In the

United States Court of Appeals

For the Seventh Circuit

No. 20-1483

BRENDA QUINN, as administrator for the Estate of Travis Fredrickson,

Plaintiff-Appellant,

v.

WEXFORD HEALTH SOURCES, INC., *et al*.,

Defendants-Appellees.

Appeal from the United States District Court for the
Southern District of Illinois.
No. 3:17-cv-00669-NJR — **Nancy J. Rosenstengel**, *Chief Judge*.

ARGUED JANUARY 20, 2021 — DECIDED AUGUST 9, 2021

Before EASTERBROOK, WOOD, and BRENNAN, *Circuit Judges*.

WOOD, *Circuit Judge*. Travis Fredrickson was a troubled person. Events not pertinent to this appeal landed him in Illinois's prison system, where he spent time at several institutions. Throughout that time, he received services to manage his serious mental-health problems, which included anxiety, depression, and the effects of long-term drug dependence. While in custody at the Pinckneyville Correctional Center

(operated by the Illinois Department of Corrections, or IDOC), he died by suicide.

Frederickson's mother and representative, Brenda Quinn, filed this lawsuit under 42 U.S.C. § 1983 for violations of her son's Eighth Amendment rights two years to the date after his death. She alleges that several IDOC employees, of whom two now remain, showed deliberate indifference to her son's risk of harm, and she accuses Wexford Health Sources, Inc., which contracts with Illinois to provide health services in its prisons, of failing to implement and follow procedures to ensure that incarcerated persons receive continuous mental-health services during transfers between IDOC facilities. The district court granted the defendants' motions for summary judgment. We agree with its assessment of the record, and so we affirm.

I

In the month that preceded Fredrickson's death, IDOC transferred him twice: first, from Shawnee Correctional Center to Jacksonville Correctional Center; and then from Jacksonville to Pinckneyville Correctional Center. Quinn's claims stem from what happened (or did not) at every step of the way, and the facts paint a sad picture.

Shawnee Correctional Center

Fredrickson did not express any mental-health concerns when he arrived at Shawnee in December 2012. Mental-health staff first learned of his mental-health risks when he attempted death by suicide in February 2013. Shawnee placed him on "crisis watch," meaning that he was put in a special cell and monitored at five, ten, 15, or 30-minute intervals, depending on his mental state. While he was at Shawnee,

Wexford psychiatrist Dr. Sayed Raza diagnosed him with major depressive disorder. Today, such a finding would automatically categorize Fredrickson as "seriously mentally ill," but at the time, prison health staff reserved the "serious" label for incarcerated persons experiencing moments of crisis, decreased functioning, and increased need. Dr. Raza started Fredrickson on a combination of anti-depressants and psychotropic medications. Another Wexford employee, licensed clinical social worker Amanda Smith, became Fredrickson's primary therapist. Over the course of Fredrickson's counseling sessions, Smith and her supervisor, IDOC social worker Katherine Hammersley, viewed Fredrickson as an active, even model, participant in therapy sessions. Nonetheless, these efforts were not enough to prevent Fredrickson's return to crisis watch at Shawnee in October 2014, after he expressed suicidal ideation, hopelessness, anxiety, panic, and (as a side-effect of drug abuse) an inability to cope. Dr. Raza, in consultation with Hammersley, decided that Fredrickson would be better served at a facility that could offer drug-treatment programming and additional therapeutic attention for mood stabilization.

At the same time the transfer was being discussed, Fredrickson continued to struggle. Staff placed him on crisis watch in February 2015, and again from May 27, 2015, to June 1, 2015 (from this point, all relevant events occur in 2015). There was good news, too. IDOC accepted Fredrickson's transfer request and agreed to send him to Jacksonville Correctional Center on June 3. Jacksonville was closer to Fredrickson's family, and it provided drug-treatment programs. Fredrickson himself, as well as Shawnee's staff, were hopeful that he would be allowed eventually to participate in those programs. Satisfied that Fredrickson was mentally stable and

concerned with fulfilling his wish for drug treatment, Shawnee's mental health staff cleared him for the transfer to Jacksonville. Normally, staff would have scheduled a follow-up appointment seven days after Fredrickson's removal from crisis watch, on June 8, but the timing of the transfer precluded that. Alternatively, Fredrickson should have had a follow-up appointment at Jacksonville, but that never happened either.

Jacksonville Correctional Center

Jacksonville received Fredrickson on June 3. With him came his IDOC master file, medical records, and mental-health records, including an "offender health status transfer summary" that contained notes about his current medications and his recent mental-health crisis. Concerned about Fredrickson's extensive mental-health needs and accompanying records, Hammersley directly called the Jacksonville mental-health team. She spoke briefly with two staff members, but they were busy with direct service. She followed the call with an email to two members of Jacksonville's mental-health team, including psychologist Dr. Francis Asama. In the email, Hammersley noted Fredrickson's history of addiction, anxiety, depression, and diagnoses of major depressive disorder and meth abuse disorder. She also discussed his status as someone who was seriously mentally ill, noting his recent stint under crisis watch; listed Fredrickson's medications; and invited the Jacksonville mental-health team to call her or Smith for any further information. No one responded to Hammersley's email or otherwise reached out to Shawnee.

Dr. Asama conducted a mental health screening and an evaluation of suicide potential that day. The doctor noted that Fredrickson reported that he was experiencing feelings of hopelessness or helplessness, depression, and anxiety. The

notes do not mention any time spent on crisis watch, or Fredrickson's past attempts at death by suicide or suicidal ideation. A different page of the same form, however, reflects Fredrickson's 2001 hospitalization for psychiatric treatment for "att[empted] suicide." Jacksonville staff provided no screening summary; instead, they simply referred Fredrickson for services as a "routine mental health referral" and a "psychiatric referral." The evaluation of suicide potential indicated that there were no contemporaneous reports that Fredrickson was, or might be, at risk of death by suicide, but it also failed to indicate previous attempts at death by suicide. In conflict with Jacksonville's own mental-health screening, it also reported no indications of anxiety or depression.

There was an additional element that affected Fredrickson's time at Jacksonville. Upon his arrival, he earned a disciplinary charge for carrying a "cuff key," a homemade device to remove handcuffs, in his boot. For this infraction, staff placed him in disciplinary segregation. On June 8, Fredrickson wrote to his mother, Brenda Quinn, explaining his predicament.

> Well fuck, bad luck strikes again. … A homemade sewing needle was hidden in the boots my cell[illegible] gave me when my shoes got stolen. … They are fucking shipping me somewhere; probably way worse that Shawnee. … I got 30 days … segregation. … [illegible] here because of my mental problems and need for drug treatment. I can't express in words how important this is other than life or death. Does God hate me? Why do I always seem to get the worst possible outcome? Is my time up? Are my chances in life all over. I'm beyond hopelessness now, I'm trying not to be but WTF. Call

> the Warden, email also EVERDAY!! Please. I did not do this, it was an accident and I fully cooperated and told them the truth. I was told I would be able to stay here if I told the truth and I did. I would have never jeopardized it or took a risk. … I did not know ….

A correctional counselor saw Fredrickson in segregation that day. She noted Fredrickson "said he was okay." Despite being assessed by a correctional counselor for visual signs of distress (something normally done for mental-health patients in segregation), Fredrickson never received counseling at Jacksonville. Also, as we noted earlier, he did not receive the post-crisis-watch follow-up appointment he should have had on June 8.

Licensed clinical social worker Debbie Webb observed Fredrickson on June 9. She reported that he was "reading on his bunk [and] stated he was 'ok'." But on June 10, Fredrickson was found guilty of a reduced disciplinary charge for the contraband in his boot, which turned out to be a broken, sharpened pair of toenail clippers. He sent another letter to his mother that day.

> Well I have wrote the warden and spoke to him in person. It does not look good. I really need your support in changing his mind. … If all fails, I know it's a lot to ask, but call the headquarters is springfield and see if they will send me to Big Muddy River prison in Ina. They are a disciplinary prison and the have drug treatment. I feel like I'm living in a living Hell. Most likely I'll be shipped back to Shawnee, but Picknyville will be the runner up, which is way worse than Shawnee. I'm so upset. I cant even get mad or cry. In Picknyville, you only get 2 showers a week, only out 1 hour a day. I

> should have just stayed a Shawnee! For once in my life Im not fucking up and karma from my past is killing me. Imma try to do my best. Suck it up, and hopefully come home someday. I think the anti-phsychotic medicine is helping. … What a turnaround. I didn't even make it one foot in the door, and Im going to Real Real Prison. I'm not mentally equipped nor physically equipped for a place like that. I really really need EVERY-ONE'S HELP, as many people you can think of to help me get them to change their mind or ship me somewhere w/ drug treatment.

In the margins of his letter, Fredrickson inserted the words "Transfer Coordinator," indicating exactly who he thought his mother should speak with at IDOC headquarters. He also included a note to "call Amanda Smith Mental Health of Shawnee and see if she can help!"

Webb saw Fredrickson again on June 12 and completed a mental-health evaluation. The eleven-page document was thorough; it recorded Fredrickson's history with addiction, drug treatment, depression, suicidal ideation, and past attempts at suicide, as well as his most recent period of crisis watch, his 2001 psychiatric hospitalization, his past and current medications, and information about his family. Fredrickson also reported feelings of depression and hopelessness. In the summary section of the evaluation, Webb included narrative observations.

> The offender is a recent transfer from Shawnee CC. He is currently in segregation for having a homemade needle in boot. "They say it is a handcuff key." He is on the list to be transferred. He repeats being depressed most of his life. He states he feels helpless and

> hopeless. He states he will have times of increased depression. During these times he will be depressed most of the day, have low energy and will sleep most of the time. He has difficulty thinking & concentrating. He has been diagnosed with Major Depressive Disorder and [illegible]. He has been in drug treatment several times. His incarcerations are related to drug use. He states he [illegible] never tried to hurt himself, but was [illegible] … suicidal ideations. He reports he was having withdrawal and did not have [illegible] detox. … He does not have [illegible] good coping skills for stress & gets overwhelmed easily.

Webb concluded that Fredrickson was suited for a general outpatient housing unit rather than crisis watch. On June 13, a Jacksonville nurse completed another offender health status transfer summary. She noted Fredrickson's medications, anxiety, history of substance abuse, and attempts at death by suicide albeit without providing any date for the latter occurrence, despite a prompt for that information. When asked about Fredrickson's "current treatments," the nurse responded "None." Two days later, on June 15, a correctional officer reported seeing Fredrickson during segregation rounds. Once again, "[Fredrickson] said he was ok." Webb observed Fredrickson on June 16. She recorded his dislike for being "locked up so much" and his desire "to have more movement," but she ultimately found no action required. That same day, Quinn fulfilled Fredrickson's request, penning letters to Jacksonville's then-warden Marvin Reed and Amanda Smith at Shawnee.

In her letter to "Mr. Reed", Quinn pleaded for her son. She explained that Fredrickson's shoes had been stolen at

Shawnee. He was unable to purchase more while "confined to the health care ward" before his transfer (presumably a reference to his period of crisis watch just before his transfer from Shawnee to Jacksonville), and so he borrowed shoes that his cellmate gave him. She added that Fredrickson "has been working for this transfer for over a year[,]" doing "everything his counselor and the doctors at Shawnee Correctional asked him to do" because he was in "dire need of counseling and a drug program." She asked the Warden to contact Amanda Smith and closed with a final appeal:

> Please believe his story. I am asking that you please give him a chance to stay at Jacksonville where he will get the medical and mental help he needs to have to eventually become a productive member of society, find a job, and raise a family once released.

On June 17, Quinn sent a fax to Amanda Smith; it contained Fredrickson's two letters, Quinn's letter to Smith, and Quinn's letter to Mr. Reed. Quinn's letter to Smith begged her to read Fredrickson's letters and contact Jacksonville. Upon receipt of the fax, Smith and Hammersley discussed Fredrickson's situation. They found it "very strange" that Fredrickson would do anything that might jeopardize his chances of staying at Jacksonville given how hard he had worked to get there and how hard they had worked to get him there. Hammersley felt "worried" and "concerned" for his wellbeing and viewed the letters as obvious signs of distress and anxiety. But when asked about her initial impressions of Fredrickson's letters after the initiation of this lawsuit, she recalled that she did not think Fredrickson was at risk of hurting himself.

Smith and Hammersley took the fax to Shawnee's Assistant Warden, Camille Etienne, to determine if there was

anything they could do on behalf of Fredrickson. Because Fredrickson was no longer at Shawnee, Etienne responded that there was nothing for them to do and suggested that Quinn contact Jacksonville directly. Neither Smith nor Hammersley responded to Quinn's fax. In any event, Jacksonville decided not to keep Frederickson; it transferred him to Pinckneyville Correctional Center the day that Shawnee received Quinn's fax, unbeknownst to Shawnee's staff or Quinn.

Pinckneyville Correctional Center

Fredrickson was transferred directly from segregation housing at Jacksonville to segregation housing at Pinckneyville. Nancy Knope, a Wexford licensed practical nurse, conducted an intake interview upon his arrival. She recorded that Frederickson's medications should be continued as ordered. The following day a different mental-health professional completed a new evaluation of suicide potential. She found that there were no present reports of a risk of suicide and documented Fredrickson's past attempts at death by suicide. For follow-up, she recommended adding Fredrickson to the mental-health caseload and noted that he is "on meds." During mental-health segregation rounds on June 21, another mental-health professional observed Fredrickson "sitting on bunk reading a book" and wrote that Fredrickson "report[ed] no issues or concerns." A correctional counselor checked on him again on June 23 and reported no issues. His medical records reflect, and Quinn acknowledges, that Fredrickson received his medications without any interruption across the three IDOC facilities.

On June 26, mental-health staff placed Fredrickson's cellmate, John Cain, on crisis watch in a "naked cell," leaving Fredrickson in his cell alone. Cain later revealed that he and

Fredrickson had devised a plan for each of them to get a single cell. The plan required Fredrickson to write a request slip on Cain's behalf. Cain did not know that Fredrickson fabricated the slip, writing that Cain was hearing voices. With well over fifty percent of Pinckneyville's population on the mental-health caseload and a completed death by suicide in the same housing unit one week earlier, staff removed Cain swiftly.

Correctional Officer Alexander Rodman was on duty that evening between 3:00 p.m. and 11:00 p.m. Rodman completed rounds of the segregation unit every thirty minutes and conducted a "final wing check" at 10:30 p.m. At the end of Rodman's shift, Correctional Officer Frederico Fernandez replaced him for the 11:00 p.m. to 7:00 a.m. shift. At approximately 12:04 a.m. on June 27, Fernandez found Fredrickson unresponsive as a result of an apparent suicide by hanging.

As part of its investigation into the circumstances surrounding Fredrickson's death, IDOC interviewed a number of men housed on Fredrickson's housing wing. Michael Williams had a cell near Fredrickson's and told investigators that he heard Fredrickson kicking the cell door and asking for help around midnight on June 27. Williams recalled hearing other men in the unit taunt Fredrickson to go ahead and take his own life. Williams also recalled seeing Fredrickson tie bedsheets together. Jody Lagresse heard Fredrickson kicking on the cell door calling out for "C.O." and confirmed that he also heard the taunts. Willie White, for his part, overheard someone having a conversation with staff about having suicidal ideation at the 10:00 p.m. wing check. Rodman, who had participated in annual mental-health training sessions as part of his employment, reported that he never heard Fredrickson

make any remarks indicating that he was in any sort of distress or needed help.

In her complaint, Quinn alleged that Wexford's policies resulted in its failures to provide continuity of care during transfers between IDOC facilities. Quinn also accused Wexford and the state of Illinois of having an unwritten agreement knowingly to provide substandard medical care to IDOC's population. Quinn further argued that individual IDOC and Wexford employees, including Dr. Raza, Nancy Knope, Kristin Hammersley, Correctional Officers Rodman and Fernandez, and two other Wexford employees who came into contact with Fredrickson, showed deliberate indifference to Fredrickson's medical needs. This, Quinn asserted, led to his mental anguish and loss of life.

The district court granted defendants' motions for summary judgment on all claims. On appeal, Quinn has narrowed her arguments significantly. She appeals only the district court's judgment rejecting her claims of deliberate indifference against individual defendants Hammersley and Rodman and against Wexford for failing to provide continuity of care during the transfers between IDOC facilities, all in violation of the Eighth Amendment.

II

We consider a district court's grant of summary judgment *de novo*, construing all facts and inferences in the light most favorable to Quinn as the nonmoving party. *Figgs v. Dawson*, 829 F.3d 895, 902 (7th Cir. 2016). Summary judgment is proper "if the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a

matter of law." *Jajeh v. County of Cook*, 678 F.3d 560, 566 (7th Cir. 2012); FED. R. CIV. P. 56(a).

A. Individual Defendants Hammersley and Rodman

We begin with Quinn's claims against the remaining two individual defendants—social worker Kristin Hammersley and Correctional Officer Alexander Rodman. To survive summary judgment, Quinn had to present evidence from which a reasonable jury could find that one or both of them exhibited deliberate indifference to Fredrickson's mental health risks. As the Supreme Court put it in *Farmer v. Brennan*, 511 U.S. 825 (1994):

> [A] prison official cannot be found liable under the Eighth Amendment for denying an inmate humane conditions of confinement unless the official knows of and disregards an excessive risk to inmate health or safety; 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 other words, there is both an objective and a subjective component to the claim, each of which must be satisfied. See *Collins v. Seeman*, 462 F.3d 757, 760 (7th Cir. 2006). The objective element is not disputed here: the imminent risk of death by suicide is not something that might be objectively reasonable, in contrast to the use of force to quell a riot, see *Whitley v. Albers*, 475 U.S. 312 (1986). The risk of suicide is a grave one, "not one that today's society chooses to tolerate." *Helling v. McKinney*, 509 U.S. 25, 36 (1993); see also *Minix v. Canarecci*, 597 F.3d 824, 831 (7th Cir. 2010).

We therefore focus on the subjective element. For that part of her case, Quinn must present evidence that would permit a trier of fact to find that the individual defendant in question "(1) subjectively knew the prisoner was at substantial risk of [death by] suicide and (2) intentionally disregarded the risk." *Collins*, 462 F.3d at 761. It is not enough to show that prison officials "*should have been* aware" of the risk. *Id*. (emphasis in the original). A defendant is not liable where she was "not alerted to the likelihood" of the risk of death by suicide. *Id.*

Viewing this record sympathetically to Quinn, it is possible to view certain decisions made by IDOC and Wexford employees as poor, even negligent. The focus of Shawnee's medical staff on Fredrickson's desire to have drug treatment may have led them prematurely to release him from crisis watch and transfer him to Jacksonville, and thereby to disregard his fragile mental state and the level of support that had helped him cope in past moments of crisis. Similarly, by failing to respond to Hammersley's email and phone call, Jacksonville staff may have allowed Fredrickson's unreliable statements about his own mental-health history to have an outsized influence upon his entry into Jacksonville. Documentation and record keeping also may have been sloppy. That in turn may explain why Fredrickson did not have a follow-up appointment at Jacksonville on June 8, seven days after he left crisis watch at Shawnee.

But the bar for the defendants is low. In order to defeat a summary-judgment motion in an Eighth Amendment case, Quinn must show that the defendants exhibited "more than mere or gross negligence, but less than purposeful infliction of harm." *Lisle v. Welborn*, 933 F.3d 705, 717 (7th Cir. 2019) (quotation omitted). Quinn has failed to meet that standard.

We first look at her claim against Hammersley. Quinn argues that Hammersley exhibited deliberate indifference toward Fredrickson's serious mental illness when she failed to contact appropriate medical staff or respond to Quinn after reading Fredrickson's June 8 and June 10 letters. Quinn reasons that the letters, along with Hammersley's professional training and her personal experience treating Fredrickson, establish the subjective-knowledge element of the claim.

We can assume that Hammersley realized that Fredrickson was not doing well when she read the two letters to his mother. Indeed, she said so. Hammersley also testified that Shawnee's staff had helped Fredrickson develop tools to express his emotions. Hammersley viewed Fredrickson's June 8 discussions of karma and whether God hates him less as indicators of a risk of self-harm and more as his way to articulate anger, sadness, and a desire for advocacy. Fredrickson's June 10 letter talked about the efficacy of his medications, his goal to do his best despite his feelings of hopelessness, and his expectation to come home one day. Hammersley observed that Fredrickson was looking to the future, a "good sign." Subjectively, therefore, she did not think that Fredrickson was at risk of death by suicide.

Quinn analogizes Hammersley's actions to those of the defendant in *Mathison v. Moats*, 812 F.3d 594 (7th Cir. 2016), but that situation was a far cry from Frederickson's. In *Mathison*, the defendant had a heart attack while incarcerated and alerted a guard immediately. The guard summoned his lieutenant, who called a nurse. The nurse told the lieutenant that Mathison's condition was not an emergency and instructed Mathison to go to the infirmary the following day. *Id.* at 596. We found that the nurse and lieutenant both displayed

deliberate indifference and reversed the district court's grant of summary judgment. *Id*. at 598–99.

Hammersley, in contrast, had no responsibility for Fredrickson's mental-health care after his departure from Shawnee nor did she have any up-to-date information about his status at Jacksonville. The fact that she voluntarily discussed possible next steps with her assistant warden does not change things. Furthermore, unlike the obvious crisis in *Mathison*, there was no objective sign in Fredrickson's letters or elsewhere indicating the need for immediate intervention.

Quinn fares no better with her claim against Rodman. She asserts that summary judgment was wrong because the parties dispute whether Fredrickson sought mental-health services from Rodman. Rodman was trained to know what to do when someone is experiencing a mental-health crisis. Although he was not regularly told whether an incarcerated person was receiving mental-health services, he testified that any time someone reported a mental-health crisis, he would document that fact by filling out a mental-health referral and an incident report.

The problem is that Rodman had not interacted with Fredrickson before the night of his death. He reported that their first interaction occurred during his 10:00 p.m. check of the segregation unit. At that time, Rodman said, Fredrickson was alive. The dispute is over whether Frederickson later asked Rodman to help him. Rodman testified that Frederickson never did so, through his final wing check at 10:30 p.m.

Quinn sees a dispute of material fact with respect to the alleged request. She points out that inmates Michael Williams, Jody Lagresse, and Willie White reported that

Fredrickson desperately called out for mental-health services just before his death. Viewing the evidence in the light most favorable to Fredrickson, the testimony shows that Fredrickson was banging on his cell door to the point of annoying other men in his housing unit. Rodman was on duty at the time. But that is as far as the record can take us. We have no evidence that Rodman heard or could have heard Fredrickson's pleas, the banging, or the responses from other men. Too many questions remain to establish a factual dispute. What time did Fredrickson request help? Was Rodman in the housing unit to hear the request? How large is the housing unit? What other housing units did Rodman monitor that night? Could Rodman hear the segregation wing when he was surveying a different housing unit?

At oral argument, we asked whether any evidence existed in the record to answer these questions. Plaintiff's counsel said no and tried to shift the consequences of that gap to the defendants. But this was not an issue on which the defendants bore the burden of proof, and thus they did not have an obligation to submit such evidence. We are a little surprised that this question even arose, as the respective burdens of the parties have been well established since the Supreme Court's decision in *Celotex Corp. v. Catrett*, 477 U.S. 317 (1986). "A party seeking summary judgment always bears the initial responsibility of informing the district court of the basis for its motion, and identifying those portions of [the record] … which it believes demonstrate the absence of a genuine issue of material fact." *Id*. at 323. Pertinent here, the Court found "no express or implied requirement in Rule 56 that the moving party support its motion with affidavits or other similar materials *negating* the opponent's claim." *Id*. (emphasis in the original). That settles this point.

B. Wexford

Quinn also seeks to hold Wexford responsible for Frederickson's death. See *Monell v. New York City Dep't of Soc. Servs.*, 436 U.S. 658 (1978) (municipality liability); *Glisson v. Indiana Dep't of Corrections*, 849 F.3d 372, 378–79 (7th Cir. 2017) (private corporate liability for those providing essential public services). In order to move ahead on this part of the case, Quinn must prove that Wexford's official policy, or an established custom, or a decision by a final decision maker, caused the alleged constitutional violation. Often the lack of liability on the part of the subordinate actors means that there is nothing unlawful for which the entity might be liable, but that is not always the case. "[I]f institutional policies are themselves deliberately indifferent to the quality of care provided, institutional liability is possible." *Glisson*, 849 F.3d at 379. Plaintiffs can make this showing in a number of ways, including by demonstrating that "pervasive systemic deficiencies … were the moving force behind" an injury. *Dixon v. County of Cook*, 819 F.3d 343, 349 (7th Cir. 2016). Quinn has not pointed to any such institutional policy.

In support of her argument, Quinn relies on deposition testimony from several Wexford employees: Dr. Roderick Matticks (Wexford's Lead Regional Medical Director for Illinois) and Amanda Smith (Wexford employee and Frederickson's primary therapist at Shawnee); Hammersley (Smith's supervisor at Shawnee and an IDOC employee); and plaintiff's expert Dr. Kathryn Burns. According to Dr. Matticks, while Wexford expects transferring and receiving IDOC facilities to communicate with each other for purposes of continuity of care, he could not recall a specific written policy to that effect. Quinn argues that a jury could find that there was no

such policy, and that its absence accounts for the missing, misleading, and inconsistent information in Fredrickson's mental health records. Those gaps in turn resulted in the failure of the Jacksonville staff to conduct the follow-up appointment Frederickson should have had seven days after leaving crisis watch at Shawnee. Quinn also ties the lack of any written policy to Hammersley and Smith's inability to chart or communicate their concerns for Fredrickson's well-being after he was unexpectedly placed in segregation upon his arrival to Jacksonville and after receiving Quinn's June 17 fax.

No doubt, the Wexford employees could have done more to ensure better continuity of care for Frederickson, as he transferred across three facilities. But Quinn has not pointed to evidence sufficient to allow a trier of fact to find "systemic and gross deficiencies" in Wexford's procedures or lack thereof. *Dixon*, 819 F.3d at 348. This is a difficult task when allegations stem from the experiences of one person. See *Grievson v. Anderson*, 538 F.3d 763, 774 (7th Cir. 2008). Quinn's argument ignores the fact that *IDOC* had protocols for intrasystem transfers (a fact of which Fredrickson was aware, as reflected in his June 10 letter). She also fails to point to more than individual statements made by subordinate employees from both Wexford and IDOC based on their review of Fredrickson's mental-health records. Wexford is responsible for the mental-health needs of IDOC's incarcerated population, but IDOC is responsible for transfers. Dr. Matticks testified that Wexford "defaults to IDOC policies and procedures when it comes to … intrasystem transfers."

IDOC policy mandates that transferring and receiving facilities write down offender health-status transfer summaries, evaluations of suicide potential, mental-health screenings,

mental-health evaluations, and nurse-intake interviews. They also require transferring facilities to send sealed medical records to the receiving facility. Shawnee, Jacksonville, and Pinckneyville were responsible for different parts of that form, and they did their job. Fredrickson received an evaluation of suicide potential and a mental-health screening on June 3, upon his arrival to Jacksonville, and on June 18 Pinckneyville staff conducted another evaluation of suicide potential.

Hammersley noted that IDOC requires the completion of a mental-health evaluation within 14 days of when a transferee is referred for mental-health services. Licensed social worker Debbie Webb completed the 11-page form on June 12, nine days after Fredrickson's arrival to Jacksonville. Nurse Nancy Knope completed the nurse-intake interview when Fredrickson arrived at Pinckneyville on June 17, and she referred him to mental-health services. IDOC also requires mental-health staff to conduct segregation rounds at least every seven days as a wellness check. Jacksonville staff did so, viewing Fredrickson during segregation rounds on June 9 and June 16. At Pinckneyville, staff saw him in segregation on June 21 and were due in the wing again on June 27. Even though those checks were not themselves mental-health treatment, they provided the necessary first step of identifying need. Though Dr. Matticks is unable to point to *Wexford's* written policies concerning IDOC intra-system transfers, the record establishes that IDOC has written policies that were followed, albeit imperfectly.

III

The fact that Quinn was not able to put together a case that, if believed by a trier of fact, would have shown an Eighth

Amendment violation against one or more of the defendants in no way minimizes her personal loss. But if there is a legal theory here, it must lie in another area of law. Mental health is notoriously difficult to assess and treat, and unfortunately the relevant staff did not appreciate how dire Frederickson's crisis was. Quinn has not pointed to sufficient evidence on which a reasonable jury could tie either individual defendants Hammersley or Rodman, or institutional defendant Wexford, to Fredrickson's death. In light of these conclusions, we have no need to reach the question whether the individual defendants had qualified immunity.

We AFFIRM the judgment of the district court.