dep. at 32.³²

Dr. Peterson concluded that, as of the beginning of December, when Dr. Katz again changed Hale's medications, Hale probably was withdrawing from the Xanax partly because he did not get one dose of Xanax and of Klonopin during the twenty-four hour period prior to his suicide. Plaintiffs' Additional SMF ¶ 60; Guard Defendants' Reply SMF ¶ 60; Peterson Dep. at 7, 42-43.

Dr. Peterson testified that it is up to the prescribing physician and nursing staff to monitor the patient. Plaintiffs' Additional SMF ¶ 61; Guard Defendants' Reply SMF ¶ 61; Peterson Dep. at 32-33. Hale had already missed one dose of Xanax on November 25 when the nurse thought that the medication had been discontinued. Plaintiffs' Additional SMF ¶ 61; Peterson Dep. at 44, 56.³³ In

Deposition of Dr. David Loboizzo ("Loboizzo Dep."), filed with County Defendants' SMF, at 14.

²⁹ The plaintiffs' additional assertion that depression was consistent with Hale's symptoms, Plaintiffs' Additional SMF ¶ 57, is admitted only by the Guard and County defendants.

³⁰ The PHS Defendants qualify this assertion by stating that Dr. Loboizzo asked Hale on each visit if he were suicidal, and each time Dr. Loboizzo did not consider him suicidal. PHS Defendants' Reply SMF ¶ 58; Loboizzo Dep. at 37-38.

³¹ The PHS Defendants note that, with respect to "close monitoring," Dr. Peterson testified that she typically will see outpatients in this situation a couple of times a month and have them call in once a week. PHS Defendants' Reply SMF ¶ 59; Peterson Dep. at 38-39. Hale was seen at least daily by the nursing staff. *Id.*

³² The plaintiffs' further assertion that when one is switching a patient from one to the other "even more careful monitoring is required," Plaintiffs' Additional SMF ¶ 59, is admitted only by the Guard and County defendants.

³³ The plaintiffs' further statement that "the nurses here did [not] follow the doctor's orders" to taper down Xanax while adding Klonopin, Plaintiffs' Additional SMF ¶ 61, is admitted only by the Guard Defendants.

addition, according to Dr. Peterson, there is indication of an intent to commit suicide in only about sixty percent of cases. Plaintiffs' Additional SMF ¶ 61; Guard Defendants' Reply SMF ¶ 61; Peterson Dep. at 40. Dr. Peterson testified that other cases are "sub-intentioned," that is, "people who do something impulsive, not knowing whether it's going to end their life or not and kind of take the risk." Plaintiffs' Additional SMF ¶ 61; Guard Defendants' Reply SMF ¶ 61; Peterson Dep. at 59.³⁴ Typically, in order to monitor adequately for that, medical personnel have to look at behavioral changes and assess the increased risk in those changes. Plaintiffs' Additional SMF ¶ 61; Guard Defendants' Reply SMF ¶ 61; Peterson Dep. at 40. In Dr. Peterson's opinion, Hale's increasingly frequent episodes of out-of-control behavior were a warning sign that he was at high risk for causing violence to himself. Plaintiffs' Additional SMF ¶ 61; Peterson Dep. at 41.³⁵ He was paranoid and hearing voices; "probably medications could have helped if they'd been able to tone down those aggressive outbursts, because then he wouldn't have gotten into altercations with the guards in the first place[.]" Plaintiffs' Additional SMF ¶ 61; Guard Defendants' Reply SMF ¶ 61; Peterson Dep. at 60.

In Dr. Peterson's view, rather than considering Hale's escalation in violence as a medical problem, the PHS nurses simply tossed it off as "behavioral." Plaintiffs' Additional SMF ¶ 62; Guard Defendants' Reply SMF ¶ 62; Peterson Dep. at 49. But, testified Dr. Peterson, Hale's "ability to control himself was deteriorating because the incidents were getting more frequent." Plaintiffs' Additional SMF ¶ 62; Guard Defendants' Reply SMF ¶ 62; Peterson Dep. at 84-85.³⁶

³⁴ The PHS Defendants object to Dr. Peterson's testimony regarding "sub-intentional" suicidal acts on the ground of relevance inasmuch as there is no indication that Hale's suicide was other than an intentional act. PHS Defendants' Reply SMF ¶ 61. However, the testimony as a whole indicates that Dr. Peterson was distinguishing between persons who communicate an intent to commit suicide and those who do not. See Peterson Dep. at 40-41. Inasmuch as it is not clearly irrelevant, I decline to exclude it on that basis.

³⁵ The Guard Defendants deny this statement, pointing out that Dr. Peterson testified that the behavior in question would have been a warning sign "to me," and she thus did not opine that it should have been a warning to anyone other than herself. Guard Defendants' Reply SMF ¶ 61; Peterson Dep. at 41. The plaintiffs' additional assertion that Dr. Peterson testified that if Hale had been appropriately medicated and monitored, it "would have made a difference," Plaintiffs' Additional SMF ¶ 61, is admitted only by the Guard Defendants.

³⁶ The PHS Defendants deny this statement, asserting that rather than being unable to control himself, Hale was misbehaving. PHS (continued on next page)

Dr. Peterson offered the opinion that getting sent to disciplinary segregation when a person is claustrophobic and knowing he is about to be locked down twenty-three hours a day is “probably pretty horrible.” Plaintiffs’ Additional SMF ¶ 63; Guard Defendants’ Reply SMF ¶ 63; Peterson Dep. at 54-55.³⁷ Dr. Peterson further testified, “My concern was that this gentleman was escalating for quite a while and that it appeared that people saw this as primarily a problem with his being antisocial, if you will, up until probably that November 27” Plaintiffs’ Additional SMF ¶ 63; Guard Defendants’ Reply SMF ¶ 63; Peterson Dep. at 82. According to Dr. Peterson, even though a layperson might not equate at-risk behavior with suicide, he or she should seek treatment for that person. Plaintiffs’ Additional SMF ¶ 63; Peterson Dep. at 112.³⁸ Finally, Dr. Peterson testified that Hale had a mental illness, which automatically puts him in a higher risk category, and “he’s increasingly demonstrating that he’s violent and out of control and unable to effectively inhibit

Defendants’ Reply SMF ¶ 62; Newton Dep. at 174. The plaintiffs’ additional statement that the PHS nurses “failed to notice the escalation in the violence of [Hale’s] condition,” Plaintiffs’ Additional SMF ¶ 62, is admitted only by the Guard Defendants.

³⁷ The following further statements are admitted only by the Guard Defendants: “Dr. Peterson is of the opinion that the slide in Hale’s behavior clearly indicated a deterioration in his psychological condition. Significant events clearly coincided with lapses in providing medication. This deterioration was only exacerbated and accelerated through the punitive and disciplinary actions taken against him by the correctional officers at the Cumberland County Jail. Getting sent to disciplinary segregation . . . happened increasingly over the fall as his medication regime also deteriorated[.]” Plaintiffs’ Additional SMF ¶ 63 (citations omitted).

³⁸ The Guard Defendants object to this statement on the grounds that Dr. Peterson’s opinion as to laypersons is outside the scope of her designation and that she is not qualified to offer opinions as to what laypersons would realize from observing Hale’s behavior. Guard Defendants’ SMF ¶ 63. Dr. Peterson was designated *inter alia* to offer testimony “that the correctional staff failed to adequately monitor and refer Robert Hale for adequate medical treatment.” Letter dated April 13, 2001 from Tyler N. Kolle to Mark E. Dunlap, Esquire, attached as Exh. B to Motion To Strike, at 2. Her testimony as to what the correctional staff, *qua* laypersons (as opposed to medical professionals), should have observed falls within the scope of that designation. The Guard Defendants offer no evidence as to Dr. Peterson’s asserted lack of qualification to opine as to laypersons. I therefore decline to disregard the statement on the bases proffered. The Guard Defendants object to the following additional statement on the ground that it is based solely on speculation: “In the case of Lawson, McNamara and Gillman, Dr. Peterson presumed that they certainly were aware of Mr. Hale’s hearing voices, and prior attempts to harm himself by banging his head against the wall.” Plaintiffs’ Additional SMF ¶ 63; Guard Defendants’ Reply SMF ¶ 63; *see also* Motion To Strike at 4-5. The subject of an expert’s testimony must be knowledge, a word that “connotes more than subjective belief or unsupported speculation.” *Daubert v. Merrell Dow Pharms., Inc.*, 509 U.S. 579, 589-90 (1993). When asked if her review of documents led her to believe that any of the Guard Defendants knew Hale was suicidal before December 5, 1998, Dr. Peterson testified, “Well, I would presume that they were aware of him making suicidal threats and his behavior of banging his head against the wall because I would assume that was communicated to them.” Peterson Dep. at 120. She thus, in essence, acknowledged that the asserted “fact” was unsupported speculation. The statement accordingly is properly excluded.

behaviors that he knows are going to cause him trouble.” Plaintiffs’ Additional SMF ¶ 64; Peterson Dep. at 97-98.

According to plaintiffs’ expert Dr. Alvin Cohn, who holds a master’s degree in psychiatric social work and a doctorate in criminology and established the corrections graduate program at American University, Hale’s condition escalated throughout the fall. Plaintiffs’ Additional SMF ¶¶ 65-66; PHS Defendants’ Reply SMF ¶ 65; Guard Defendants’ Reply SMF ¶¶ 65-66; County Defendants’ Reply SMF ¶ 65; Deposition of Alvin W. Cohn (“Cohn Dep.”), filed with County Defendants’ SMF, at 41, 44-45. The violence resulted in him being put in disciplinary segregation six times. Plaintiffs’ Additional SMF ¶ 66; Guard Defendants’ Reply SMF ¶ 66; Cohn Dep. at 43.³⁹ More importantly, the acts were increasingly self-abusive. Plaintiffs’ Additional SMF ¶ 66; Guard Defendants’ Reply SMF ¶ 66; Cohn Dep. at 45, 49, 51.⁴⁰ In Dr. Cohn’s opinion, corrections officers aware of these acts did not respond appropriately and medical personnel were not involved soon enough. Plaintiffs’ Additional SMF ¶ 66; Guard Defendants’ Reply SMF ¶ 66; Cohn Dep. at 46-47, 60, 63-64.⁴¹ In his view, Hale should have been placed on suicide watch no later than the evening of November 27 or the morning of November 28. Plaintiffs’ Additional SMF ¶ 66; Guard Defendants’ Reply SMF ¶ 66; Cohn Dep. at 65.

³⁹ The plaintiffs’ assertion that Hale was placed in disciplinary segregation six times “in a couple of months,” Plaintiffs’ Additional SMF ¶ 66, is admitted only by the Guard Defendants.

⁴⁰ The plaintiffs’ further statement that “the clues were sufficient that the corrections officers should have noticed them and the likelihood of substantial self-injurious behavior, including suicide,” Plaintiffs’ Additional SMF ¶ 66, is admitted only by the Guard Defendants with the caveat that, per Dr. Cohn’s testimony, that opinion was inapplicable to them, *see* Guard Defendants’ Reply SMF ¶ 66; Cohn Dep. at 170-71.

⁴¹ The Guard Defendants again admit this and all additional statements made in paragraph 66 of the Plaintiffs’ Additional SMF with the caveat that, per Dr. Cohn’s testimony, those statements are inapplicable to them. *See* Guard Defendants’ Reply SMF ¶ 66. The County Defendants deny this and all additional statements made in paragraph 66 on the basis that the plaintiffs have admitted that at least two of the County Defendants, Brown and Breton, responded appropriately. County Defendants’ Reply SMF ¶ 66; County Defendants’ SMF ¶¶ 55, 70-72, 78; Plaintiffs’ Responsive Statement of Material Facts in Support of Its [sic] Objection to [County Defendants’] Motion for Summary Judgment (“Plaintiffs’ Opposing SMF/County”) (Docket No. 50) ¶¶ 55, 70-72, 78.

In Dr. Cohn's opinion it was incomprehensible that Hale was allowed to remain in a cell with a handicap railing and was permitted to possess a plastic bag, which was contraband. Plaintiffs' Additional SMF ¶ 67; Cohn Dep. at 98. McNamara, Gillman and Lawson understood that they had an order for the handrail to be removed, and to remove all non-handicapped inmates from such a cell. Plaintiffs' Additional SMF ¶ 67; Cohn Dep. at 172.⁴² They were aware that someone such as Hale should not have been in such a cell. *Id.* In Dr. Cohn's view, if Gillman, Lawson and McNamara had worked for more than a day or two in that pod, they should have known about Hale's prior behaviors, and certainly should have learned about them through the log or hot book. Plaintiffs' Additional SMF ¶ 67; Cohn Dep. at 188.⁴³ The next night, Hale had time to spread soap on the floor, which also suggested to Dr. Cohn that staff did not observe Hale as they should have. Plaintiffs' Additional SMF ¶ 68; Cohn Dep. at 99.

In Dr. Cohn's opinion, training should be provided by medical and corrections staff to recognize behavior clues. Plaintiffs' Additional SMF ¶ 69; Cohn Dep. at 75. A corrections officer should not diagnose but should be sensitive to and aware of mood changes, behavior and attitude that are reflective of problems, including reactions to psychotropic medications. *Id.* That training is required to help officers recognize various behaviors and their meaning. *Id.* Yet only two corrections officers brought forward concerns about Hale. *Id.* There was no indication of concern by Dr. Katz about suicide or followup after December 2. Plaintiffs' Additional SMF ¶ 69; Cohn Dep. at 90.

One of the standards of the American Correctional Association is that corrections officers should at all times be within the sight and sound of inmates for immediate response. Plaintiffs'

⁴² The Guard Defendants deny this statement to the extent it implies that they were aware that cell A107 was equipped with a handicap rail prior to Hale's suicide attempt on December 5, 1998. Guard Defendants' Reply SMF ¶ 67.

⁴³ The Guard Defendants deny this statement, noting *inter alia* that Dr. Cohn elsewhere testified that he could excuse the Guard Defendants' not being aware; did not know whether they were aware or not, although he assumed they were; and had no documents to prove they were. Guard Defendants' Reply SMF ¶ 67; Cohn Dep. at 189-90.

Additional SMF ¶ 69; Cohn Dep. at 97. There had already been two suicides, which in Dr. Cohn's opinion should have produced heightened sensitivity in staff to changes in moods/behaviors/attitudes on the part of inmates. *Id.* According to Dr. Cohn, the likelihood of suicide attempts significantly increases from the copycat point of view and should put staff on alert. Plaintiffs' Additional SMF ¶ 69; Cohn Dep. at 103-04. The Jail was not even aware it had not had training that year until after Hale's suicide on December 5. Plaintiffs' Additional SMF ¶ 69; Cohn Dep. at 162.

B. Additional Facts Relating to PHS Defendants

At the time relevant to the events alleged in the Complaint, PHS contracted with Cumberland County to provide medical services to inmates at the Jail. PHS Defendants' SMF ¶ 1; Plaintiffs' Opposing SMF/PHS ¶ 1. Dixon was the health services administrator in overall charge of the administration of the medical department for PHS. *Id.*

On November 11, 1998 Hale was seen by the medical department; he was agitated and said he was "going crazy" being locked down in the maximum-security unit. *Id.* ¶ 4. Dixon assessed him as having a potential for self-injury, which she distinguished from having suicidal intent. *Id.* As a result of this assessment, Dixon requested that Dr. Katz review Hale's chart. *Id.* ¶ 5. Sometime between November 11 and November 17 Dr. Katz reviewed Hale's chart and adjusted his medication. *Id.*

On November 30 Breton contacted the Jail medical department with a concern about Hale's behavior and asked that he be seen by the psychiatrist. *Id.* ¶ 6. Dixon arranged for Dr. Katz to see Hale. *Id.* Dr. Katz saw him on December 2. *Id.* He ordered that Hale's anti-anxiety medication be changed from Xanax to Klonopin. *Id.* The medical administration record shows that Xanax was discontinued and Klonopin was administered on December 3 pursuant to doctor's orders. *Id.*

Dixon was aware that Hale was a friend of Mitchell's. PHS Defendants' SMF ¶ 7; Affidavit of Phebe Dixon (Docket No. 32) ¶ 5. She recalls speaking with Hale after Mitchell's suicide on her

regular morning rounds in the maximum-security unit to see if he was feeling safe. *Id.* At that time, Hale assured her that he was dealing with Mitchell's death all right. *Id.* He gave her no indication that he was considering suicide himself. *Id.* Dixon understood that in a closed society such as a jail there is an increased danger of copy-cat suicide after an initial death. Plaintiffs' Opposing SMF/PHS ¶ 7; Dixon Dep. at 81.

Inmates in disciplinary segregation were seen by a nurse once a day because the isolation of disciplinary segregation increased the risk of emotional trauma and of self-harm by inmates. Plaintiffs' Opposing SMF/PHS ¶ 8; Dixon Dep. at 53. The medical staff would rely on the corrections officers to alert them if an inmate was having a particular problem. PHS Defendants' SMF ¶ 8; Dixon Dep. at 37.

On December 4 Dixon received word from the maximum-security unit that Hale was experiencing increased anxiety. PHS Defendants' SMF ¶ 9; Plaintiffs' Opposing SMF/PHS ¶ 9. She requested that he be brought to the medical department, where she allowed him to stay in one of the medical holding cells for a period of time. *Id.* She called Dr. Katz and requested that Hale be provided additional anti-anxiety medication. *Id.* Dr. Katz prescribed Xanax as needed, and Dixon administered this to Hale. *Id.* She also administered his regular dose of Klonopin. *Id.* After an hour, Hale told Dixon that he was feeling better and felt safe and was returned to the maximum-security unit. *Id.*

Although Dixon was aware that Hale had experienced violent outbursts and problems with increased anxiety during his incarceration at the Jail, she was not aware that he intended to commit suicide. *Id.* ¶ 10. He did not indicate that he intended to commit suicide, and no member of the correctional staff or the medical staff ever indicated to Dixon that Hale was considered a risk for suicide or had stated an intent to commit suicide. *Id.*

Dr. Peterson is of the opinion that the Jail medical staff showed deliberate indifference to Hale, which she defined as people having knowledge of a situation and not acting on that knowledge when it would be appropriate to act for the inmate's well-being. *Id.* ¶ 11. She also defined deliberate indifference as knowing that there was a problem with an inmate that needed to be addressed and was not acted upon. Plaintiffs' Opposing SMF/PHS ¶ 11; Peterson Dep. at 87-88.

Xanax is a short-acting benzodiazapine that takes only a few days to reach a steady state in the blood; Klonopin is a longer acting benzodiazapine that takes a longer time to reach a steady state. PHS Defendants' SMF ¶ 12; Plaintiffs' Opposing SMF/PHS ¶ 12. It is appropriate to switch from a short-acting to a longer acting benzodiazapine when a patient reports that he or she is "escaping," *i.e.*, experiencing increased anxiety between doses of medication. *Id.* When a patient is switched from one medication to the other, it takes several weeks for the longer acting medication to reach its full effect, and the doctor must "cover" the patient during that time by continuing frequent doses of the short-acting medication. *Id.* ¶ 13. Dr. Peterson "would have preferred to see" Hale kept on a half-dose of Xanax while the Klonopin was started. *Id.* In a prison setting, it would be appropriate to order a continuing dose of Xanax during this transition period rather than ordering it "p.r.n." (as needed). *Id.*

According to Hale's medical records, which Dr. Peterson reviewed, he received two doses of Klonopin and one dose of Xanax on December 3 and a morning dose of Klonopin and a dose of Xanax on December 4. PHS Defendants' SMF ¶ 14; Peterson Dep. at 42-43. There is no record of his receiving an evening dose of Klonopin on December 4. *Id.* Dr. Peterson believes Hale was in a "constant state of withdrawal" from Xanax on December 4 and 5, and that this was a "fairly significant contribution" to his demise. PHS Defendants' SMF ¶ 14; Peterson Dep. at 7, 43. Hale got only a single milligram of Xanax on the morning of December 4, as opposed to the six milligrams he had

previously been on, an inadequate amount to prevent him from escaping. Plaintiffs' Opposing SMF/PHS ¶ 14; Peterson Dep. at 42-43. However, Dr. Peterson cannot say that Hale would not have committed suicide had he received his medication. PHS Defendants' SMF ¶ 14; Peterson Dep. at 56.

Defendant nurse Accardi was the PHS staff nurse on the day shift on December 5. PHS Defendants' SMF ¶ 15; Plaintiffs' Opposition/PHS ¶ 15. On her afternoon "med pass" in the maximum-security unit she administered Klonopin to Hale. *Id.* Hale requested Xanax as well. *Id.* Accardi was confused by this request because Xanax had just been discontinued and Klonopin started. *Id.* It was unusual for the two medications to be administered at the same time. *Id.* She told Hale that she would check the doctor's order and get back to him. *Id.* By the time she finished "med pass" it was close to the end of her shift. *Id.* At report, she discussed Hale's request with the evening nurse, Jen Plummer. *Id.* They checked Hale's chart and determined that the doctor had prescribed Xanax "as needed." *Id.* Plummer assured Accardi that she would take care of this during the evening shift. *Id.*

At approximately 5 p.m. Hale told defendant corrections officer Morin that the medical department had "screwed up" his medications and that he might "go off." *Id.* ¶ 16. Morin asked Hale if he wanted her to call the medical department, and he told her that he could wait until the next "med pass" that evening. *Id.* Hale also indicated to Morin that the next "med pass" seemed "like a very long time away." Plaintiffs' Opposing SMF/PHS ¶ 16; Morin Dep. at 26.

There is no evidence in Hale's medical records from his final incarceration at the Jail that he intended to commit suicide, although there is evidence of an attempt during an earlier incarceration in 1997. PHS Defendants' SMF ¶ 17; Peterson Dep. at 40. Although Dr. Peterson opined that Hale's increasing episodes out of control behavior were a "warning sign" that he was at high risk to injure himself or others, she did not know whether the result in Hale's case would have been different had he been seen by a psychiatrist in October or November. PHS Defendants' SMF ¶ 18; Peterson

Dep. at 40-41, 100. Dixon admits that agitation can indicate suicidal ideation and that individuals can be suicidal prior to making an attempt. Plaintiffs' Opposing SMF/PHS ¶ 18; Dixon Dep. at 45.

Dr. Peterson's sole basis for believing that PHS showed a "malicious intent" to harm Hale was a statement attributed to corrections officer Ryder. PHS Defendants' SMF ¶ 19; Peterson Dep. at 52-54. Ryder testified that a PHS nurse made a statement to him when he called the medical department to request additional medication for Hale. PHS Defendants' SMF ¶ 20; Plaintiffs' Additional SMF/PHS ¶ 20. This occurred about a month before Hale's suicide. *Id.* This is the only such incident that stands out in Ryder's mind. *Id.* He could not remember who the nurse was, but believed she was relatively new to the Jail and worked only on a part-time, off-and-on basis. *Id.* Ryder's general impression was that the nursing staff had a "very negative" attitude toward the prisoners and treated them like scum. *Id.*; *see also* Plaintiffs' Opposing SMF/PHS ¶ 21; Deposition of Charles Ryder, filed with County Defendants' SMF, at 20. The remark alleged by Ryder was never reported to Dixon. PHS Defendants' SMF ¶ 21; Plaintiffs' Opposing SMF/PHS ¶ 21. If it had been she would have disciplined the nurse. *Id.* The alleged comment does not reflect the attitude or philosophy of PHS or the Jail medical department. *Id.*

Dr. Katz provided consultation to the inmates pursuant to a contract with PHS. PHS Defendants' SMF ¶ 22; Affidavit of Joanna Garcia (Docket No. 31).

C. Additional Facts Relating to Guard Defendants

Defendant corrections officers Gillman, Lawson and McNamara were were on duty for the 7 a.m. to 3 p.m. shift at the Jail on December 4, 1998. Guard Defendants' SMF ¶ 5; Plaintiffs' Responsive Statement of Material Facts in Support of Its [sic] Objection to [Guard Defendants'] Motion for Summary Judgment ("Plaintiffs' Opposing SMF/Guard") (Docket No. 51) ¶ 5. In the "max" area of the Jail there was a marked handicapped equipped cell, A127, which housed a non-

handicapped inmate on December 4, 1998. *Id.* ¶ 12. Gillman and Lawson were the corrections officers working in the “max” area on December 4. *Id.* On that particular morning, Gillman and Lawson, who had very limited prior experience in the “max” area, became inundated with their work when they started their shift. *Id.* They forgot about the order issued at the pass-down meeting that morning and, as a result, failed to remove the inmate from cell A127 in accordance with the Jail Administrator’s order. *Id.* McNamara, their immediate supervisor, failed to ensure that the order was carried out. *Id.*

According to the Guard Defendants, notwithstanding the fact that they did not comply with the order, even if they had remembered to remove the inmate in cell A127 they still would not have removed Hale from cell A107. *Id.* ¶ 13. They assert that they did not believe that cell A107 was a handicapped-equipped cell, did not know that it was equipped with a handicap railing and therefore did not know that the order would have been applicable to cell A107. *Id.* According to the plaintiffs, these averments are not credible inasmuch as corrections officers were required to make fifteen-minute checks on Hale, who was in his cell twenty-three hours a day, and the handicap sinks were visible from the cell windows. Plaintiffs’ Opposing SMF/Guard ¶ 13; Newton Dep. at 19, 22; McNamara Dep. at 25.

Gillman, Lawson and McNamara did not believe that Hale posed any risk of suicide at any time during his incarceration from July 24, 1998 to December 5, 1998. Guard Defendants’ SMF ¶ 14; Plaintiffs’ Opposing SMF/Guard ¶ 14. Hale never expressed suicidal ideations to them; nor did they observe behavior that they believed raised concerns that he was a suicide risk. *Id.* ¶ 15. However, Hale was housed in a “high maximum” security cell reserved for inmates with behavioral problems. Plaintiffs’ Opposing SMF/Guard ¶ 15; Newton Dep. at 16. Corrections officers are required to review the pod hot book every shift and to read as far back as necessary to inform themselves of what

is happening in the pod. Plaintiffs' Opposing SMF/Guard ¶ 15; Lawson Dep. at 9. Gillman, Lawson and McNamara never received any information, written or oral, that Hale posed a risk of suicide. Guard Defendants' SMF ¶ 16; Plaintiffs' Opposing SMF/Guard ¶ 16.

D. Additional Facts Relating to County Defendants

Although, during the fall and early winter of 1998 inmates other than Hale complained on a regular basis that they were not receiving their medications, no systematic or Jail-wide investigation of those accusations was performed by the Jail. County Defendants' SMF ¶ 9; Plaintiffs' Opposing SMF/County ¶ 9; Newton Dep. at 76-77.⁴⁴

The Jail has a set of policies and procedures. County Defendants' SMF ¶ 15; Plaintiffs' Opposing SMF/County ¶ 15. Dr. Cohn reviewed certain Jail policies and procedures and thought they were appropriate. Plaintiffs' Opposing SMF/County ¶ 16; Cohn Dep. at 134-35. It is also the opinion of Lindsay Hayes that the Jail's policies and procedures were appropriate and adequate and met state and local standards as of December 5, 1998. Plaintiffs' Opposing SMF ¶ 16; Affidavit of Lindsay Hayes ("Hayes Aff.") (Docket No. 38) ¶ 8.⁴⁵ Dr. Cohn testified that a memorandum of November 27, 1998 written by Sergeant Brown did not demonstrate deliberate indifference to Hale. Plaintiffs' Opposing SMF/County ¶ 17; Cohn Dep. at 56, 76.

During the time Newton was the Jail administrator (1996-present), if a corrections officer thought that a particular inmate required some sort of medical service, that officer's responsibility was to contact the medical department. County Defendants' SMF ¶ 19; Plaintiffs' Opposing SMF/County ¶

⁴⁴ In addition to their initial and reply statements of material facts, the County Defendants submit a supplemental statement of material facts that is neither contemplated by Loc. R. 56 nor the subject of a motion for leave to file such a document. *See* County Defendants' Reply Statement of Material Facts (RSMF) (Docket No. 58). It accordingly is disregarded.

⁴⁵ The plaintiffs dispute that the Hayes affidavit lays an adequate foundation for this sweeping statement, Plaintiffs' Opposing SMF/County ¶ 16; however, Hayes' qualifications as well as his review of Maine Department of Corrections Detention and Correction Standards and "numerous jail medical and mental health policies of the Cumberland County Sheriff's Office", Hayes Aff. ¶¶ 2-7, suffice to lay such a foundation..

19. Then it was up to the medical department to determine what care appropriately should be given. *Id.* Any corrections officer could contact the mental health counselor in the event an inmate was perceived to require mental health services. Plaintiffs' Opposing SMF/County ¶ 19; Newton Dep. at 83-84. Corrections officers were responsible not only for notifying the mental health counselor but also the medical staff and their supervisor in the event they felt an inmate was at increased risk for suicide. Plaintiffs' Opposing SMF/County ¶ 19; Newton Dep. at 119. The supervisor was obliged to take some action to ensure the inmate's safety and to ensure that the medical department did an assessment. *Id.* Breton's November 30, 1998 request that medical personnel have Hale seen by a psychiatrist was appropriate under Jail policies and procedures. County Defendants' SMF ¶ 20; Plaintiffs' Opposing SMF/County ¶ 20.

The State of Maine requires that suicide training be done for corrections officers on an annual basis. *Id.* ¶ 21. In Hayes' opinion, the suicide training provided by the Jail for its corrections officers was sufficient and appropriate as of December 5, 1998. *Id.* ¶ 23. The plaintiffs disagree, noting that no suicide prevention training had been held as of that date. Plaintiffs' Opposing SMF/County ¶ 23; Newton Dep. at 116-17.

In Hayes' opinion, Newton's order of December 4 (that all non-handicapped inmates be removed from cells equipped with handicap bars) was appropriate and timely and would make copycat suicides less likely. County Defendants' SMF ¶ 27; Plaintiffs' Opposing SMF/County ¶ 27. Breton orally gave the order to all of the corrections officers on duty prior to commencement of the 7 a.m. shift on December 4. *Id.* ¶ 28. Later in that shift, Breton was told by Sergeant Burke that the order had been complied with. *Id.* ¶ 29. She did nothing further with respect to that order. Plaintiffs' Opposing SMF/County ¶ 30; Affidavit of Francine Breton (Docket No. 36) ¶ 24.

The Jail corrections staff responded appropriately to Hale's misbehavior in terms of keeping the facility quiet. County Defendants' SMF ¶ 32; Cohn Dep. at 161. However, in Dr. Cohn's view, "[p]utting a guy in a restraint chair only makes life easier for correctional staff. It doesn't resolve the problem of the inmate." Plaintiffs' Opposing SMF/County ¶ 32; Cohn Dep. at 161.

During the fall of 1998 Hale was an inmate who was having an extraordinary number of disciplinary problems. County Defendants' SMF ¶ 34; Plaintiffs' Opposing SMF/County ¶ 34. Newton felt, from his review of the records, that Hale was manifesting increasing amounts of misconduct, was a very angry individual and it did not take too much for him to demonstrate anger and violence. *Id.* ¶ 35. That conduct is not an indicator or predictor of suicidal behavior in and of itself. *Id.*

Hale was in disciplinary segregation from September 30-October 10, October 19-31, November 1-2 and November 25-December 5, 1998. *Id.* ¶ 41. Disciplinary segregation is a sanction for misconduct. Plaintiffs' Opposing SMF/County ¶ 40; Newton Dep. at 33. Each time Hale was placed in disciplinary segregation in 1998, an incident report was created and there was a hearing and determination by the disciplinary board. County Defendants' SMF ¶ 44; Plaintiffs' Opposing SMF/County ¶ 44. Hale had no serious behavioral problems from December 2 until the time of his suicide on December 5. *Id.* ¶ 49. However, Hale became very upset on December 4 following the suicide of Mitchell, and had at least three interactions with the medical department on that date as a result of his increasing anxiety. Plaintiffs' Opposing SMF/County ¶ 49; Dixon Dep. at 78-80, 100.

The pro-restraint chair used on Hale on November 24 is to protect the inmate and the staff. County Defendants' SMF ¶ 50; Plaintiffs' Opposing SMF/County ¶ 50. Leather restraints were placed on Hale to protect him on November 27. County Defendants' SMF ¶ 53; Deposition of Sean D. Brown ("Brown Dep."), filed with County Defendants' SMF, at 20-21. Sergeant Brown wrote a memorandum

to Breton on November 27 as a result of Hale's behavior, which was the "most rageful" Brown had ever witnessed in his eight years of working as a corrections officer. Plaintiffs' Opposing SMF/County ¶ 54; Brown Dep. at 39-40. Sergeant Brown's memorandum bringing Hale's behaviors to the attention of the Jail administration was appropriate and evidenced his concern for Hale. County Defendants' SMF ¶ 55; Plaintiffs' Opposing SMF/County ¶ 55. On November 30, the first day she saw this memorandum, Breton approached the medical staff and requested that Hale see a psychiatrist. *Id.* ¶ 56.

Cell A107 was a high-max cell. *Id.* ¶ 59. One of the corrections officers assigned Hale to a high-max cell because of his conduct in the preceding weeks and because it was felt he needed closer supervision. *Id.* ¶ 61. Dr. Cohn acknowledges that the corrections officers did not completely ignore Hale's self-injurious behavior but states that they failed to act appropriately to resolve its causes. Plaintiffs' Opposing SMF/County ¶ 64; Cohn Dep. at 160-61.

Corrections officer Ryder appropriately transmitted information on Hale's behalf to the medical staff weeks before his suicide. County Defendants' SMF ¶ 65; Plaintiffs' Opposing SMF/County ¶ 65. After the episode on December 5 during which Hale threw items around his cell, Gillman talked to him, and he calmed down. *Id.* ¶ 66. Dr. Peterson testified that corrections officers appeared to be concerned about Hale when they put him in restraints to keep him from injuring himself. Plaintiffs' Opposing SMF/County ¶ 68; Peterson Dep. at 85.

Brown's action in writing the November 27 memorandum was taken to assist Hale and was not in this regard indifferent. County Defendants' SMF ¶¶ 69-70; Plaintiffs' Opposing SMF/County ¶¶ 69-70. In going to the medical staff and requesting that Hale be seen by a psychiatrist, Breton evidenced concern for Hale, and her actions were timely. *Id.* ¶¶ 71-72. Fallon, at approximately 5:10 p.m. on December 5, told Hale he would call medical to deal with problems with his medications if Hale

wished him to. *Id.* ¶ 76. Hale declined. *Id.* In general, based on a review of relevant documents in this case, the actions of the Jail corrections officers showed concern for Hale's well-being. *Id.* ¶ 78.

Hale did not exhibit suicidal behavior or words during his incarceration at the Jail between July 24 and December 5. *Id.* ¶ 79. Engaging in deliberate self-injurious behavior does not necessarily reflect suicidal intent on the part of an inmate. *Id.* ¶ 81. Newton, in his investigation of Hale's suicide, did not identify any individuals to whom Hale had expressed a suicidal intent. *Id.* ¶ 85. Newton concluded that Hale was not placed on suicide watch because he was not determined to be a suicide risk. *Id.* ¶ 86. In retrospect, based on all the information that he had, Vitiello did not think Hale exhibited any pre-suicidal behavior. *Id.* ¶ 88. Hale's suicide was a shock, or a complete surprise. *Id.* ¶ 90. Hale's hanging was a shock to Morin, who never would have thought of it in a million years. *Id.* ¶ 94.

In Dr. Cohn's view, the fact that the corrections staff did not receive annual suicide training for 1998 until after December 5 did not in and of itself cause Hale's suicide. County Defendants' SMF ¶ 95; Cohn Dep. at 163. However, Dr. Cohn believes that it was a contributory factor in Hale's death and indicative of sloppy, inadequate management of the Jail. Plaintiffs' Opposing SMF/County ¶ 95; Cohn Dep. at 163-64. There is no way to tell whether, even if the corrections officers had looked in on Hale every fifteen minutes, such a level of observation would have prevented the suicide. County Defendants' SMF ¶ 100; Plaintiffs' Opposing SMF/County ¶ 100.

The psychiatrist, Dr. Katz, is at the top of the hierarchy when it comes to being able to refer inmates to suicide watch. *Id.* ¶ 101. One of psychiatrists' primary duties is to determine whether their patients are at risk to themselves or others. *Id.* ¶ 102. On December 2, 1998 Dr. Katz did not treat Hale as being suicidal, although there is no evidence from his note that he made an assessment as to whether Hale was suicidal. Plaintiffs' Opposing SMF/County ¶ 105; Affidavit of Carlyle B. Voss

(Docket No. 39) ¶ 11; Dixon Dep. at 107; Peterson Dep. at 95. After Hale was seen by Dr. Katz on December 2, the corrections officers were not given any information from Dr. Katz that would indicate to them that they should take extra precautions with Hale. County Defendants’ SMF ¶ 108; Plaintiffs’ Opposing SMF/County ¶ 108. Dr. Katz did not instruct anyone to change the way Hale was being cared for at the Jail. *Id.* ¶ 109.

III. Analysis

The plaintiffs allege (i) in Count I of their complaint, that all of the defendants manifested deliberate indifference toward Hale, violating his federal constitutional rights (Fourteenth Amendment due process and Eighth Amendment right to freedom from cruel and unusual punishment) and Maine constitutional right to freedom from cruel and unusual punishment (Article I, section 9 of the Maine Constitution), Complaint ¶¶ 8-17; (ii) in Count II, that all of the defendants are liable pursuant to 42 U.S.C. § 1983 for their reckless and deliberate indifference to Hale’s constitutional rights, *id.* ¶¶ 18-24; and (iii) in Count III, that the Guard and County Defendants were negligent, warranting award of damages pursuant to 14 M.R.S.A. § 8101 *et seq.*, 18-A M.R.S.A. § 2-803 and Maine common law, *id.* ¶¶ 25-28.⁴⁶ The plaintiffs in Count IV seek punitive damages as against all defendants, *id.* ¶¶ 29-30; however, they concede in their opposing memorandum that the County cannot be held liable for punitive damages, Plaintiffs’ Omnibus Objection to Defendants’ Motions for Summary Judgment (“Plaintiffs’ Opposition”) (Docket No. 53) at 21 n.4.

The parties treat Counts I and II together as asserting a cause of action pursuant to section 1983. *See, e.g.*, PHS Defendants’ Motion at 1-2; Guard Defendants’ Motion at 1-2; County

⁴⁶ Puzzlingly, the plaintiffs point out that the PHS Defendants do not claim that they are entitled to absolute immunity pursuant to the Maine Tort Claims Act. Plaintiffs’ Opposition at 28 n.6. Count III of the Complaint, which asserts the plaintiffs’ state-law claims, does not name the PHS Defendants, *see* Complaint ¶¶ 25-28, who understandably did not perceive themselves as the target of any state-law claim, *see generally* PHS Defendants’ Motion.

Defendants’ Motion at 7-8, 13-15; Plaintiffs’ Opposition at 11-15.⁴⁷ They do not suggest that analysis pursuant to the Maine constitutional claim differs in any respect from that applicable to its federal constitutional counterpart. *See, e.g., id.* Inasmuch as I find all defendants entitled to summary judgment on the section 1983 (and subsumed Maine constitutional) claim, I do not reach the remaining state-law claims, which I recommend be remanded to the Maine Superior Court. *See Camelio v. American Fed’n*, 137 F.3d 666, 672 (1st Cir. 1998) (“[T]he balance of competing factors ordinarily will weigh strongly in favor of declining jurisdiction over state law claims where the foundational federal claims have been dismissed at an early stage in the litigation.”).⁴⁸

A. PHS Defendants’ Motion

The PHS Defendants seek summary judgment on grounds that (i) the plaintiffs fall short of demonstrating that any of the PHS Defendants were deliberately indifferent to Hale’s known medical needs; (ii) PHS cannot be liable for the acts or omissions of Dr. Katz, an independent contractor (who in any event is guilty of no more than mere negligence); and (iii) PHS cannot be held vicariously liable for the actions of its employees. *See generally* PHS Defendants’ Motion.

⁴⁷ It is unclear, from the facts cognizable on summary judgment, whether Hale was serving a sentence (in which case his claim properly would be analyzed under the Eighth Amendment) or whether he was a pretrial detainee (in which case his claim would implicate Fourteenth Amendment due-process protections). *See, e.g., Gaudreault v. Municipality of Salem, Mass.*, 923 F.3d 203, 208 (1st Cir. 1990). However, inasmuch as none of the defendant groups disputes that Hale was in fact a pretrial detainee, *see, e.g.,* Guard Defendants’ Motion at 8; County Defendants’ Motion at 15; Reply of Defendants Prison Health Services Inc., Phebe Dixon, Sherry Littlefield, Susan Accardi, and Patricia Rinehart to Plaintiffs’ Opposition to Defendants’ Motion for Summary Judgment (Docket No. 65) at 1-2, I shall likewise so assume. In any event, the distinction is immaterial inasmuch as the First Circuit has applied the deliberate-indifference standard drawn from Eighth Amendment jurisprudence in denial-of-medical-care and inmate-suicide cases involving pretrial detainees. *See, e.g., id.; see also Mahan v. Plymouth County House of Corr.*, 64 F.3d 14, 17 (1st Cir. 1995) (“Eighth Amendment claims by pretrial detainees alleging denials of medical assistance essentially turn on whether the challenged official action constituted ‘deliberate indifference’ to a ‘serious medical need.’”); *Bowen v. City of Manchester*, 966 F.2d 13, 16 (1st Cir. 1992) (“[P]olice officers violate the fourteenth amendment due process rights of a detainee if they display a ‘deliberate indifference’ to the unusually strong risk that a detainee will commit suicide.”). To the extent that the plaintiffs invite the court to rule that a pretrial detainee asserting a claim such as this need not meet the exacting standard of deliberate indifference, *see* Plaintiffs’ Opposition at 14, that invitation is declined.

⁴⁸ The plaintiffs’ Maine constitutional claim, which is disposed of on the same basis as their federal constitutional claims, properly is reached on the merits. *See Van Harken v. City of Chicago*, 103 F.3d 1346, 1354 (1st Cir. 1997) (noting appropriateness of exercise of supplemental jurisdiction to adjudicate state-law claim that is coterminous on merits with federal claim).

The plaintiffs rejoin that, as to the individual PHS Defendants, “the record is replete with instances where these Defendants were aware of Mr. Hale’s needs and his requests for medical assistance, were aware of orders for prescriptions and disregarded these orders, were aware of his deteriorating condition and yet refused medication or did not alert a physician, and most egregiously, in the period from December 2 – 5, did not monitor him or ensure he received his medications even though they knew he had just lost a friend to suicide and was undergoing a complete shift in his medications.” Plaintiffs’ Opposition at 20. Further, “Defendants failed to provide even that level of diagnostic care that they themselves believed necessary,” with the care provided “so cursory as to amount to no treatment at all.” *Id.*

With respect to PHS, the plaintiffs dispute the propositions that it cannot be held liable for the acts or omissions of Dr. Katz or vicariously liable for the acts or omissions of its own employees; they further argue that in any event “PHS has its own record of establishing a policy of non-compliance with good record-keeping and attention to inmates [sic] medical needs” – “insidious” policies that fairly are attributable to the fact that PHS’s primary business is earning money. *Id.* at 26-27.

1. Individual PHS Defendants

Turning first to the individual PHS Defendants, I note as an initial matter that there is not a shred of evidence concerning the role of Littlefield and Rinehart (if any) in Hale’s suicide. They accordingly are entitled to summary judgment as to all applicable claims (Counts I, II and IV).

The liability of the remaining two individual PHS Defendants, Accardi and Dixon, hinges on whether either knew that Hale “face[d] a substantial risk of serious harm and disregard[ed] that risk by failing to take reasonable measures to abate it.” *Farmer v. Brennan*, 511 U.S. 825, 847 (1994). The focus is on the defendant’s subjective state of mind; “the official must both be aware of facts from

which the inference could be drawn that a substantial risk of serious harm exists, and he must also draw the inference.” *Id.* at 837.

In turn, “[w]hether a prison official had the requisite knowledge of a substantial risk is a question of fact subject to demonstration in the usual ways, including inference from circumstantial evidence, and a factfinder may conclude that a prison official knew of a substantial risk from the very fact that the risk was obvious.” *Id.* at 842 (citation omitted). “Because, however, prison officials who lacked knowledge of a risk cannot be said to have inflicted punishment, it remains open to the officials to prove that they were unaware even of an obvious risk to inmate health and safety.” *Id.* at 844. “[A]n official’s failure to alleviate a significant risk that he should have perceived but did not, while no cause for commendation, cannot under our cases be condemned as the infliction of punishment.” *Id.* at 838.

There is a further, important gloss in the medical-needs context: When an inmate has in fact received some medical attention, the treatment received must be “so clearly inadequate as to amount to a refusal to provide essential care” before it can be characterized as “deliberate indifference.” *Layne v. Vinzant*, 657 F.2d 468, 474 (1st Cir. 1981) (citation and internal quotation marks omitted). “Whether or not a jury would be warranted in finding [the] course of treatment substandard, even to the point of malpractice, is not the issue Thus, where a prisoner has received some medical attention and the dispute is over the adequacy of the treatment, federal courts are generally reluctant to second guess medical judgments and to constitutionalize claims which sound in state tort law.” *Id.* (citations and internal quotation marks omitted). *Accord Torraco v. Maloney*, 923 F.2d 231, 234 (1st Cir. 1991) (“[W]here there is no evidence of treatment so inadequate as to shock the conscience, let alone that any deficiency was intentional, or evidence of acts or omissions so dangerous (in respect to

health or safety) that a defendant's knowledge of a large risk can be inferred, summary judgment is appropriate.") (citations and internal quotation marks omitted).

The plaintiffs adduce evidence of one incident involving Accardi: her failure to provide Xanax upon Hale's request at noon on December 5, approximately five hours before his suicide attempt. Accardi told Hale that she thought the Xanax had been discontinued and that she would check his chart and get back to him. He never heard back from her or received any Xanax before he attempted to take his life. Accardi explains that she was confused by Hale's request for Xanax because it had just been discontinued and Klonopin started; that it was unusual that the two medications would be administered at the same time; that by the time she finished "med pass" it was close to the end of her shift; that at report she discussed Hale's request with the evening nurse, Plummer; that the two checked Hale's chart and determined that the doctor had prescribed Xanax "as needed"; and that Plummer assured Accardi she would take care of it during the evening shift.

While the plaintiffs suggest that a jury would be entitled to disbelieve the nurse's explanation for her actions, Plaintiffs' Opposition at 20, there is no basis on these facts for a reasonable trier of fact to do so. Dr. Katz had indeed discontinued Xanax on December 2, albeit with the notation, "[d]o not stop Xanax til Klonopin in." Upon completing "med pass" Accardi did follow up on Hale's request, checking the chart and receiving assurance from Plummer that the Xanax would be dispensed. Most importantly, there is no evidence that Accardi appreciated the magnitude of the risk to Hale – *i.e.*, that anyone ever communicated to her that he was suicidal; that the behavior she observed should have made that risk obvious; or that anyone apprised her, as she completed her "med pass" rounds that afternoon, that Hale required her immediate attention. Nor is there any other reason (*i.e.*, evidence of comments by Accardi or other interactions between herself and Hale or other inmates) to impute to Accardi the hostile attitude attributed by Ryder to unspecified nurses at the Jail. On this record,

Accardi's failure to administer Hale's Xanax has all of the earmarks of a tragic mistake, rather than of a deliberately indifferent refusal to render care. Accardi accordingly is entitled to summary judgment as to all applicable claims (Counts I, II and IV).

Nor could a reasonable trier of fact find that the conduct of Dixon, PHS's health services administrator, reflected deliberate indifference. While Dixon assessed Hale on November 11, 1998 as having a potential for self-injury, she did not equate this with being suicidal. Nor is there evidence that Hale or anyone else communicated to Dixon that he was suicidal. In fact, when Dixon checked in with Hale on December 4 following Mitchell's suicide, Hale indicated that he was dealing with it all right.

In any event, to the extent that Dixon perceived risk of harm to Hale, there is no evidence that she disregarded it by failing to take reasonable steps to prevent it. When Dixon first assessed Hale on November 11, she took the precaution of requesting that Dr. Katz review Hale's chart. Within a week Dr. Katz did so. When contacted on November 30 by Breton with further concerns about Hale's behavior, Dixon arranged for Hale to be seen by Dr. Katz. On December 4, upon receiving word from the maximum-security unit that Hale was experiencing increased anxiety, Dixon requested that he be brought to the medical department, where she allowed him to stay in a holding cell for a period of time. She called Dr. Katz to request that Hale be provided with additional anti-anxiety medication, which Dr. Katz prescribed, and she administered it to Hale. Dixon's conduct could not reasonably be viewed, in the words of *Layne*, as "so clearly inadequate as to amount to a refusal to provide essential care."

Dixon accordingly is entitled to summary judgment as to all applicable claims (Counts I, II and IV).

2. PHS

PHS suggests that it, as a corporate entity, is entitled to summary judgment on the bases that it cannot be liable for the acts of Dr. Katz, an independent contractor (whose conduct it contends was in any event at most negligent), and it is not vicariously liable for the acts of its employees. PHS Defendants' Motion at 9-11. Both assertions have merit.

The question whether, in a section 1983 action, an entity such as PHS can be held liable for the acts of an independent contractor is determined with reference to the law of the state wherein the court having jurisdiction over the matter sits. *See, e.g., Carroll v. Federal Express Corp.*, 113 F.3d 163, 165 n.1 (9th Cir. 1997). The Law Court has held that “[g]enerally, an employer may be vicariously liable for the negligence of its employees, but not for the negligence of independent contractors.” *Legassie v. Bangor Publ’g Co.*, 741 A.2d 442, 444 (Me. 1999). While it is clear from the cognizable record that Dr. Katz was a “contractor,” it is not clear that he necessarily was an “independent contractor” versus an employee. Nonetheless, even if PHS could be held liable for the acts of Dr. Katz, the facts cognizable on summary judgment do not show, nor do the plaintiffs’ experts (Dr. Peterson and Dr. Cohn) opine, that Dr. Katz knew Hale was suicidal or that his treatment was so clearly inadequate as to be tantamount to a refusal to provide care.

Turning next to the question whether PHS can be held vicariously liable for the acts of its own employees, the plaintiffs rely on a footnote in which the District Court for the District of New Jersey questioned the wisdom of permitting a private entity performing a municipal function to escape vicarious liability for employees’ acts or omissions in the context of a section 1983 claim. Plaintiffs’ Opposition at 26-27; *Taylor v. Plousis*, 101 F. Supp.2d 255, 263-64 n.4 (D.N.J. 2000). Nonetheless, despite its doubts, the *Plousis* court “accept[ed] the holdings” of what it characterized as “the majority of courts” to have considered the issue that “such a corporation may not be held vicariously liable

under § 1983.” *Id.* at 263. There is no reason to believe that the First Circuit, if confronted with this issue, would deviate from this path.

The plaintiffs finally suggest that, in any event, PHS can be held liable in this case on the basis of “its own record of establishing a policy of non-compliance with good record-keeping and attention to inmates [sic] medical needs[.]” Plaintiffs’ Opposition at 27. However, the plaintiffs neither adduce evidence of PHS’s actual policies nor demonstrate malfeasance pervasive enough to amount to a policy or custom. *See Elliott v. Cheshire County, N.H.*, 940 F.2d 7, 12 (1st Cir. 1991) (“The asserted policy must have been so well-settled and widespread that the policymaking officials of the [corporation] can be said to have either actual or constructive knowledge of it yet did nothing to end the practice.”) (citation and internal quotation marks omitted). That Hale and another inmate who committed suicide did not receive certain doses of prescribed medications, that there is evidence of bad record-keeping in certain instances, that complaints were made by an unspecified number of inmates in the fall and winter of 1998 that they were not receiving their medications, and that a consultant concluded PHS’s medical care was adequate but its record-keeping not as good as it should have been,⁴⁹ do not fairly evidence a custom so “widespread” or “well-settled” as to amount to a policy of inattention to inmates’ medical needs.

PHS accordingly is entitled to summary judgment as to all applicable claims (Counts I, II and IV).

B. Guard Defendants’ Motion

The Guard Defendants seek summary judgment as to the section 1983 portion of the plaintiffs’ claim primarily on the basis that their failure to remove Hale from cell A107 as ordered by Newton did not stem from “deliberate indifference” as defined in *Farmer*. Guard Defendants’ Motion at 8-17;

⁴⁹ An asserted custom or policy also must be shown to have “caused the alleged constitutional deprivation,” *Elliott*, 940 F.2d at 12. It (continued on next page)

see also Elliott, 940 F.2d at 10-11 (“The key to deliberate indifference in a prison suicide case is whether the defendants knew . . . of the detainee’s suicidal tendencies.”)⁵⁰ The Guard Defendants assert that it is undisputed that they did not know that Hale was suicidal. Guard Defendants’ Motion at 16.

The plaintiffs argue that (i) liability under section 1983 will lie against any person who personally participates in the deprivation of rights, which can be found in acquiescence in an illegal action or failure to intervene when an actor has a duty to do so; (ii) the lesser involvement of some of the Guard Defendants at most goes to the factual issue of their causal responsibility for the plaintiffs’ damages; (iii) suicide is not the only issue in this case, which also concerns Hale’s propensity for harming himself and being punished for it; and (iv) the Guard Defendants’ knowledge is not entirely dependent on their testimony inasmuch as circumstances were such that, objectively, they should have known of the danger of leaving Hale unattended on December 4 in a handicap cell on the day after his friend died, without assuring that he received his medication. Plaintiffs’ Opposition at 18-19.

These counterarguments miss the mark. *Farmer* makes clear that, no matter what the level of a particular defendant’s involvement and whether that defendant is alleged to have acted or failed to act, a plaintiff asserting a “deliberate indifference” claim must demonstrate the defendant’s subjective awareness that his or her actions or inactions entailed a substantial risk of serious harm to an inmate. *Farmer*, 511 U.S. at 837. The plaintiffs’ arguments notwithstanding, the risk at stake in this case clearly was the danger of attempted suicide (not a generalized risk of self-harm); in any event, *Farmer* requires that the risk ignored be one “of serious harm.” *Id.* Finally, whatever the merit of the plaintiffs’ argument that “objectively,” the Guard Defendants should have known of the danger of

is unclear how a custom of inadequate record-keeping would have contributed to Hale’s suicide.

⁵⁰ I redact the phrase, “or should have known,” from this quote inasmuch as it appears inconsistent with the teaching of the subsequent *Farmer* case that a prison official must have been shown subjectively to have appreciated a risk of serious harm to an inmate.

leaving Hale unattended, there is no evidence that they subjectively appreciated those dangers, that the facts cited by the plaintiffs made those dangers obvious or even that certain of the Guard Defendants were aware of some of those underlying facts, such as Hale's friendship with Mitchell (who committed suicide on December 3) or any failure to supply Hale with prescribed dosages of medications.⁵¹

The Guard Defendants accordingly are entitled to summary judgment as to Counts I, II and that portion of Count IV seeking punitive damages predicated on the plaintiffs' section 1983 claim.

C. County Defendants' Motion

Turning finally to the motion of the County Defendants, this group seeks summary judgment as to the plaintiffs' section 1983 claims on grounds that: (i) no policy or custom is identified on the basis of which the County itself, as a municipality, could be held liable for harm to Hale, County Defendants' Motion at 7-8; (ii) the plaintiffs fail to make out a case of supervisory liability against Ridlon, Newton, Pike or Breton inasmuch as, *inter alia*, there is neither subordinate liability nor a failure to train, *id.* at 13-14; (iii) all of the individual defendants (Ridlon, Newton, Pike, Breton, Brown, Morin, Fallon and Vitiello)⁵² are entitled to qualified immunity inasmuch as their conduct cannot reasonably be found to have amounted to "deliberate indifference" as defined in *Farmer, id.* at 14-24.

⁵¹ While the plaintiffs adduce evidence that McNamara knew cell A107 was handicapped-accessible and was aware of the risk of copy-cat suicides, there still is insufficient evidence that she knew of and ignored a substantial risk of harm that Hale would commit suicide. To the extent the plaintiffs press any argument that the Guard Defendants "punished" Hale or provided him with inadequate medical care, *see* Plaintiffs' Opposition at 19, there is no evidence that those defendants had anything to do with him apart from their failure to remove him from his cell the day before his attempted suicide.

⁵² Counsel for the County Defendants inadvertently omitted Vitiello's name from portions of the County Defendants' initial brief. *See* Letter dated July 6, 2001 from Mark E. Dunlap to William S. Brownell, Clerk (Docket No. 45). I treat the brief as encompassing Vitiello.

The plaintiffs respond that: (i) for purposes of qualified-immunity analysis, Hale’s rights to medical treatment, to be kept safe and to be free from punishment were clearly established in 1998, and there is ample evidence that the Jail officers acted objectively unreasonably in not seeking medical treatment for Hale sooner, punishing him instead of assisting him when his medications were being changed or withheld, and failing to keep him safe, Plaintiffs’ Opposition at 15-18; (ii) the County is liable for its own failure to train staff properly as well as for any constitutional deprivations caused by the policies or customs of PHS, *id.* at 21-22; and (iii) supervisors Newton, Ridlon, Pike and Brown were aware of a grave risk of harm (in that every person who committed suicide in 1998 had been the victim of violations of the medication-disbursement policy and had committed suicide in the same manner, by using the handicap bars in the cells), which they failed to take reasonable measures to prevent, and also failed to ensure adequate training (inasmuch as, at the time of Hale’s suicide, there had been no suicide prevention training in more than a year, and staff were unaware that such training needed to take place), *id.* at 22-24.

1. Individual County Defendants

As an initial matter, the County Defendants and the plaintiffs quarrel over whether a motion for summary judgment based on qualified immunity entails analysis of the underlying merits. Plaintiffs’ Opposition at 15; County Defendants’ Reply Brief (“County Defendants’ Reply”) (Docket No. 57) at 1-2. The County Defendants have the better of the argument; the Supreme Court has directed that “[a] court required to rule upon the qualified immunity issue must consider . . . this threshold question: Taken in the light most favorable to the party asserting the injury, do the facts alleged show the officer’s conduct violated a constitutional right? . . . If no constitutional right would have been violated were the allegations established, there is no necessity for further inquiries concerning qualified immunity.” *Saucier v. Katz*, 121 S. Ct. 2151, 2156 (2001).

As discussed above, to the extent the plaintiffs contend that the defendants exhibited deliberate indifference to a risk of attempted suicide, they must demonstrate that each defendant “knew . . . of the detainee’s suicidal tendencies.” *Elliott*, 940 F.2d at 10-11. To the extent they allege deliberate indifference to a serious medical need, each defendant must be shown to have “know[n] of and disregard[ed] an excessive risk to inmate health or safety,” *Farmer*, 511 U.S. at 837, with the further caveat that when an inmate has in fact received some medical attention, the treatment received must be “so clearly inadequate as to amount to a refusal to provide essential care,” *Layne*, 657 F.2d at 474 (citation and internal quotation marks omitted).

Finally, to the extent the plaintiffs assert that Hale was unconstitutionally punished, liability turns on “whether the disability [was] imposed for the purpose of punishment or whether it [was] but an incident of some other legitimate governmental purpose.” *O’Connor v. Huard*, 117 F.3d 12, 16 (1st Cir. 1997) (citation and internal quotation marks omitted). “Thus, if a particular condition or restriction of pretrial detention is reasonably related to a legitimate government objective, it does not, without more, amount to ‘punishment.’ Conversely, if a restriction or condition is not reasonably related to a legitimate goal – if it is arbitrary or purposeless – a court permissibly may infer that the purpose of the governmental action is punishment that may not constitutionally be inflicted upon detainees qua detainees.” *Id.* (citation and internal quotation marks omitted).

“The government has a valid interest in managing [a] detention facility and, toward that end, may employ administrative measures that may be discomforting or are of a nature that the detainee would not experience if he were released while awaiting trial.” *Id.* See also *Collazo-Leon v. United States Bureau of Prisons*, 51 F.3d 315, 318 (1st Cir. 1995) (“On the authority of *Bell [v. Wolfish]*, 441 U.S. 520 (1979)], it may be divined that even if a restriction or condition may be viewed as having a punitive effect on the pretrial detainee, it is nonetheless constitutional if it also furthers some

legitimate governmental objective such as addressing a specific institutional violation and is not excessive in light of the seriousness of the violation.”).

The plaintiffs adduce no evidence that any of the individual defendants knew that Hale had suicidal tendencies, something that even Dr. Katz and the PHS nursing staff did not detect.⁵³ Nor do the plaintiffs succeed in demonstrating deliberate indifference to serious medical needs. The Jail staff on several occasions requested that the medical staff attend to Hale or asked Hale directly whether he needed medical attention. While, in the opinion of Dr. Cohn, corrections officers who were aware of Hale’s escalating behaviors should have sought medical help sooner, this does not establish as a legal matter that these officers subjectively appreciated and disregarded a risk of serious harm to Hale.

Turning finally to the question of punishment, the record reveals that Hale was restrained in a pro-restraint chair and/or leather straps on four occasions from September 30 through November 27 following violent outbursts. The use of these restraints was rationally related to the legitimate Jail objectives of maintaining order in the facility and preventing Hale from hurting himself or others. Hale also was housed in disciplinary segregation, entailing lockdown in his cell twenty-three hours a day and loss of commissary privileges, almost continuously from September 30 through December 5. The plaintiffs assert that Hale was “punish[ed] . . . instead of assisting him when his medications were being changed or withheld,” Plaintiffs’ Opposition at 17, but do not argue that the discipline meted out was excessive in light of Hale’s underlying disciplinary infractions (as to which, in each instance, a hearing was afforded by the Jail’s disciplinary board). They thus do not establish unconstitutional “punishment.” *See, e.g., Collazo-Leon*, 51 F.3d at 316 & n.1, 317 (holding that imposition of sixty-day term of disciplinary segregation, entailing lockdown twenty-three hours a day, as result of

⁵³ Hale’s girlfriend’s father, Haase, testifies that he phoned an unspecified person at the Jail, reported Hale’s suicidal status and sought assurance that something would be done. However, there is neither direct evidence that any named individual defendant was aware of this report nor circumstantial evidence from which one reasonably could infer such awareness.

attempted bribe and attempted escape did not amount to impermissible punishment of pretrial detainee).

At bottom, the plaintiffs' theory is that Hale was punished when he should have been medicated. *See, e.g.*, Plaintiffs' Opposition at 10-11, 24. With proper medication, Hale would not have misbehaved; without misbehavior, he would not have been confined to disciplinary segregation; without disciplinary segregation, he would not have acted out further or, ultimately, attempted to take his life. While this theory, tragically, is plausible on these facts, the hurdle to making out a constitutional violation based on failure to medicate adequately or the unwarranted infliction of punishment is high. Here, where there were repeated (if bungled) attempts to address Hale's problems with medication, and where there is no evidence that disciplinary segregation was imposed for any reason other than underlying misconduct (even if that misconduct stemmed from improper medical management), the plaintiffs fall short of making out a case of failings of constitutional magnitude on the part of the corrections officers entrusted with Hale's care.

The plaintiffs' failure to demonstrate either liability on the part of any subordinate (whether Guard Defendant or individual County Defendant) or (as discussed below) the establishment of an unconstitutional policy or practice on the part of the Jail is dispositive of their supervisory-liability claims. *See, e.g., Aponte Matos v. Toledo Dávila*, 135 F.3d 182, 192 (1st Cir. 1998) ("There is supervisory liability only if (1) there is subordinate liability, and (2) the supervisor's action or inaction was 'affirmatively linked' to the constitutional violation caused by the subordinate.").⁵⁴

⁵⁴ The First Circuit recently has suggested that lack of subordinate liability, alone, is not necessarily dispositive of a supervisory-liability claim, which can be predicated on proof of the existence of inadequate policies or systems. *See Giroux v. Somerset County*, 178 F.3d 28, 34 n.10 (1st Cir. 1999).

The individual County Defendants accordingly are entitled to qualified immunity and to summary judgment as to the plaintiffs' section 1983 claims – Counts I, II and that portion of Count IV relating to the plaintiffs' federal claims.

2. County

I turn finally to the plaintiffs' claim against the County, predicated on (i) liability for PHS's allegedly unconstitutional policies and customs and (ii) failure to train. *See* Plaintiffs' Opposition at 21-22. Inasmuch as the plaintiffs fail to demonstrate the existence of any unconstitutional PHS policy or custom, PHS cannot serve as a springboard for County liability. In similar vein, the lack of evidence of underlying liability on the part of any of the individual defendants casts doubt on the viability of the failure-to-train claim. *See, e.g., Hayden v. Grayson*, 134 F.3d 449, 456 n.13 (1st Cir. 1998) (“If Grayson never violated plaintiffs' constitutional rights in the first instance, it is difficult to see how a failure to train him could have *caused* any ‘constitutional injury’ to plaintiffs.”) (emphasis in original).

In any event, to make out a claim against a municipality on a failure-to-train theory, a plaintiff must both “put forth evidence of a failure to train that amounts to deliberate indifference to the rights of persons with whom the police come into contact” and “show a direct causal link between the municipal action and the deprivation of federal rights.” *Fletcher v. Town of Clinton*, 196 F.3d 41, 55 (1st Cir. 1999) (citations and internal quotation marks omitted). The plaintiffs point to the Jail's failure to conduct annual suicide-prevention training in 1998 prior to Hale's suicide attempt on December 5, despite the suicides of two other Jail inmates by identical means earlier that year. However, even assuming *arguendo* that failure to conduct the annual training under those circumstances amounted to “deliberate indifference,” the plaintiffs do not forge a sufficient causal link to withstand summary judgment. They adduce no evidence as to the content of the missing training or

otherwise detail the connection between its absence and Hale's demise. To the extent that the training would have emphasized detection of suicidal tendencies, it is a stretch to speculate that in this case (in which neither Dr. Katz nor the PHS nurses noted such ideation on Hale's part), such training would have equipped layperson corrections officers to have perceived the risk to Hale. To the extent that the training would have heightened sensitivity to the risk of copycat suicides or of handicap bars in cells, the evidence shows that Jail supervisors already were aware of those risks and, for this reason, gave the order following Mitchell's suicide that all non-handicapped inmates be removed from handicapped-equipped cells. *See Grayson*, 134 F.3d at 457 n.14 (“*City of Canton [v. Harris]*, 489 U.S. 378 (1989)] requires not only deliberate indifference but that the alleged failure to train be shown to have been the ‘closely related’ cause of the constitutional injury. . . . Yet there has been no showing that whatever training was not provided to Grayson could have thwarted [his alleged] purposeful discrimination.”).

For these reasons, the plaintiffs fail to raise a triable issue of section 1983 liability on the part of the County. The County accordingly is entitled to summary judgment as to the plaintiffs' section 1983 claims (Counts I and II) as well as Count IV, the plaintiffs having conceded that a municipality cannot be held liable for punitive damages.

IV. Conclusion

For the foregoing reasons, I **GRANT** the Motion To Strike in part⁵⁵ and recommend that the court (i) **GRANT** the summary judgment motion of the PHS Defendants; (ii) **GRANT** the summary judgment motion of the County as to Counts I, II and IV; (iii) **GRANT** the summary judgment motions of the Guard Defendants and the remaining County Defendants (the individual defendants) as to Counts I, II and that portion of Count IV seeking punitive damages predicated on liability pursuant to 42

U.S.C. § 1983; and (iv) refrain from exercising its supplemental jurisdiction over the remaining state-law claims asserted against the Guard and County defendants, which I recommend be remanded to the Maine Superior Court (Cumberland County).

NOTICE

A party may file objections to those specified portions of a magistrate judge's report or proposed findings or recommended decisions entered pursuant to 28 U.S.C. § 636(b)(1)(B) for which de novo review by the district court is sought, together with a supporting memorandum, within ten (10) days after being served with a copy thereof. A responsive memorandum shall be filed within ten (10) days after the filing of the objection.

Failure to file a timely objection shall constitute a waiver of the right to de novo review by the district court and to appeal the district court's order.

Dated this 30th day of November, 2001.

David M. Cohen
United States Magistrate Judge

TRLIST STNDRD

U.S. District Court
District of Maine (Portland)

CIVIL DOCKET FOR CASE #: 00-CV-382

MULKERN, et al v. CUMBERLAND COUNTY, et al Filed: 11/30/00
Assigned to: JUDGE GENE CARTER Jury demand: Both
Demand: \$0,000 Nature of Suit: 440
Lead Docket: None Jurisdiction: Federal Question
Dkt# in other court: None

⁵⁵ If my recommended decision is adopted, that portion of the Motion To Strike that remains will become moot.

Cause: 28:1983 Civil Rights

LYNN MULKERN, As Personal TYLER N. KOLLE, ESQ.
Representative of the Estate 784-3586
of Robert Hale [COR LD NTC]
plaintiff BERMAN & SIMMONS, P.A.
P. O. BOX 961
LEWISTON, ME 04243-0961
784-3576

SHERYL ANN HALE, As Personal TYLER N. KOLLE, ESQ.
Representative of the Estate (See above)
of Robert Hale [COR LD NTC]
plaintiff

v.

PRISON HEALTH SERVICES, INC. JAMES E. FORTIN, ESQ.
defendant [COR LD NTC]
DOUGLAS, DENHAM, ROGERS & HOOD
103 EXCHANGE STREET
P.O. BOX 7108
PORTLAND, ME 04112-7108
207-774-1486

WESLEY RIDLON MARK E. DUNLAP
defendant 774-7000
[COR LD NTC]
NORMAN, HANSON & DETROY
415 CONGRESS STREET
P. O. BOX 4600 DTS
PORTLAND, ME 04112
774-7000

defendant

JOHN ZSIDISIN
defendant

PRISON HEALTH SERVICES, INC.
cross-claimant

WESLEY RIDLON MARK E. DUNLAP
cross-claimant 774-7000
[COR LD NTC]
NORMAN, HANSON & DETROY
415 CONGRESS STREET
P. O. BOX 4600 DTS
PORTLAND, ME 04112
774-7000

JEFFREY NEWTON MARK E. DUNLAP
cross-claimant (See above)
[COR LD NTC]

SEAN BROWN MARK E. DUNLAP
cross-claimant (See above)
[COR LD NTC]

CUMBERLAND, COUNTY OF MARK E. DUNLAP
cross-claimant (See above)
[COR LD NTC]

v.

PRISON HEALTH SERVICES, INC.

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NORMAN, HANSON & DETROY

415 CONGRESS STREET

P. O. BOX 4600 DTS

PORTLAND, ME 04112

774-7000

JEFFREY NEWTON MARK E. DUNLAP

cross-defendant (See above)

[COR LD NTC]

SEAN BROWN MARK E. DUNLAP

cross-defendant (See above)

[COR LD NTC]

CUMBERLAND, COUNTY OF MARK E. DUNLAP

cross-defendant (See above)

[COR LD NTC]

MICHAEL VITIELLO, In his MARK E. DUNLAP

individual and official 774-7000

capacity as correctional [COR LD NTC]

officer NORMAN, HANSON & DETROY

defendant 415 CONGRESS STREET

P. O. BOX 4600 DTS

PORTLAND, ME 04112

774-7000

FRANCINE BRETON, Individually MARK E. DUNLAP
and in her official capacity (See above)
as correctional officer [COR LD NTC]
defendant

WAYNE L PIKE, Individually and MARK E. DUNLAP
in his official capacity as (See above)
Captain, Cumberland County [COR LD NTC]
Jail
defendant

ANNE-MARIE MORIN, Individually MARK E. DUNLAP
and her official capacity as (See above)
correction officer [COR LD NTC]
defendant

JOSEPH FALLON, Individually MARK E. DUNLAP
and in his official capacity (See above)
as correctional officer [COR LD NTC]
defendant

WESLEY RIDLON MARK E. DUNLAP
cross-claimant 774-7000
 [COR LD NTC]
 NORMAN, HANSON & DETROY
 415 CONGRESS STREET
 P. O. BOX 4600 DTS
 PORTLAND, ME 04112
 774-7000

JEFFREY NEWTON MARK E. DUNLAP
cross-claimant (See above)
 [COR LD NTC]

SEAN BROWN MARK E. DUNLAP
cross-claimant (See above)
[COR LD NTC]

MIKE STEVENS MARK E. DUNLAP
cross-claimant (See above)
[COR LD NTC]

CUMBERLAND, COUNTY OF MARK E. DUNLAP
cross-claimant (See above)
[COR LD NTC]

MICHAEL VITIELLO MARK E. DUNLAP
cross-claimant (See above)
[COR LD NTC]

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cross-claimant (See above)
[COR LD NTC]

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cross-claimant (See above)
[COR LD NTC]

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cross-claimant (See above)
[COR LD NTC]

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cross-claimant (See above)
[COR LD NTC]

v.

PRISON HEALTH SERVICES, INC. JAMES E. FORTIN, ESQ.

cross-defendant [COR LD NTC]

DOUGLAS, DENHAM, ROGERS & HOOD
103 EXCHANGE STREET
P.O. BOX 7108
PORTLAND, ME 04112-7108
207-774-1486

SUSAN ACCARDI JAMES E. FORTIN, ESQ.

defendant [COR LD]

DOUGLAS, DENHAM, ROGERS & HOOD
103 EXCHANGE STREET
P.O. BOX 7108
PORTLAND, ME 04112-7108
207-774-1486

SHERRY LITTLEFIELD JAMES E. FORTIN, ESQ.

defendant (See above)

[COR LD]

PAT RINHARDT JAMES E. FORTIN, ESQ.

defendant (See above)

[COR LD]

PHEBE DIXON JAMES E. FORTIN, ESQ.

defendant (See above)

[COR LD]

