

UNITED STATES OF AMERICA  
DISTRICT OF MAINE

DONALD PELLETIER, as Personal )  
Representative of the Estate of )  
Ronald H. Pelletier, )  
 )  
Plaintiff )  
 )  
v. ) Civil No. 00-212-B-K  
 )  
MARTIN A. MAGNUSSON, et al., )  
 )  
Defendants )

***MEMORANDUM OF DECISION***<sup>1</sup>

I presided at a bench trial in this case on June 18 through 20, 2002. These are my findings of fact and conclusions of law.

**Findings of Fact**

1. Ronald Pelletier (“Ronald”) was the middle of three children born to Judy and Donald Pelletier of Auburn, Maine. Throughout most of Ronald’s childhood his parents believed he was functioning normally, but after he graduated from high school Ronald began to evidence symptoms of a major mental illness. He underwent various hospitalizations and received treatments. Ronald qualified to receive social security disability payments when he became a young adult and moved out of his parents’ home. He lived a chaotic lifestyle ultimately resulting in his arrest and conviction for arson of the dwelling where he was living. He was sentenced to a term of five years imprisonment.

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<sup>1</sup> Pursuant to Federal Rules of Civil Procedure 73(b), the parties have consented to allow the United States Magistrate Judge to conduct any and all proceedings in this matter.

2. Prior to Ronald's conviction he spent upward of three months in the Androscoggin County Jail awaiting trial. During that time period he was on an almost constant suicide watch and did not have access to his personal clothing including items such as a belt or shoelaces.
3. After his conviction Ronald was initially sent to the correctional facility in Windham, Maine, but the authorities there quickly determined that his mental illness made him unmanageable in that setting and he was immediately ordered transferred to the Mental Health Stabilization Unit (MHSU) at the Maine State Prison (MSP), then in Thomaston, Maine, on July 30, 1998.
4. The MHSU began operation in January 1998 as a specialized unit within MSP designed for those inmates with serious mental illnesses. The MHSU consisted of four separate corridors: the acute, the sub-acute, the stabilization and the respite corridor. The corridors differed in the amount of relative freedom accorded to the inmates. The acute unit consisted of cells where the inmates were "stripped out" with no items of clothing other than a "security" blanket (nonshredable). Inmates on the acute corridor were monitored very closely, sometimes on a one-on-one constant watch. The other corridors were less protective, the stabilization unit allowing the inmates to have their personal belongings and to wear their own personal clothing, including belts.
5. Even Pelletier's expert, Alvin Cohn, acknowledged that the concept of a MHSU within a prison was an enlightened and forward looking concept designed in theory to provide better treatment to prisoners who suffered from serious mental illness.
6. Ronald met all of the criteria for admission to the MHSU in that he had an established diagnosis of paranoid schizophrenia and had extreme difficulties suffering from paranoid

delusions and intense auditory hallucinations. Throughout his stay at MSP he was maintained on appropriate anti-psychotic medications.

**7.** During Ronald's incarceration defendant Paul Lipman was the acting director of the MHSU. Lipman's employment at the MSP began in 1997 and he became the acting director of the MHSU in early July 1998, when the founding director, Dr. Zubord, went on medical leave. Lipman worked with other individuals on the MHSU, including Cecelia Blake, a social worker employed by Prison Health Services, various medical and nursing staff, corrections officers, and Dr. Michael Tofani, the consulting psychiatrist at the prison. As director Lipman had supervisory responsibility over other clinical workers on the MHSU, training responsibilities vis-à-vis security staff, and responsibility for coordinating with the security officers who were supervised by Sergeant Roach, another full-time member of the MHSU staff.

**8.** Lipman was a "hands on" director in the sense that during the weekdays he was on the MHSU every day interacting with the inmates and making decisions about their placement and therapies. Lipman had almost daily contact with Ronald and, in association with Blake, was the person responsible for charting Ronald's progress and making decisions about his care. Lipman and Blake would decide on a weekly basis which inmates needed to meet with the consulting psychiatrist, although Tofani could request to see an inmate on his own initiative.

**9.** Tofani saw Ronald at the time of his initial admission when he was believed to be actively suicidal and was housed on the acute corridor. He then later saw him for four weekly visits, occurring on August 25, September 1, September 8, and September 15. By the time of the September 15 visit Ronald was "struggling miserably" and Tofani felt that

greater intervention, including possible hospitalization at a mental health institute or possibly a major change in medications, was going to be required. Tofani made some minor adjustments to Ronald's medication dosage at the visit on September 15, including ordering an injection of Haldol that was anticipated to last for a three week period.

Tofani would have needed to see Ronald again by October 6 to keep his medications "on board." However, neither Lipman nor Blake scheduled Ronald for any visit with Tofani after September 15 and Ronald committed suicide prior to the October 6 date.

**10.** Documentation and testimony present a mixed picture of Ronald's progress during the time period from September 15 until his suicide on October 3. He continued to suffer from auditory hallucinations and had a number of instances when he became agitated. However, he also interacted positively with Blake and Lipman during that period, taking a number of outside walks with them. He appeared in some respects to be adjusting to the other inmates, playing cards with them and even attending a group therapy session on September 28. Both Blake and Lipman believed that Ronald's attendance at the group session was an extremely positive step for him.

**11.** Ronald appeared to enjoy the personal attention he received from Blake who testified as a defense witness and appeared to be a well meaning and caring individual. Ronald's better days and more positive interactions occurred when Blake was on the MHSU. During the weekends when Ronald did not have that sort of personal contact, his condition would deteriorate. Lipman failed to be fully aware of the degree of Ronald's decompensation during the weekends.

**12.** Ronald killed himself on a Saturday night, October 3, 1998. That Friday, October 2, Blake did not work on the MHSU but Lipman did. When Lipman left work on that

Friday he had no concern that Ronald would hurt himself over the weekend. Lipman could have moved Ronald to a more secure corridor, but he believed that Ronald would perceive such a move as a form of punishment and Lipman's emphasis was to try to encourage Ronald to adjust to life on the stabilization unit.

**13.** As director of the MHSU Lipman could have put in place a policy that would have forbidden all inmates on the unit from keeping belts, shoelaces, or other readily identifiable instruments of self-destruction in their possession. That he did not do so was contrary to almost all established correctional unit policies according to Cohn. I find it surprising that any inmate on this unit, no matter which corridor, would be allowed to keep an item like a belt because of the ease with which it could be used to hang oneself. However, Lipman perceived, not unreasonably, that any inmate intent upon suicide by hanging while housed on the corridor that allowed him to have clothing and other items would be able to find some instrument such as a torn sheet or other article of clothing to accomplish that goal. Lipman sincerely believed that he had to balance the need to treat the inmates humanely and to assist them with adjusting to life in prison with the known risk of self harm that these inmates with serious mental illnesses all harbored. Lipman's failure to be aware of the heightened risk posed by access to a belt was, at worst, negligent.

**14.** Lipman's other alleged shortcomings as director of the MHSU involved the lack of ongoing training for correctional staff in suicide prevention and his failure to properly document the mental status of inmates. However, I do not find that Lipman deliberately withheld any treatment from Ronald. His failure to refer Ronald to Tofani for follow-up

after September 15 and prior to October 6 was based upon Lipman's perception that Ronald was "stable," meaning not better, but not necessarily any worse.

**15.** Some of the records that should have been in Lipman's custody, including most notably a treatment plan for Ronald, have gone missing. Other records that were retained have been criticized by Doctor Linda Peterson, a defense expert, and Lorraine Spiller, an employee of the Maine Department of Corrections, working in the division of inspections, quality assurance, and professional practices, as containing inadequate documentation. I do not find that Lipman or anyone connected with the clinical treatment on the MHSU deliberately destroyed those records and I draw no inference surrounding the missing records. To the extent experts have testified as to inadequacies or criticisms of the record keeping, I do not find that Lipman intentionally failed to adequately document his treatment.

**16.** On the afternoon of Ronald's suicide, a corrections officer named Edward Mazurek was on duty for the first shift, until approximately 2:30 p.m. Mazurek is no longer employed as a corrections officer. He was an extremely credible witness who testified that he remembered the day of Ronald's suicide because that evening he was at a local tavern and spoke with a local ambulance worker who told him that they had responded to the prison as a result of an inmate's suicide. Mazurek was genuinely shocked because he remembered seeing Ronald in the dayroom with other inmates playing cards and seeming in good spirits when he left work that day. His testimony corroborates the observations of Blake and Lipman made during the last week of Ronald's life.

**17.** Corrections Officers Jason Stewart and Alan Bartlett were on duty at the time of Ronald's suicide. Their shift began at approximately 2:30 p.m. that day.

**18.** The prisoners were locked into their cells at 2:45 p.m. in anticipation of being fed at 3:00 p.m. This process took place one hour earlier than usual because of a prison-wide Alcoholics Anonymous banquet meeting that disrupted the normal schedule. As a result of the accelerated dinner hour, the prisoners were going to be locked into their cells an hour earlier than the norm.

**19.** Ronald became extremely upset about this change in schedule and remonstrated with Stewart, exhibiting a great deal of anger about the situation. Stewart explained the reason for the early lock-down and felt that Ronald was satisfied with his explanation.

**20.** After the prisoners had been locked in their cells, Bartlett heard bars rattling and went to investigate. He determined that it was Ronald rattling the bars. When Bartlett questioned him about his conduct, Ronald told him he was doing it because of what the voices were saying. Ronald wouldn't tell Bartlett what the voices were saying, but did tell him not to worry about it because the voices would go away. Bartlett did not believe the exchange was significant enough to be recorded in the log book. He had no further contact with Pelletier and did not discuss him with Stewart.

**21.** Prior to discovering Ronald hanging, Stewart responded to bars rattling in the corridor on two separate occasions. On neither occasion did he actually see Ronald rattling the bars and Stewart did not hear any yelling. When Stewart walked by Ronald's cell, Ronald was sitting on his bed and did not appear agitated. Stewart thought that Ronald had calmed down after he explained the reason behind the early lock down.

**22.** Neither Bartlett nor Stewart believed that Ronald was actively suicidal on October 3, 1998, but they were aware that he suffered from a serious mental illness that could impact his thought process.

## Conclusions of Law

1. A deliberate indifference constitutional claim contains both objective and subjective elements. Walker v. Benjamin, \_\_\_ F.3d \_\_\_, 2002 WL 1313006, \*4 (7<sup>th</sup> Cir. June 18, 2002).
2. "In the medical care context, the objective element requires that the inmate's medical need be sufficiently serious." Gutierrez v. Peters, 111 F.3d 1364, 1369 (7<sup>th</sup> Cir. 1997). Accord Walker, 2002 WL 1313006, at \*4 (quoting Gutierrez, 111 F.3d at 1369).
3. The subjective element requires that the defendants acted with a sufficiently culpable state of mind. Walker, 2002 WL 1313006, at \*4.
4. A negligent or inadvertent failure to provide adequate medical treatment is insufficient to state a 42 U.S.C. § 1983 claim because such a failure is not an "an unnecessary and wanton infliction of pain" and is not "repugnant to the conscience of mankind." Estelle v. Gamble, 429 U.S. 97, 105-106 (1976) (quoting Louisiana ex rel. Francis v. Resweber, 329 U.S. 459 (1947)). "Medical malpractice does not become a constitutional violation merely because the victim is a prisoner." Id. at 106.
5. On the other hand, a plaintiff need not prove that a defendant acted or failed to act with a specific purpose of causing harm or with knowledge that harm will result; it is enough to show that defendants actually knew of a substantial risk of harm to the inmate and acted or failed to act in disregard of that risk. Farmer v. Brennan, 511 U.S. 825, 842 (1994). It is permissible to conclude that the defendant knew of a substantial risk because the risk was obvious. Hope v. Pelzer, \_\_\_ U.S. \_\_\_, 2002 WL 1378412, \*4 (June 27, 2002); Farmer, 511 U.S. at 842.

6. While Ronald had a serious medical condition that posed a risk of suicidal behavior, the substantial risk that he would commit suicide on or around October 3, 1998, after spending more than sixty days on the MHSU, was not obvious.
7. The decision by Lipman to allow Ronald and other inmates on the MHSU to have belts and shoelaces may have been ill-advised and even negligent, but it was not a decision motivated by deliberate indifference to Ronald's serious mental health needs; the motivation for allowing the prisoners to have these items was a desire to make the MHSU seem more like the outside world and a concurrent desire to treat the mentally ill prisoners humanely.
8. Neither Bartlett nor Stewart was deliberately indifferent to Ronald Pelletier's serious medical needs during the afternoon hours of October 3, 1998.
9. Therefore, none of the three defendants have violated Ronald Pelletier's constitutional rights.
10. Accordingly, the clerk shall enter judgment in the defendants' favor on the complaint.

***So Ordered.***

July 8, 2002.

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Margaret J. Kravchuk  
U.S. Magistrate Judge

CLOSED STNDRD

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

CIVIL DOCKET FOR CASE #: 00-CV-212

PELLETIER v. MAGNUSSON, MARTIN A, et al  
10/17/00

Filed:

Assigned to: MAG. JUDGE MARGARET J. KRAVCHUK

Demand: \$0,000

Nature of Suit: 440

Lead Docket: None

Jurisdiction: Federal

Question

Dkt # in Knox Superior Court : is N/A  
Cause: 42:1983 Civil Rights Act

DONALD PELLETIER, as Personal  
Representative of the Estate of  
Ronald H. Pelletier  
    plaintiff

TYLER N. KOLLE, ESQ.  
784-3586  
[COR LD NTC]  
BERMAN & SIMMONS, P.A., P. O. BOX 961  
LEWISTON, ME 04243-0961  
784-3576

v.

MAINE, STATE OF  
    defendant  
[term 01/31/01]

DIANE SLEEK  
[term 01/31/01]  
[COR]  
SUSAN A. SPARACO, ESQ.  
[term 01/31/01] [COR LD NTC]  
ASSISTANT ATTORNEY GENERAL  
STATE HOUSE STATION 6  
AUGUSTA, ME 04333-0006  
626-8800

MARTIN A MAGNUSSON,  
Individually and in his  
Official Capacity as  
Commissioner of the Maine  
Department of Corrections (2d  
amended complaint filed  
3/5/01. Dft listed only in  
official capacity in 2d  
amended cmp. See #33)  
    defendant [term 04/17/02]

DIANE SLEEK  
[term 04/17/02]  
(See above)  
[COR]  
SUSAN A. SPARACO, ESQ.  
[term 04/17/02]  
(See above)  
[COR LD NTC]

JEFFREY MERRILL, Individually  
and in his Official Capacity  
as Warden of the Maine State  
Prison (2d amended Complaint  
filed 3/5/01. In 2d Amend Cmp  
(#33) this dft listed only in  
official capacity)  
    defendant  
[term 04/17/02]

DIANE SLEEK  
[term 04/17/02]  
(See above)  
[COR]  
SUSAN A. SPARACO, ESQ.  
[term 04/17/02]  
(See above)  
[COR LD NTC]

STEFAN ZUBROD, Individually  
and in his Official Capacity  
as Chief Medical Officer at  
the Maine State Prison  
    defendant  
[term 04/17/02]

DIANE SLEEK  
[term 04/17/02]  
(See above)  
[COR]  
SUSAN A. SPARACO, ESQ.  
[term 04/17/02]  
(See above) [COR LD NTC]

PAUL WHITAKER, Individually  
and in his Official Capacity  
as Correctional Caseworker at  
the Maine State Prison  
    defendant  
[term 01/31/01]

DIANE SLEEK  
[term 01/31/01]  
(See above)  
[COR]  
SUSAN A. SPARACO, ESQ.  
[term 01/31/01]  
(See above) [COR LD NTC]

UNKNOWN DEFENDANTS  
defendant

=====

ALAN BARTLETT, Individually  
and in his official capacity  
as guard at the Maine State  
Prison  
defendant

DIANE SLEEK  
[COR]  
SUSAN A. SPARACO, ESQ.  
[COR LD NTC]  
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JASON STEWART, individually  
and in his official capacity  
as a guard at the Maine State  
Prison  
defendant

DIANE SLEEK  
(See above)  
[COR]  
SUSAN A. SPARACO, ESQ.  
(See above) [COR LD NTC]

=====

MICHAEL TOFANI, MD  
defendant  
[term 04/17/02]

CHRISTOPHER C. TAINTOR, ESQ.  
[term 04/17/02]  
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PAUL LIPMAN, LCSW  
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C BLAKE  
defendant  
[term 04/17/02]

CHRISTOPHER C. TAINTOR, ESQ.  
[term 04/17/02]  
(See above) [COR LD NTC]

MAJOR CURTIS  
defendant  
[term 11/27/01]

NELSON RILEY  
defendant  
[term 08/10/01]

SUSAN A. SPARACO, ESQ.  
[term 08/10/01]  
(See above) [COR LD NTC]

JOE BRENNAN  
defendant  
[term 08/10/01]

SUSAN A. SPARACO, ESQ.  
[term 08/10/01]  
(See above) [COR LD NTC]

BEVERLY, DR  
defendant  
[term 04/17/02]

CHRISTOPHER C. TAINTOR, ESQ.  
[term 04/17/02]  
(See above) [COR LD NTC]

ROACH, SGT  
defendant  
[term 04/17/02]

SUSAN A. SPARACO, ESQ.  
[term 04/17/02]  
(See above) [COR LD NTC]

ALLEN BRIGGS  
defendant  
[term 04/17/02]

MAUREEN JORDAN  
defendant  
[term 08/10/01]

SUSAN A. SPARACO, ESQ.  
[term 08/10/01]  
(See above) [COR LD NTC]

SHEILA LORENZ  
defendant  
[term 11/27/01]

SUSAN SMALL  
defendant  
[term 11/27/01]