

# **TECHNICAL ASSISTANCE REPORT ON SUICIDE PREVENTION PRACTICES WITHIN THE MASSACHUSETTS DEPARTMENT OF CORRECTION**

## **A. INTRODUCTION**

The following is a summary of the observations, findings, and recommendations of Lindsay M. Hayes, Project Director of the National Center on Institutions and Alternatives, following the provision of short-term technical assistance to the Massachusetts Department of Correction (DOC). During the past year, the DOC experienced a high number of inmate suicides within its correctional system. Because the incidence of suicide was greater than in previous years, the DOC quickly began to examine the deaths through a previously established mortality review process, as well as review of various policy and procedural directives relating to suicide prevention. In order to more independently assess current practices, as well as offer any appropriate recommendations for improving DOC suicide prevention policies and practices, Commissioner Kathleen M. Dennehy decided to seek the assistance of an outside consultant.

It should be noted that the DOC's recent review of various suicide prevention protocols, mortality reviews, and subsequent determination for the need of this writer's assessment was not prompted by litigation or critical investigation of any of the recent inmate suicides. Rather, these actions were taken through the pro-active initiative of Commissioner Dennehy who was committed to determining what steps, if any, were necessary to improve suicide prevention practices within the Massachusetts Department of Correction.

In conducting the assessment, this writer toured various DOC facilities; met with and/or interviewed several correctional, medical, and mental health officials and staff from both DOC

headquarters and individual prison facilities; reviewed numerous documents [including all DOC and UMASS Correctional Health (hereafter referred to as UMCH) policies and procedures related to suicide prevention, screening/assessment protocols, and suicide prevention lesson plans/training curricula]; and reviewed the investigative reports and/or mortality reviews of 10 inmate suicides during 2005-2006.<sup>1</sup> The toured facilities and tour dates are listed as follows:

- 1) Massachusetts Correctional Institution – Concord (September 27, 2006)
- 2) Bridgewater State Hospital – Bridgewater (September 28, 2006)
- 3) Massachusetts Alcohol & Substance Abuse Center – Bridgewater (September 28, 2006)
- 4) Souza-Baranowski Correctional Center – Shirley (October 11, 2006)
- 5) Massachusetts Correctional Institution – Cedar Junction (October 12, 2006)
- 6) Massachusetts Correctional Institution – Framingham (October 13, 2006)
- 7) Old Colony Correctional Center – Bridgewater (January 2, 2007)

As of December 2006, the Massachusetts Department of Correction held approximately 10,500 inmates in 18 correctional facilities. Since 2000, the DOC has experienced 18 inmate suicides in its facilities, with more than 60 percent occurred during 2005-2006. As shown by Table 1, the suicide rate within the Massachusetts Department of Correction during the past 10 years was 26.9 deaths per 100,000 inmates. According to the most recent national data, the suicide rate in federal, state, and private prisons throughout the country during 2002 was 14 deaths per 100,000 prison inmates.<sup>2</sup> As such, the suicide rate within the DOC was almost double the national average during this 10-year period, and several times greater than the national average in 2006.

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<sup>1</sup>The complete reports for some of the cases were not yet unavailable for review.

<sup>2</sup>Mumola, Christopher J. (2005), *Suicide and Homicide in State Prisons and Local Jails*, Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.

**TABLE 1**  
**INMATE SUICIDES AND AVERAGE DAILY POPULATION WITHIN THE**  
**MASSACHUSETTS DEPARTMENT OF CORRECTION<sup>3</sup>**  
**(1997 thru 2006)**

<u>Year</u>	<u>Suicides</u>	<u>Average Daily Population</u>	<u>Rate</u>
1997	8	10,849	73.7
1998	2	10,847	18.4
1999	0	10,856	0.0
2000	2	10,465	19.1
2001	2	10,302	19.4
2002	1	10,068	9.9
2003	0	9,973	0.0
2004	1	9,949	10.0
2005	4	10,155	39.3
2006	8 <sup>4</sup>	10,463	76.4
<b>1997-2006</b>	<b>28</b>	<b>103,927</b>	<b>26.9</b>

In addition, this writer reviewed the investigative reports and/or mortality reviews of 10 inmate suicides during 2005-2006.<sup>5</sup> The following findings were noted in the reviewed cases:

- The inmate suicides were distributed amongst several medium and maximum security facilities: MCI – Cedar Junction (2), Old Colony Correctional Center – (2), Souza-Baranowski Correctional Center (2), Bridgewater State Hospital (1), MCI – Concord (1), MCI – Framingham (1), and MCI – Shirley (1);
- All but one (9 of 10) of the suicides were by hanging (asphyxiation) -- with anchoring devices including a clothing hook, shower knob, cell door, sink, ventilation grate, window, and smoke detector;
- All but one (9 of 10) of the suicides occurred in special housing units -- with 5 in segregation, 3 in health services units, and 1 in the multipurpose unit of a residential treatment program;

<sup>3</sup>Data provided by the Massachusetts Department of Correction.

<sup>4</sup>Includes a suicide attempt at Bridgewater State Hospital that left the victim without any brain activity.

<sup>5</sup>Sufficient data on two cases were not available to be included in the analysis.

- Half (5 of 10) of the victims had recently been on suicide precautions (i.e. mental health watches), with discharge from that observation level ranging from a few hours to a few weeks prior to their deaths; and included one victim who was on mental health watch at the time of the incident, and another victim was on a medical watch (resulting from a hunger strike) at the time of the suicide;
- The majority (6 of 10) of the victims had documented mental health histories, and half (5 of 10) had documented histories of suicidal behavior; and
- There were a variety of precipitating factors that were theorized during the investigative/mortality review processes as possible contributors to the deaths, including concern/anxiety at being reclassified to a higher security institution, concern regarding medical condition, grieving loss of a child, loved one having extramarital relationship, and guilt regarding committing offense.

## B. FINDINGS AND RECOMMENDATIONS

Detailed below is this writer's assessment of suicide prevention practices within the Massachusetts Department of Correction. It is formatted according to this writer's eight (8) critical components of a suicide prevention policy: staff training, identification/screening, communication, housing, levels of supervision, intervention, reporting, and follow-up/mortality review. This protocol was developed in accordance with both Standard 4-4373 of the American Correctional Association's *Standards for Adult Correctional Institutions* (2003) and Standard P-G-05 of the National Commission on Correctional Health Care's *Standards for Health Services in Prisons* (2003).<sup>6</sup> Where indicated, recommendations are also provided.

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<sup>6</sup>American Correctional Association (2003), *Standards for Adult Correctional Institutions*, 4<sup>th</sup> Edition, Lanham, MD: Author; National Commission on Correctional Health Care (2003), *Standards for Health Services in Prisons*, Chicago, IL: Author.

1) **Staff Training**

***All correctional, medical, and mental health staff should receive eight (8) hours of initial suicide prevention training, followed by two (2) hours of annual training. At a minimum, training should include avoiding negative attitudes to suicide prevention, prison suicide research, why correctional environments are conducive to suicidal behavior, potential predisposing factors to suicide, high-risk suicide periods, warning signs and symptoms, identifying suicidal inmates despite the denial of risk, components of the agency's suicide prevention policy, and liability issues associated with inmate suicide.***

The key to any suicide prevention program is properly trained correctional staff, who form the backbone of any correctional system. Very few suicides are actually prevented by mental health, medical or other professional staff. Because suicides usually are attempted in inmate housing units, often during late evening hours and on weekends, they are generally outside the purview of program staff. Therefore, these incidents must be thwarted by correctional staff who have been trained in suicide prevention and are able to demonstrate an intuitive sense regarding the inmates under their care. Simply stated, correctional officers are often the only staff available 24 hours a day; thus they form the front line of defense in suicide prevention.

Both the American Correctional Association (ACA) and National Commission on Correctional Health Care (NCCHC) standards stress the importance of training as a critical component to any suicide prevention program. ACA Standard 4-4084 requires that all correctional staff receive both initial and annual training in the “signs of suicide risk” and “suicide precautions;” while Standard 4-4373 requires that staff be trained in the implementation of the suicide prevention program. As stressed in NCCHC Standard P-G-05 -- “All staff

members who work with inmates are trained to recognize verbal and behavioral cues that indicate potential suicide, and how to respond appropriately. Initial and at least biennial training are provided, although annual training is highly recommended.”

**FINDINGS:** The issue of suicide prevention is briefly addressed in both DOC and UMCH policies. For example, DOC Policy 650.07 (Suicide Prevention Plan) requires that “all staff members who work directly with inmates shall receive, on an annual basis, comprehensive training in suicide prevention,” whereas UMCH Policy 53.00 (Suicide Prevention) simply requires that “mental health staff will support and participate in the Department of Correction training program as developed and implemented through the DOC Regional Training Coordinator.”

Upon employment within the DOC, all correctional staff are required to complete a basic training program at the Correction Training Academy. Over the past several years, the **pre-service training** has varied from between two (2) and four (4) hours in length. For example, when this writer conducted an assessment of suicide prevention practices at the Bridgewater State Hospital (BSH) in June 2000, approximately 2.5 hours were devoted to suicide prevention at the Correction Training Academy.<sup>7</sup> Based upon this writer’s recommendation to expand the pre-service training from 2.5 to 8 hours instruction, the training program was scheduled to be expanded to 4 hours. However, review of the following training curricula suggests that the pre-service suicide prevention training program is currently at 2 hours duration.

In 1999, through a joint venture of DOC, UMCH, and Correctional Medical Services, a training curriculum entitled *Suicide Prevention: Risks, Roles and Responses for Massachusetts Correctional Staff* was developed. The 56-page trainer's manual, designed for 2 hours of instruction, was very comprehensive and included the following topics: "prevalence of suicide in correctional institutions, who commits suicide?, common methods of suicide, when and where are suicides committed?, roles and responsibilities, and case studies." The curriculum included both research and possible risk factors to suicide that were exclusive to prison facilities. However, as this writer noted in reviewing of the curriculum for the previous BSH assessment, there was a concern as to whether all of the above topics could be adequately addressed in a 2-hour format. Finally, this writer was recently presented with a lesson plan cover sheet and training curriculum that represented the DOC's current pre-service suicide prevention training program. Although the lesson plan cover sheet, entitled "Recruit Training Program – Suicide Prevention" listed the course at 4-hours duration, the companion training curriculum was the same 2-hour *Suicide Prevention: Risks, Roles and Responses for Massachusetts Correctional Staff* from 1999.

With regard to **in-service training** for suicide prevention, this writer reviewed two distinct lesson plans -- a 36-PowerPoint slide presentation entitled "In-Service Training Program – Suicide Prevention Review" listed as 1-hour duration that was developed in 1999 and revised in August 2001, and a computer lab-based program entitled "In-Service 2005 – Suicide Prevention for Massachusetts Correctional Staff" listed as 30 to 60 minutes duration that was developed in August 2004. Although brief in length, both curricula were quite good.

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<sup>7</sup>See Hayes, L. M. et al (2000), *An Evaluation of Bridgewater State Hospital's Suicide Prevention Policies and*



Finally, this writer conversed with training coordinators at each of the toured facilities regarding pre-service and in-service suicide prevention training. Although there was consistency reported in all correctional staff being required to complete the 2-hour pre-service course at the Correction Training Academy, there was little uniformity regarding annual in-service training. For example, at MCI-Framingham, the mental health director offered a 1-hour block on suicide prevention; at MASAC, a 30-minute workshop was *optional* for correctional staff; at MCI-Concord, the computer lab-based program was available; at Souza-Baranowski, the 2-hour pre-service course was repeated at the annual workshop; and at BSH, the in-service program had been reduced to 45 minutes. In addition, although most mental health clinicians appeared to receive some suicide prevention training on an annual basis, many nursing personnel did not receive any suicide prevention training on an annual basis.

**RECOMMENDATIONS:** Several recommendations are offered to strengthen both the content and consistency of suicide prevention training within the Massachusetts Department of Correction. *First*, although national correctional standards do not recommend a specific number of hours for suicide prevention training, it is strongly recommended that the DOC increase the **pre-service** suicide prevention training from 2 to 8 hours. At a minimum, the revised training program should include much of information currently offered in the *Suicide Prevention: Risks, Roles and Responses for Massachusetts Correctional Staff* training curriculum, with additional emphasis placed on avoiding negative attitudes to suicide prevention, updated statistics and case studies on inmate suicides within the Massachusetts DOC, identifying suicidal inmates despite

the denial of risk, dealing with manipulative inmates,<sup>8</sup> components of the DOC/UMCH suicide prevention policies, and liability issues associated with inmate suicide.

*Second*, it is strongly recommended that *all* correctional, medical, and mental health staff complete the 8-hour pre-service suicide prevention training program, either at the Correction Training Academy or respective agency.

*Third*, it is strongly recommended that DOC and UMCH officials ensure that all personnel (i.e., correctional, medical, and mental health) receive a consistent and uniform 2-hour block of suicide prevention training on a yearly basis. At a minimum, the annual 2-hour training program should include a review of predisposing factors to suicide, warning signs and symptoms, negative attitudes to suicide prevention, identifying suicidal inmates despite the denial of risk, and review of changes in the DOC/UMCH's suicide prevention policies. It is also recommended that the training program include general discussion on any inmate suicides and/or serious attempts occurring within the previous year. Material from 1) the current *Suicide Prevention: Risks, Roles and Responses for Massachusetts Correctional Staff* from 1999, 2) 36-PowerPoint slide presentation entitled "In-Service Training Program – Suicide Prevention Review," and 3) computer lab-based program entitled "In-Service 2005 – Suicide Prevention for Massachusetts Correctional Staff" could be utilized in developing this revised in-service program. Finally, it is strongly recommended that the in-service suicide prevention training program for correctional, medical and mental health staff be integrated, not separate and

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<sup>8</sup>This writer conversed with a number of correctional staff at varying facilities who offered the view that most inmates on suicide precautions (mental health watches) were manipulative, engaged and/or threatened suicide for secondary gain, and were at little risk for suicide.

overlapping, as currently administered. Interdisciplinary training would prove to be more efficient and insightful.

*Fourth*, it is strongly recommended the both DOC and UMCH suicide prevention policies be revised to include a richer description of the requirements for both pre-service and annual in-service suicide prevention. Much of the inconsistency found in both the length and content of in-service training at the toured facilities could be corrected with policy revisions that specified the required length and description of the training programs.

## 2) **Identification/Screening**

**Intake screening for suicide risk must take place immediately upon confinement and prior to housing assignment. This process may be contained within the medical screening form or as a separate form, and must include inquiry regarding: past suicidal ideation and/or attempts; current ideation, threat, plan; prior mental health treatment/hospitalization; recent significant loss (job, relationship, death of family member/close friend, etc.); history of suicidal behavior by family member/close friend; suicide risk during prior confinement; transporting officer(s) believes inmate is currently at risk. The intake screening process should include procedures for referral to mental health and/or medical personnel. Any inmate assigned to a special housing unit should receive a written assessment for suicide risk by mental health staff upon admission.**

Identification/screening is also critical to a correctional system's suicide prevention efforts. An inmate can attempt suicide at any point during incarceration -- beginning immediately following reception and continuing through a stressful aspect of confinement. Although there is disagreement within the psychiatric and medical communities as to which factors are most predictive of suicide in general, research in the area of jail and prison suicides has identified a number of characteristics that are strongly related to suicide, including: intoxication, emotional state, family history of suicide, recent significant loss, limited prior incarceration, lack of social support system, psychiatric history, and various "stressors of confinement."<sup>9</sup> Most importantly, prior research has consistently reported that at least two thirds of all suicide victims communicate their intent some time prior to death, and that any individual with a history of one or more suicide attempts is at a much greater risk for suicide than those

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<sup>9</sup>Bonner, R. (1992), "Isolation, Seclusion, and Psychological Vulnerability as Risk Factors for Suicide Behind Bars," in R. Maris et. al. (Editors) *Assessment and Prediction of Suicide*, New York, NY: Guilford Press, 398-419.

who have never made an attempt.<sup>10</sup> The key to identifying potentially suicidal behavior in inmates is through inquiry during both the intake screening/assessment phase, as well as other high-risk periods of incarceration. Finally, given the strong association between inmate suicide and special management (i.e., disciplinary and/or administrative segregation) housing unit placement, any inmate assigned to such a special housing unit should receive a written assessment for suicide risk by mental health staff upon admission.

Both the ACA and NCCHC standards address the issue of assessing inmates assigned to segregation. According to ACA Standard 4-4400: “When an offender is transferred to segregation, health care personnel will be informed immediately and will provide assessment and review as indicated by the protocol as established by the health authority.” NCCHC Standard P-E-09 states that “Upon notification that an inmate is placed in segregation, a qualified health care professional reviews the inmate’s health record to determine whether existing medical, dental, or mental health needs contraindicate the placement or require accommodation.”

**FINDINGS:** Overall, it would be this writer’s opinion that DOC and UMCH have very good intake screening and assessment procedures to identify potentially suicidal inmates, but that these procedures are in need of slight revision. Upon admission, booking/admissions staff access the statewide Criminal Justice Information System (CJIS) to perform a “Q-5 Inquiry” on each inmate admitted into the DOC. Positive results of inmates who have a history of suicide

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<sup>10</sup>Clark, D. and S.L. Horton-Deutsch (1992), “Assessment in Absentia: The Value of the Psychological Autopsy Method for Studying Antecedents of Suicide and Predicting Future Suicides,” in R. Maris et. al. (Editors) *Assessment and Prediction of Suicide*, New York, NY: Guilford Press, 144-182.

“attempts or threatens”<sup>11</sup> in a correctional facility, county jail, or police lockup within the Commonwealth of Massachusetts are recorded in the DOC’s computerized Inmate Management System (IMS) and referred to medical staff for further assessment. In addition, all inmates receive basic intake screening (via the “Medical History and Screening” form) by medical staff upon admission into one of the DOC’s reception centers (MCI-Concord or MCI-Framingham). The form contains the following pertinent questions regarding mental health and potential suicide risk:

- 1) Have you ever been treated for a psychiatric illness?
- 2) During the past two weeks have you had on-going problems with your sleep, appetite, energy level or mood?
- 3) Have you ever attempted suicide?
- 4) Do you have any thoughts or plans to hurt yourself or someone else?
- 5) Are you hearing voices?
- 6) Does the inmate appear tearful?
- 7) Is the inmate’s communication incoherent?
- 8) Is the inmate demonstrating bizarre/unusual behavior?

Within 14 days of admission, all inmates are subsequently administered a “Mental Health Evaluation” by mental health staff. The evaluation contains inquiry regarding suicide risk.

Further, all inmates placed in segregation are given an “Initial Segregation Assessment” by medical staff to determine whether existing medical and/or mental health problems contraindicate the housing placement. This form contains the same lines of inquiry regarding suicide risk that is found on the “Medical History and Screening” form. Inmates with a history of mental illness and/or are considered “open” mental health cases are assessed by mental health staff within 24 hours or the next business day. Inmates remaining in segregation beyond 30 days

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<sup>11</sup>See *Massachusetts General Laws*, Chapter 40, Section 36A.

are assessed by mental health staff via the “Mental Health Status Update” form which is completed during the initial 30 days and then every 90 days.

In addition, during this writer’s visits to the toured facilities, several other good practices were observed in the area of identification of potentially suicidal behavior. For example, at MCI-Cedar Junction, all newly transferred inmates into the facility serving natural life sentences were assessed by mental health staff upon arrival. At Old Colony Correctional Center, medical staff briefly assessed all inmates returning from court hearings.

Finally, however, this writer found several areas of concern regarding the screening and assessment process. *First*, the DOC reception centers (MCI-Concord or MCI-Framingham) receive few, if any, medical and mental health records from county jurisdictions regarding the inmate’s adjustment and possible suicide risk within the county jail. *Second*, although a “Q5 Inquiry” is performed upon admission, neither booking/admission staff or medical personnel access the IMS to determine if the inmate was at risk for suicide and on suicide precautions (mental health watch) during a prior DOC confinement. This information is available in both the “Medical/Mental Health Section” and “Mental Health Watch” screen of IMS but, according to both correctional and medical personnel who were interviewed, is not accessed on a routine basis. In addition, when an inmate is placed on a mental health watch for threatening or engaging to suicidal behavior, that information is not entered into the Q5 Inquiry section of CJIS. Therefore, upon intake into the DOC, neither booking/admission staff or medical personnel assessing the inmate are aware as to whether the inmate has a prior history of being on mental health watch within the DOC.

*Third*, although DOC and UMCH have adequate policies requiring an assessment of inmates designated to segregation to determine whether existing medical and/or mental health problems contraindicate the housing placement, in reality, few, if any, inmates are ever diverted from segregation based upon their serious mental illness because there are no alternative housing and/or program options available. In fact, the mortality reviews conducted in at least two recent cases (Inmate Case No. 1 and Inmate Case No. 2) indicated that, based upon serious mental illness, both victims should not have been designated to segregation. These cases exemplify the problem of inadequate alternative housing and programming within the DOC for seriously mentally ill inmates who have co-existing disciplinary sanctions. Mental health personnel also complain that they are not regularly invited participants in the institution's segregation review meetings.

**RECOMMENDATIONS:** A few recommendations are offered. *First*, consistent with current Old Colony Correctional Center practices, it is strongly recommended that DOC and UMCH explore the feasibility of formalizing into agency policy a requirement that medical staff briefly assess all inmates returning from court hearings. *Second*, in order to increase the availability of information regarding an inmate's suicide risk within the county correctional system, it is strongly recommended that the sending agency (e.g., county jail, etc.) and/or transporting personnel be required to complete and submit a brief discharge/transfer form to DOC booking/reception staff documenting any immediate concerns about the newly arrived inmate. The form should be reviewed by the intake nurse and subsequently placed in the inmate's health care file. UMCH currently utilizes an "IntraSystem Transfer Form" to



communicate the health care needs of inmates between DOC facilities. This is an excellent form and could be adapted for use by county jail personnel as a discharge and transfer form.

*Third*, it is strongly recommended that the Q5 Inquiry section of CJIS be updated each time an inmate is placed on mental health watch for suicide risk (regardless of whether or not actual injury occurs), and that booking/admission staff and medical personnel access both the “Medical/Mental Health Section” and “Mental Health Watch” screen of IMS to determine if the newly arrived inmate was on a mental health watch during a previous DOC confinement.

*Fourth*, in the recommendation sections of both the mortality reviews conducted for Inmate Case No. 1 and Inmate Case No. 2, the following was stated:

- The DOC will explore the feasibility of creating a work group to review the current policies and procedures as they pertain to the placement of those seriously ill inmates, who additionally pose significant security risks, in segregation units. The goal of the group would be to ensure that the DOC is meeting established national standards in the manner by which it provides the clinical programming and security measures necessary to service the needs of this specific population;” and
- The DOC in conjunction with UMCH should work to develop effective alternative placement options for those inmates suffering from severe and persistent mental illness, but whose behavioral difficulties and security needs require more strict containment than can be afforded in general population.”

To date, little progress appears to have been made in this area and few, if any, alternative housing/programming options are available for inmates housed in segregation with serious mental illness. Therefore, the previous DOC recommendation is repeated here again for emphasis -- it is strongly recommended that the DOC, in conjunction with UMCH, develop effective alternative placement options for those inmates suffering from severe and persistent

mental illness, but whose behavioral difficulties and security needs require more strict containment than can be afforded in general population. (In beginning to address this problem, mental health personnel must be regularly invited participants in the institution's segregation review meetings.) *This issue should be among the highest priorities facing the DOC in its efforts to improve suicide prevention practices within the agency.*

### 3) Communication

**Procedures that enhance communication at three levels: 1) between the sending institution/transporting officer(s) and correctional staff; 2) between and among staff (including medical and mental health personnel); and 3) between staff and the suicidal inmate.**

Certain signs exhibited by the inmate can often foretell a possible suicide and, if detected and communicated to others, can prevent such an incident. There are essentially three levels of communication in preventing inmate suicides: 1) between the sending institution/transporting officer and correctional staff; 2) between and among staff (including mental health and medical personnel); and 3) between staff and the suicidal inmate. Further, because inmates can become suicidal at any point in their incarceration, correctional staff must maintain awareness, share information and make appropriate referrals to mental health and medical staff.

**FINDINGS:** Effective communication between correctional, medical, and mental health staff is not an issue that can be easily written as a policy directive, and is often dealt with more effectively through recurring training sessions and shift briefings. DOC Policy 650.03 (Communication Regarding Mental Health Status/Needs of Inmates) requires that each superintendent meet with the mental health director of the facility on a daily basis. These meetings typically occur during the superintendent's daily meetings with other management staff. During the meeting, inmates who are on the facility's "Mental Health Risk List" are discussed. According to policy, "this list shall contain the names, identification numbers and housing assignments of those inmates who may be at risk to themselves or others because of mental illness but who do not require placement on a mental health watch."

In addition, correctional and medical/mental health personnel can communicate through various established forms, including, but not limited to, the “Intrasystem Transfer Form,” “Referral to Mental Health,” and the Health Status Report.” Finally, mental health staff meets together during daily triage meetings to discuss inmates currently on mental health watches in the facility.

However, despite these adequate *policies* and procedures, there are concerns regarding the *practices* of communicating the management need of potentially suicidal inmates. For example, in addition to the issue of communication between the sending institution (e.g., county jail, etc.) and the DOC as described in the previous section, two other recent suicides involve the issue of inadequate communication amongst both agencies and personnel. In the recent suicide of Inmate Case No. 3, medical and/or mental health personnel from Lemuel Shattuck Hospital’s Correctional Unit failed to inform medical and/or mental health personnel at the receiving DOC prison that the inmate had been treated for both depression and suicidal ideation during his hospital stay. For inexplicable reasons, this information was not contained on the inmate’s “Intrasystem Transfer Form.” One clinician opined that psychiatric information is rarely, if ever, included in the discharge summary.” How can this be? In addition, correctional staff failed to initiate a mental health referral after determining that the inmate had a positive “Q5 Inquiry.” In the case of Inmate Case No. 2, it appears that mental health personnel did not fully communicate the seriousness of the inmate’s mental illness amongst themselves (e.g., he was placed on the Mental Health Risk List at one prison yet left off the same list when transferred to another facility) and, in Inmate Case No. 4, failed to work collaboratively with medical staff in

determining whether the inmate's complaints were the result of a medical or mental problem, or a combination of both.

Finally, this writer has concerns regarding the effectiveness of the Mental Health Risk List. In theory, an institution having increased concern for "those inmates who may be at risk to themselves or others because of mental illness but who do not require placement on a mental health watch" is a good idea. In practice, however, how are these concerning inmates being managed differently by both DOC and UMCH personnel? According to DOC personnel, the risk list is "under-utilized" and "misunderstood," while UMCH personnel refer to the process as meaningless. Theoretically, any inmate who displays a dramatic change of behavior or whose mental health is deteriorating should be referred to mental health personnel. In practice, however, few, if any, line correctional staff know the names of inmates on the Mental Health Risk List and, therefore, are much more likely not to be observant of such behavior in specific inmates. In sum, both DOC and UMCH acknowledge that there is little that currently distinguishes the management of a mentally ill inmate on or off the Mental Health Risk List.

**RECOMMENDATIONS:** A few recommendations are offered. *First*, as previously stated, effective communication is difficult to promulgate in a policy and correcting inadequate communication amongst personnel and agencies is challenging. Both DOC and UMCH have effective policies, but inconsistent communication remains. The most effective way to correct such deficiencies is to regularly audit security files and health care charts before a sentinel event occurs. As such, it is strongly recommended that DOC and UMCH embark upon a quality assurance process to audit selective security files and health care charts on a regular basis and

take corrective action when appropriate. Initially, it is suggested that the files of inmates on the Mental Health Risk List be selected for audit.

*Second*, it is strongly recommended that the process for developing and maintaining inmates on the Mental Health Risk List be revised collaboratively by DOC and UMCH. In order for the List to be effective, selected inmates must receive increased attention from both mental health and correctional personnel. If the sole criteria remains that inmates are maintained on the list when they are determined to be “at risk to themselves or others because of mental illness,” then those inmates should be observed more frequently by correctional staff (e.g., at documented 30-minute intervals) and assessed more frequently by mental health staff (e.g., at least three times per week). In addition, inmates on the List should be stronger candidates to be excluded from designation to segregation. Simply stated, if there is increased concern regarding an inmate, then DOC and UMCH must demonstrate increased attention to that inmate.

#### 4) Housing

**Isolation should be avoided. Whenever possible, house in general population, mental health unit, or medical infirmary, located in close proximity to staff. Inmates should be housed in suicide-resistant, protrusion-free cells. Removal of an inmate's clothing (excluding belts and shoelaces), as well as use of physical restraints (e.g. restrain chairs/boards, straitjackets, leather straps, etc.) and cancellation of routine privileges (showers, visits, telephone calls, recreation, etc.), should be avoided whenever possible, and only utilized as a last resort for periods in which the inmate is physically engaging in self-destructive behavior.**

In determining the most appropriate location to house a suicidal inmate, there is often the tendency for correctional officials in general to physically isolate and restrain the individual. These responses may be more convenient for staff, but they are detrimental to the inmate. The use of isolation not only escalates the inmate's sense of alienation, but also further serves to remove the individual from proper staff supervision. National correctional standards stress that, to every extent possible, suicidal inmates should be housed in the general population, mental health unit, or medical infirmary, located in close proximity to staff.

Of course, housing a suicidal inmate in a general population unit when their security level prohibits such assignment raises a difficult issue. The result, of course, will be the assignment of the suicidal inmate to a housing unit commensurate with their security level. Within a correctional system, this assignment might be a "special housing" unit, e.g., restrictive housing, disciplinary confinement, administrative segregation, etc., However, to every extent possible, such inmates should be housed in suicide-resistant, protrusion-free cells. Further, cancellation of routine privileges (showers, visits, telephone calls, recreation, etc.), removal of clothing (excluding belts and shoelaces), as well as the use of physical restraints (e.g., restraint

chairs/boards, straitjackets, leather straps, etc.) should be avoided whenever possible, and only utilized as a last resort for periods in which the inmate is physically engaging in self-destructive behavior. Housing assignments should not be based on decisions that heighten depersonalizing aspects of incarceration, but on the ability to maximize staff interaction with inmates.

**FINDINGS:** According to the DOC's suicide prevention policy (650.07), the "plan shall designate specific cells in the Health Services Unit that have been made appropriately *suicide resistant*....The plan shall also provide that when an inmate is placed on watch, he/she *may* be issued safety smock to promote his/her personal safety while decreasing any potential humiliation and degradation." According to UMCH's suicide prevention policy (53.01), "The inmate will only be allowed personal property/clothing appropriate to level of suicidal potential. If the risk of suicide is clear and immediate, the inmate will be issued a paper gown or security gown and/or security blanket."

Currently, most suicidal inmates are housed in designated cells within the Health Services Units (HSUs) of the DOCs. Contrary to the above directives, however, these cells are not always suicide resistant. For example, at MCI – Concord, cells designated for suicide precautions within the HSU had bed rails and ventilation grates above the sinks containing large gauge openings that could act as an anchoring device in a hanging attempt. At BSH, suicidal inmates were housed in the Intensive Treatment Unit, B-1 Unit, and Infirmary. These units had bunk holes and ventilation grates containing large gauge openings that could act as an anchoring



device in a hanging attempt.<sup>12</sup> At Souza-Baranowski CC, cells designated for suicide precautions within the HSU had bunk holes and ventilation grates containing large gauge openings that could act as an anchoring device in a hanging attempt. On a restricted basis, mental health watches could also occur in designated cells within the Special Management Unit. These cells, however, contained bunk holes, clothing hooks (which could be jammed), and window bars.

At MCI – Cedar Junction, cells designated for suicide precautions within both the HSU and Departmental Disciplinary Unit contained ventilation grates with small openings that were suicide-resistant. It should be noted, however, that the HSU at MCI – Cedar Junction was loud and filthy, with a foul smell permeating the unit during the writer’s tour. The atmosphere was certainly not conducive to housing and managing suicidal and other vulnerably mentally ill inmates. A similar, but not as harsh, environment was found within the HSU at MCI – Framingham.

At MCI – Framingham, although cells designated for suicide precautions within the HSU contained ventilation grates with small openings that were suicide-resistant, the cells also contained dangerous window bars and bunk holes. This HSU was also the location of a recent inmate suicide by hanging. At Old Colony CC, cells designated for suicide precautions within the HSU had bunk holes and ventilation grates containing large gauge openings that could act as an anchoring device in a hanging attempt. This HSU was also the location of a recent inmate suicide by hanging from a ventilation grate above the sink.

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<sup>12</sup>These hazards were previously identified in this writer’s 2000 *Evaluation of Bridgewater State Hospital’s Suicide*

In addition, although both DOC and UMCH policies suggest that the issue of clothing removal will be determined commensurate with the individual level of risk, almost all suicidal inmates (regardless of risk level) are stripped of their clothing and issued safety garments.

Further, although there are no written directives contained in either DOC or UMCH policies that prohibit routine privileges (family visits, telephone calls, recreation, showers, etc.), virtually all inmates placed on suicide precautions (i.e., mental health watches) are prohibited from family visits, telephone calls, showers, or any other out-of-cell-time. In fact, few inmates on suicide precautions are even allowed out of their cells for daily mental health assessments -- instead, the clinician conducts a cell front interview through the food slot which lacks privacy and confidentiality. DOC Policy 650.07 places strict limitations on attorney visits for inmates on suicide precautions by stating that “due to the acute nature of an inmate’s mental status if placed on Mental Health Watch, visits of any kind, including attorney visits, are not permitted during the Watch period.”<sup>13</sup>

It would be this writer’s opinion that current management of suicidal inmates within the DOC is overly restrictive and seemingly punitive. Confining a suicidal inmate to their cell for 24 hours a day only enhances isolation and is anti-therapeutic. Under these conditions, it is also difficult, if not impossible, to accurately gauge the source of an inmate’s suicidal ideation. Take, for example, the almost daily scenario of a clinician interviewing an inmate on mental health

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*Prevention Policies and Practices.*

<sup>13</sup>On a restricted basis, the policy allows for an attorney visit within 72 hours of the request for the visit as long as the inmate is not on constant (“eyeball”) observation. DOC statistics, however, suggest that most mental health

watch in the HSU. The inmate has been in the cell for a few days, dressed in a safety garment. He has not been out of the cell, not allowed to shower, not allowed a telephone call, or visit from his family or attorney. The clinician asks “Are you suicidal?” Given the circumstances he finds himself in, the likelihood of an inmate answering affirmatively to that question, the result of which will be his continued placement under these conditions is highly questionable.

Therefore, it would be this writer’s opinion that the punitive environment of suicide precautions within the HSUs influences an inmate’s suicide risk assessment by mental health staff. In fact, several clinicians told this writer that, based upon the conditions of mental health watches, they attempt to reduce an inmate’s length of stay on suicide precautions -- the result of which might be an inmate’s premature discharge from mental health watch. It should be noted that two inmate suicides during 2005-2006 came within 8 hours and 48 hours following discharge from mental health watch. In a related matter, with one noted exception, the DOC lacks any type of transitioning or step-down housing to bridge the stark differences (e.g., environment and staffing) between the HSUs, segregation, and general population. The one exception is MCI – Framingham, where a few beds in the residential treatment unit are informally used on occasion to temporarily house inmates discharged from suicide precautions.

DOC officials stress that the conditions of mental health watches are not intentionally punitive, but driven by concern for the safety of the inmate and staff assigned to the HSU. The DOC’s commitment to safety is not being challenged here. Safety of the inmate is, of course, of utmost concern when developing a suicide prevention policy. But the number and types of

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watches average 3 days, thus it would appear that attorney visits under these circumstances would be infrequently

restrictions imposed in the name of safety must be reasonable and commensurate with the inmate's level of risk. Safety of staff is, of course, also of utmost concern when developing a suicide prevention policy. But safety of staff also extends to all inmates housed in the HSU and segregation units within the DOC. Yet inmates housed in the HSUs for medical issues are permitted to have out-of-cell time, showers, and other activities that are prohibited to inmates on suicide precautions. Ironically, inmates assigned to segregation also have more privileges and out-of-cell time than inmates on suicide precautions.

DOC officials also argue that the rationale for these restrictions is that suicidal inmates are unpredictable and bad news received from a family or attorney visit, or from a telephone call, might result in an increased risk for suicide. This rationale, however, ignores the obvious -- what better opportunity is there to observe an inmate's reaction to potentially negative news than when they are on suicide precautions, as well as the fact that interaction with the outside world can be therapeutic and reduce isolation -- a leading cause for suicidal behavior.

It is also argued that these measures are effective in managing those inmates suspected as being manipulative. However, as one observer has stated, "There are no reliable bases upon which we can differentiate 'manipulative' suicide attempts posing no threat to the inmate's life from those 'true, non-manipulative' attempts which may end in death. The term 'manipulative' is simply useless in understanding, and destructive in attempting to manage, the suicidal

behavior of inmates (or of anybody else).<sup>14</sup> Regardless, it is simply unfair and anti-therapeutic to impose such prohibitions on *all* inmates placed on suicide precautions.

In addition, HSU cells designated to house suicidal inmates are also often utilized to house inmates with medical problems, including those going through the detoxification process. It would also appear that the number of cells designated for mental health watches within the DOC has not kept pace with the increased number of mentally ill inmates entering the correctional system. For example, between 2000 and 2005, the number of “open” mental health cases increased from 1,724 to 2,619 -- yet the number of HSU beds designated for mental health watch has remained virtually unchanged. Several clinicians admitted they have received subtle pressure from DOC staff to downgrade and/or discharge inmates from mental health watches because those beds were needed for other inmates, and one clinician surprisingly confided that there were occasions in which inmates at low risk for suicide were not placed on suicide precautions because of the unavailability of cells.

Finally, while touring the facilities, this writer was informed that inmates who engage in self-injurious behavior have, on occasion, been charged with destruction of property and received disciplinary sanctions. It would be this writer’s opinion that any punitive sanction

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<sup>14</sup>Haycock J: Listening to ‘attention seekers.’ The clinical management of people threatening suicide. *Jail Suicide Update* 4 (4): 8-11, 1992. Other clinicians would disagree and argue that self-injurious behavior displayed by “truly suicidal” and “manipulative” inmates should result in different interventions. For suicidal inmates, intervention that promotes close supervision, social support, and access to or development of psychosocial resources is crucial. For manipulative inmates, intervention that combines close supervision with behavior management is crucial in preventing or modifying such behavior. Historically, the problem has been that manipulative behavior was ignored or resulted in punitive sanctions, including isolation. Often, manipulative inmates escalate their behavior and die, either by accident or miscalculation of staff’s responsiveness. Therefore, the problem is not in how we “label” the behavior, but how we react to it -- and the reaction should not include punitive and isolative measures.

imposed upon any inmate (regardless of their mental status) is contrary to national correctional standards and practices.<sup>15</sup>

*The issue of housing suicidal inmates within the DOC will be the most challenging suicide prevention issue facing the agency and UMCH. The Health Services Units within the DOC should be the safest environments to house suicidal inmates yet, as demonstrated by three inmate suicides in these units during 2006, they simply are not. As detailed below, several recommendations are offered to revise and strengthen the process by which suicidal inmates are safely housed within the DOC.*

**RECOMMENDATIONS:** *First*, consistent with existing policy, it is strongly recommended that the DOC ensure that all cells designated to house suicidal inmates are as reasonably “suicide-resistant” as possible. For example, wall and ceiling ventilation grates should contain holes that are ideally 1/8 inches wide, and no more than 3/16 inches wide or 16-mesh per square inch; clothing hooks should be removed; gaps between window bars and glass should be closed; and bed rails and bunk holes should be removed. This writer’s complete recommended guidelines for removing obvious cell protrusions can be found in Appendix A.

*Second*, it is strongly recommended that the DOC work collaboratively with UMCH to completely revamp the use of the Health Services Unit for suicide precautions. The revised policy should include, but not be limited to, the following procedures:

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<sup>15</sup>See most recently the August 2006 settlement agreement in *Vermont Protection and Advocacy v. Robert Hofmann and the Vermont Department of Corrections* (Civil Action No. 2:04-CV-245) which stipulated that the “DOC does not punish inmates for engaging in self-harming behaviors....Under no circumstances may an inmate be placed in disciplinary segregation based upon self-harming behavior....”

- The removal of an inmate's clothing and issuance of safety garment shall be commensurate with the level of suicide risk as determined by mental health staff;
- All inmates on suicide precautions shall be allowed all routine privileges (e.g., family visits, telephone calls, recreation, etc.) unless the inmate has lost those privileges as a result of a disciplinary sanction;
- All inmates on suicide precautions shall have unimpeded access to their attorneys at any time;
- All inmates on suicide precautions shall have shower access commensurate with their security level; and
- To every extent possible, mental health staff should avoid conducting daily assessments through the food slot of the inmate's cell door. In addition, prior to discharging an inmate from suicide precautions, the inmate must be provided with an out-of-cell mental health assessment.<sup>16</sup>

*Third*, it is strongly recommended that the clinical decision regarding placement of an inmate on any level of suicide precautions should not be dictated by the availability of bed space and staff; rather it should be based upon the specific needs of the identified suicidal inmate. As such, the DOC should ensure that it provides sufficient staff to the HSU and any other unit housing suicidal inmates to ensure proper observation at constant or 15-minute intervals, as well as to allow adequate out-of-cell time for the inmate. In addition, placement and length of stay on suicide precautions should be based solely upon the clinical judgment of mental health staff, and DOC officials and staff should refrain from interfering with, and/or unduly influencing, that judgment.

*Fourth*, given the increase in suicides in the HSUs, it is strongly recommended that correctional staff conduct documented observation at 15-minute intervals within these units.

*Fifth*, it is strongly recommended that no inmate (regardless of their mental status) should receive a punitive sanction (i.e., disciplinary report) based solely upon self-injurious behavior.

*Sixth*, given the increase in the number of “open” mental health cases within the DOC during the past several years, it is strongly recommended that additional suicide-resistant cells be identified for the housing of suicide inmates. *These cells need not be necessarily located in the HSUs.*

*Seventh*, it is strongly recommended that the DOC work collaboratively with UMCH to create a transitional housing unit and/or step-down process following an inmate’s discharge from mental health watch in the HSU. On a trial basis, it might be beneficial to identify beds in the DOC’s residential treatment units to begin this initiative.

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<sup>16</sup>For example, at MCI- Framingham, an interview cage has been built in a room within the HSU that allows clinicians to interview high-security inmates in an environment that maintains privacy and safety.



5) **Levels of Supervision**

Two levels of supervision are generally recommended for suicidal inmates -- *close observation* and *constant observation*. *Close Observation* is reserved for the inmate who is not actively suicidal, but expresses suicidal ideation and/or has a recent prior history of self-destructive behavior. In addition, an inmate who denies suicidal ideation or does not threaten suicide, but demonstrates other concerning behavior (through actions, current circumstances, or recent history) indicating the potential for self-injury, should be placed under close observation. This inmate should be observed by staff at staggered intervals not to exceed every 15 minutes. *Constant Observation* is reserved for the inmate who is actively suicidal, either by threatening or engaging in self-injury. This inmate should be observed by a staff member on a continuous, uninterrupted basis. Other supervision aids (e.g., closed circuit television, inmate companions/watchers, etc.) can be utilized as a supplement to, but never as a substitute for, these observation levels.

Experience has shown that prompt, effective emergency medical service can save lives. Research indicates that the overwhelming majority of suicide attempts in custody is by hanging. Medical experts warn that brain damage from asphyxiation can occur within four minutes, with death often resulting within five to six minutes. In inmate suicide attempts, the promptness of the response is often driven by the level of supervision afforded the inmate. Both the ACA and NCCHC standards address *levels of supervision*, although the degree of specificity varies. ACA Standard 4-4257 vaguely requires that “suicidal inmates are under continuing observation,” while NCCHC Standard P-G-05 requires physical observation ranging from “constant supervision” to “every 15 minutes or more frequently if necessary.”

**FINDINGS:** For the most part, the DOC’s suicide prevention policy (650.07) adequately addresses the issue of observation provided to suicidal inmates as follows: “Suicidal inmates will be monitored by means of a mental health watch. The frequency of the watch

intervals shall be established by the mental health clinician. There are three levels of watch that may be utilized: constant or eyeball, 15-minute checks, or 30-minute checks.”

Although UMCH’s suicide prevention policies (53.00 and 53.01) do not address the varying levels of observation afforded to suicidal inmates, by practice this writer determined that mental health staff and/or a correctional supervisor may authorize suicide precautions, but only a clinician may downgrade or remove an inmate from suicide precautions. In addition, all suicidal inmates are assessed by mental health staff on a daily basis. In at least one facility (Souza-Baranowski CC), an inmate would not be discharged from suicide precautions until their case was reviewed during the daily clinical team meeting. Following discharge from suicide precautions, inmates are reassessed by mental health staff within 24 to 72 hours. In addition, medical staff make daily rounds in segregation units, whereas mental health staff conduct cell-to-cell segregation rounds three times a week. These are all very good practices.

Despite these very good practices, there remain a few areas of concern. First, neither the DOC or UMCH policies adequately address the type of behavior and/or circumstances that necessitates a specific level of observation. A policy that clearly delineates levels of observation and the concerning behavior that necessitates a specific supervision level is important for assessing clinical judgment during quality assurance audits. For example, when reviewing health care files, this writer observed several instances in which progress notes were not sufficiently descriptive of either a suicide risk assessment or justification for a particular level of observation. The review of Inmate No. 5’s file found that he had been on mental health watch for two months, vacillating between 15 and 30-minute observation. Yet the daily progress notes

documented virtually unchanged behavior during this period, with no justification for a specific watch level or a treatment plan.

Further, observation at 30-minute intervals provides far too much opportunity for a suicidal inmate to engage in suicidal behavior. This level of observation is not recommended by any national standards and should never be associated with suicide precautions. In addition, it is only appropriate to utilize the HSU when the inmate is in *crisis* only (i.e., suicidal), and assigning a 30-minute level of observation to a crisis situation is inappropriate.

During tours of the facilities, this writer observed that several inmates on suicide precautions were permitted to place blankets over their heads. As vividly demonstrated in the suicide of Inmate No. 6, this is a very dangerous practice because it obscures an officer's full visibility of the inmate.

With regard to observation levels provided to inmates that were not on suicide precautions, this writer found that although DOC policy (423.10) requires that inmates housed in segregation are to be observed at 30-minute intervals, investigative reports in at least two recent cases (Inmate No. 1 and Inmate No. 2) suggests that victims were found hanging in excess of 30 minutes. Further, correctional staff working in several HSUs who were interviewed by this writer gave inconsistent responses regarding the frequency of rounds in those units -- ranging from 30 to 60 minute intervals. These rounds were also not documented on a regular basis. Similar concerns were found in the residential treatment units. Issues raised regarding the

frequency of rounds by correctional staff might very well be related to the adequacy of staffing in these housing units.<sup>17</sup>

Finally, while touring the facilities, this writer found that “security” or “administrative” watches were sometimes being utilized by several superintendents. Although there is no DOC policy that sanctions this practice, as the process was explained, these watches were often utilized when an inmate was suspected of being in possession of contraband (e.g., they have ingested drugs) and need to be observed accordingly. However, examples were also provided in which inmates engaged in abnormal and/or bizarre behavior (e.g., smearing feces, banging their heads against the wall, etc.) and both mental health clinicians and correctional officials viewed the issue as a “behavioral” versus “mental health” problem. Although the inmate would still be observed on constant, 15 or 30-minute basis, and seen daily by mental health personnel, their behavior was “labeled” something other than requiring a mental health watch. This writer would argue that making the “bad” versus “mad” distinction here is dangerous -- as is the fact that this practice that has not been delineated in policy. If an inmate’s behavior is concerning enough to require constant, 15 or 30-minute observation, then there must be agreement that the inmate is in danger to themselves and/or others. As such, they should be placed on a mental health watch. Despite its name, a mental health watch should not be limited to only those inmates with an Axis I diagnosis, but to any inmate that is displaying concerning behavior that requires more frequent observation and management. This writer also sensed that, due to limited bed space in the HSUs, superintendents were reluctant to house “behavioral” problem inmates in these units.

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<sup>17</sup>For example, at Old Colony CC, one rover officer was responsible for conducting rounds in segregation, special

**RECOMMENDATIONS:** This writer would offer several recommendations. *First*, it is strongly recommended that both the DOC and UMCH suicide prevention policies be revised to include a better description of the type of behavior and/or circumstances that necessitates a specific level of observation. A proposed revision is offered as follows:

*Close Observation* is reserved for the inmate who is not actively suicidal, but expresses suicidal ideation and/or has a recent prior history of self-destructive behavior and would be considered a low risk for suicide. In addition, an inmate who denies suicidal ideation or does not threaten suicide, but demonstrates other concerning behavior (through actions, current circumstances, or recent history) indicating the potential for self-injury, should be placed under close observation. This inmate should be observed by staff at staggered intervals not to exceed every 15 minutes, and should be documented as it occurs.

*Constant Observation* is reserved for the inmate who is actively suicidal, either by threatening or engaging in self-injury and would be considered a high risk for suicide. This inmate should be observed by a staff member on a continuous, uninterrupted basis. The observation should be documented at 15-minute intervals.

*Second*, it is strongly recommended that reference to 30-minute observation for suicidal inmates be deleted from DOC Policy 650.07. While this level of observation would be appropriate for an inmate discharged from suicide precautions and transferred to a transitional housing unit, it is not appropriate for an inmate in suicidal crisis in the HSU.

*Third*, the DOC should ensure that all facilities are utilizing the “Correction Officer Observation Check Sheet” (DOC 650, Attachment B-4) that does not contain pre-printed 15-minute time intervals. In addition, a “Mental Health Watch Form” (DOC 650, Attachment C), completed by the assigned mental health clinician, should be attached to the door of each cell

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housing unit/protective custody, and residential treatment/multipurpose unit during the overnight shift.

housing a suicidal inmate. The report provides a daily listing of the inmate's level of observation, and personal items and privileges that are allowed/prohibited. It is also strongly recommended that the DOC develop and enforce a policy that prohibits officers from allowing inmates on suicide precautions to cover their heads with blankets or other bedding.

*Fourth*, it is strongly recommended that correctional officers conduct documented 30-minute rounds of all special housing units, including residential treatment units. As previously recommended (on page 30), documented 15-minute rounds should be conducted in the Health Services Units. In addition, to ensure compliance with these directives, it is strongly recommended that DOC officials conduct more frequent audits (via review of closed circuit telephone monitors) of these units, as well as the segregation units.

*Fifth*, it is strongly recommended that UMCH revise its suicide prevention policy to ensure that an inmate is not discharged from suicide precautions until their case was reviewed during the daily clinical team meeting. In addition an inmate placed on constant observation should always be downgraded to close (i.e., 15-minute) observation for a reasonable period of time prior to being discharged from suicide precautions. Further, progress notes regarding inmates on suicide precautions should always reflect a thorough suicide risk assessment and justification for a particular level of observation. UMCH should embark upon a quality assurance process to audit selective health care charts on a regular basis and take corrective action when appropriate.

*Sixth*, in order to safeguard the continuity of care for suicidal inmates, all inmates discharged from suicide precautions should remain on mental health caseloads and receive regularly scheduled follow-up assessments by mental health staff until their release from DOC custody. As such, unless an inmate's individual treatment plan directs otherwise or they are on the Mental Health Risk List and receive recommended visits from mental health personnel three times per week (see page 21), it is recommended that the current reassessment schedule following discharge from suicide precautions be revised as follows: daily for 5 days, once a week for 2 weeks, and then once a month until release from the DOC custody.

*Seventh*, it is strongly recommended that administrative or security watches should not be utilized in cases in which staff is concerned enough about an inmate's behavior that increased observation is necessary. These inmates, regardless of their diagnoses, should be placed on mental health watch. And as previously stated, these mental health watches need not necessarily be conducted in the HSUs.

6) **Intervention**

**A facility's policy regarding intervention should be threefold: 1) all staff who come into contact with inmates should be trained in standard first aid and cardiopulmonary resuscitation (CPR); 2) any staff member who discovers an inmate attempting suicide should immediately respond, survey the scene to ensure the emergency is genuine, alert other staff to call for medical personnel, and begin standard first aid and/or CPR; and 3) staff should never presume that the inmate is dead, but rather initiate and continue appropriate life-saving measures until relieved by arriving medical personnel. In addition, all housing units should contain a first aid kit, pocket mask or mouth shield, Ambu bag, and rescue tool (to quickly cut through fibrous material). All staff should be trained in the use of the emergency equipment. Finally, in an effort to ensure an efficient emergency response to suicide attempts, "mock drills" should be incorporated into both initial and refresher training for all staff.**

Following a suicide attempt, the degree and promptness of intervention provided by staff often foretells whether the victim will survive. Although both ACA and NCCHC standards address the issue of intervention, neither are elaborative in offering specific protocols. For example, ACA Standard 4-4389 requires that -- "Correctional and health care personnel are trained to respond to health-related situations within a four-minute response time. The training program...includes the following: recognition of signs and symptoms, and knowledge of action required in potential emergency situations; administration of basic first aid and certification in cardiopulmonary resuscitation (CPR)..." NCCHC Standard P-G-05 states -- "Intervention: There are procedures addressing how to handle a suicide attempt in progress, including appropriate first-aid measures."



**FINDINGS:** The “intervention” section of the DOC’s suicide prevention policy (650.07) states that “The plan shall include information regarding how to handle a suicide in progress, including how to cut down a hanging victim and other first-aid and emergency response measures.” In addition, DOC Policy 622 includes “Code 99/Medical Emergency Responses Guidelines” that adequately address the proper emergency response to a suicide attempt. UMCH addresses the emergency response to a suicide attempt in Policy 53.01 by stating that “Any inmate who has attempted suicide will receive immediate medical attention. Once emergency medical treatment is completed, mental health staff will complete an evaluation.” Appendix B to UMCH Policy 53.00 contains a detailed description of the proper disposition following a hanging attempt.

This writer has several concerns in the area of emergency intervention following a suicide attempt within a DOC facility. *First*, despite the DOC’s “Code 99/Medical Emergency Responses Guidelines” and UMCH’s “Disposition Following a Hanging Attempt” instructions, there were several examples of incorrect responses by correctional and nursing personnel to recent inmate suicides. For example, in Case No. 1, initiation of CPR was delayed approximately two minutes when a nurse requested that the inmate be carried from his cell to a nurse’s protocol room. The victim was placed on a mattress outside the cell and then carried by the mattress and then a sheet to the protocol room. Although the nurse later told investigators that it took only 30 seconds to transport the victim to the protocol room and she believed it was quicker to bring the victim to the code cart than the cart to the victim, the reviewed videotape of the incident found that two minutes elapsed between the time the nurse entered the victim’s cell and time the victim entered the protocol room. The videotape also indicated that correctional

staff struggled in their attempt to transport the victim using the mattress and sheet. The Quality Assurance Mortality Suicide Review of this case incorrectly concluded that the response was “felt to be timely and appropriate.” It would be this writer’s opinion that the victim should not have been placed on a mattress (because CPR is best performed on a flat surface) and time should not have been wasted transporting the victim to the protocol room. Instead, the nurse should have responded to the Code 99 with the emergency response bag (which included a CPR mask) and initiated CPR upon entering the cell and after taking vital signs. The code cart and AED should have arrived at the cell by secondary responders following the initiation of CPR.

In another example, when Inmate No. 2 was found hanging in his cell, responding officers first carried the victim down the tier to the landing area of the second floor of the cellblock. He was then moved again to a more open area and placed on a mattress. CPR was then initiated by both correctional and medical staff approximately two minutes after correctional staff had entered his cell and removed the ligature. Again, carrying the victim away from the cell risked neck and spinal cord injury, wasted time, and CPR should not have been initiated on a mattress.

In other cases, staff delayed cell entry and the Code 99 announcement for almost 10 minutes, and the nurse had difficulty finding all the necessary emergency equipment of the code cart in the case of Inmate No. 6; whereas in the case of Inmate No. 7, staff struggled to find a functional CPR mask.

Although correctional staff involved in these incidents later received refresher training in the proper emergency response techniques and other corrective action attempted, the fact that these incidents took place in separate facilities during 2005-2006 suggests that the problem is systemic and not limited to a few misinformed officers or nurses.

Finally, with regard to the two recent suicides at the Old Colony CC, it appeared that arriving emergency medical services personnel from the Bridgewater Fire Department, assessed both patients, determined that further life-saving measures would be fruitless, declined or refused to transport each victim to the local hospital, and requested that UMCH nursing staff declare each victim dead. Such a request was totally inappropriate and contrary to state law. Only a physician can pronounce a victim dead. This issue seems to be limited to the Bridgewater Fire Department and was not found in the other reviewed cases.

**RECOMMENDATIONS:** This writer would offer several recommendations. *First*, both DOC and UMCH policies should be slightly revised to better ensure a proper response of both correctional and medical personnel to a suicide attempt. At a minimum, policies should reiterate that CPR should be initiated immediately (on a flat, hard surface) and the victim should not be carried away from the cellblock area during the emergency. This writer's complete recommended guidelines for intervention following a suicide attempt can be found in Appendix A. *Second*, it is strongly recommended that the DOC ensure that *all* housing units contain an emergency response bag that includes a first aid kit; pocket mask, face shield, or Ambu-bag; latex gloves; and emergency rescue tool. All staff who come into regular contact with inmates should know the location of this emergency response bag and be trained in its use. *Third*, it is

strongly recommended that the health services administrator at each facility ensure that all equipment utilized in the response to medical emergencies (e.g., Code 99 bags, code cart, oxygen tank, AED, etc.) is inspected and in proper working order on a daily basis. *Fourth*, it is strongly recommended that the DOC review and revise its “mock drill” training at each facility to ensure that correctional and medical staff review specific instructions regarding the proper role in responding to suicide attempts and providing first aid/CPR. The mock drill training should occur on an annual basis for all correctional and medical personnel.

7) **Reporting**

**In the event of a suicide attempt or suicide, all appropriate correctional officials should be notified through the chain of command. Following the incident, the victim's family should be immediately notified, as well as appropriate outside authorities. All staff who came into contact with the victim prior to the incident should be required to submit a statement as to their full knowledge of the inmate and incident.**

**FINDING:** The reporting requirements following an inmate suicide are detailed in DOC Policies 622.02 and 622.03. Although this writer did not have an opportunity to review all of the required notifications and documentation in the recent inmates suicides, in the material that was reviewed, all reporting procedures seemed to have been appropriately followed.

**RECOMMENDATIONS:** None

8) **Follow-up/Mortality Review**

Every completed suicide, as well as serious suicide attempt (i.e., requiring hospitalization), should be examined by a mortality review. (If resources permit, clinical review through a psychological autopsy is also recommended.) The mortality review, separate and apart from other formal investigations that may be required to determine the cause of death, should include: 1) review of the circumstances surrounding the incident; 2) review of procedures relevant to the incident; 3) review of all relevant training received by involved staff; 4) review of pertinent medical and mental health services/reports involving the victim; 5) review of any possible precipitating factors that may have caused the victim to commit suicide; and 6) recommendations, if any, for changes in policy, training, physical plant, medical or mental health services, and operational procedures. Further, all staff involved in the incident should participate in each process, as well as offered critical incident stress debriefing.

Experience has demonstrated that many correctional systems have reduced the likelihood of future suicides by critically reviewing the circumstances surrounding instances as they occur. While all deaths are investigated either internally or by outside agencies to ensure impartiality, these investigations are normally limited to determining the cause of death and whether there was any criminal wrongdoing. *The primary focus of a mortality review should be two-fold: What happened in the case under review and what can be learned to help prevent future incidents?* To be successful, the mortality review team must be multidisciplinary and include representatives of both line and management level staff from the corrections, medical and mental health divisions.

**FINDINGS:** The DOC has both excellent policies and practices regarding the mortality review process following an inmate suicide. In many ways, *this mortality review process represents the strength of the DOC-UMCH suicide prevention program.* Per DOC Policy

622.07, the death is investigated by the agency's Office of Investigative Services. The DOC Commissioner also normally designates a "Departmental Medical Investigation Team" to investigate the death. The team is comprised of at least one individual from the Office of Investigative Services (OIS) and either the Health Services Division (HSD)'s Mental Health and Substance Abuse Coordinator or a Regional Administrator. The team reports almost immediately to the facility which sustained the death to begin its investigations. The OIS investigation results in a report to the Commissioner. A copy is forwarded to the Quality Assurance Mortality Review Committee. The HSD investigation results in an extensive written narrative that is discussed by the Committee during the Quality Assurance Mortality Review. In most cases, Quality Assurance Mortality Review Committee tries to meet within 30 days of the inmate suicide. The Committee is comprised of both participants and observers, and includes representatives from HSD headquarters, an independent psychiatric consultant, representatives from UMCH, and the facility superintendent or designee. Interviewed staff may be those correctional, medical, and mental health personnel who were involved in the care and custody of the inmate, as well as those who responded to the emergency. A report of the mortality review is completed and recommendations, if any, for corrective action are required to be, per policy, "acted upon in an expedient manner." It should also be noted that each death is also reviewed through the UMCH morbidity and mortality review process -- a method that was not reviewed by this writer.

This writer reviewed either the OIS, HSD, and/or Quality Assurance Mortality Review reports on 10 inmate suicides occurring in 2005-2006. In each case, the reviews were very comprehensive and insightful, and the recommendations were thoughtful and directly on-point.

*In fact, these mortality reviews were among the most comprehensive that this writer has ever reviewed.* With that said, one area of concern is raised. Several mortality reviews contained significant recommendations with very vague narrative that made it difficult to determine whether (and when) corrective action would be instituted. For example:

- “The DOC and UMCH will work to make the weekly institutional risk list a more effective management tool,”
- “The DOC in conjunction with UMCH should work to develop effective alternative placement options for those inmates suffering from severe and persistent mental illness,”
- “The DOC and UMCH will explore the feasibility of purchasing an additional Code 99 bag for each facility to function as a replacement in the event that the Code 99 bag is being restocked,” and
- “The DOC will explore the feasibility of creating a work group to review the current policies and procedures as they pertain to the placement of those seriously mentally ill inmates.”

**RECOMMENDATIONS:** This writer would offer only one recommendation. It is strongly recommended that in order to ensure that all mortality review recommendations are processed in a timely manner, a “corrective action plan” (CAP) should be developed in response to each recommendation. Each CAP should include, but not be limited to, the following: 1) the recommendation, 2) whether it has been accepted or rejected by the DOC Commissioner and UMCH program medical director (or their designees), 3) the corrective action, 4) target date for completion, 5) completion date, and 6) the mechanism for periodically monitoring continued compliance. In addition, it is suggested that the recommendations contained within this report be subject to the corrective action format described above.



## C. SUMMARY OF RECOMMENDATIONS

### Staff Training

- 1) It is strongly recommended that the DOC increase the pre-service suicide prevention training from 2 to 8 hours. At a minimum, the revised training program should include much of information currently offered in the *Suicide Prevention: Risks, Roles and Responses for Massachusetts Correctional Staff* training curriculum, with additional emphasis placed on avoiding negative attitudes to suicide prevention, updated statistics and case studies on inmate suicides within the Massachusetts DOC, identifying suicidal inmates despite the denial of risk, dealing with manipulative inmates, components of the DOC/UMCH suicide prevention policies, and liability issues associated with inmate suicide.
- 2) It is strongly recommended that *all* correctional, medical, and mental health staff complete the 8-hour pre-service suicide prevention training program, either at the Correction Training Academy or respective agency.
- 3) It is strongly recommended that DOC and UMCH officials ensure that all personnel (i.e., correctional, medical, and mental health) receive a consistent and uniform 2-hour block of suicide prevention training on a yearly basis. At a minimum, the annual 2-hour training program should include a review of predisposing factors to suicide, warning signs and symptoms, negative attitudes to suicide prevention, identifying suicidal inmates despite the denial of risk, and review of changes in the DOC/UMCH's suicide prevention policies. It is also recommended that the training program include general discussion on any inmate suicides and/or serious attempts occurring within the previous year. Material from 1) the current *Suicide Prevention: Risks, Roles and Responses for Massachusetts Correctional Staff* from 1999, 2) 36-PowerPoint slide presentation entitled "In-Service Training Program – Suicide Prevention Review," and 3) computer lab-based program entitled "In-Service 2005 – Suicide Prevention for Massachusetts Correctional Staff" could be utilized in developing this revised in-service program. Finally, it is strongly recommended that the in-service suicide prevention training program for correctional, medical and mental health staff be integrated, not separate and overlapping, as currently administered. Interdisciplinary training would prove to be more efficient and insightful.
- 4) It is strongly recommended the both DOC and UMCH suicide prevention policies be revised to include a richer description of the requirements for both pre-service and annual in-service suicide prevention. Much of the inconsistency found in both the length and content of in-service training at the toured facilities could be corrected with policy revisions that specified the required length and description of the training programs.

### **Identification/Screening**

- 5) Consistent with current Old Colony Correctional Center practices, it is strongly recommended that DOC and UMCH explore the feasibility of formalizing into agency policy a requirement that medical staff briefly assess all inmates returning from court hearings.
- 6) In order to increase the availability of information regarding an inmate's suicide risk within the county correctional system, it is strongly recommended that the sending agency (e.g., county jail, etc.) and/or transporting personnel be required to complete and submit a brief discharge/transfer form to DOC booking/reception staff documenting any immediate concerns about the newly arrived inmate. The form should be reviewed by the intake nurse and subsequently placed in the inmate's health care file. UMCH currently utilizes an "IntraSystem Transfer Form" to communicate the health care needs of inmates between DOC facilities. This is an excellent form and could be adapted for use by county jail personnel as a discharge and transfer form.
- 7) It is strongly recommended that the Q5 Inquiry section of CJIS be updated each time an inmate is placed on mental health watch for suicide risk (regardless of whether or not actual injury occurs), and that booking/admission staff and medical personnel access both the "Medical/Mental Health Section" and "Mental Health Watch" screen of IMS to determine if the newly arrived inmate was on a mental health watch during a previous DOC confinement.
- 8) Consistent with previous mortality review recommendations, it is strongly recommended that the DOC, in conjunction with UMCH, develop effective alternative placement options for those inmates suffering from severe and persistent mental illness, but whose behavioral difficulties and security needs require more strict containment than can be afforded in general population. (In beginning to address this problem, mental health personnel must be regularly invited participants in the institution's segregation review meetings.) *This issue should be among the highest priorities facing the DOC in its efforts to improve suicide prevention practices within the agency.*

### **Communication**

- 9) It is strongly recommended that DOC and UMCH embark upon a quality assurance process to audit selective security files and health care charts on a regular basis and take corrective action when appropriate. Initially, it is suggested that the files of inmates on the Mental Health Risk List be selected for audit.
- 10) It is strongly recommended that the process for developing and maintaining inmates on the Mental Health Risk List be revised collaboratively by DOC and UMCH. In order for the List to be effective, selected inmates must receive

increased attention from both mental health and correctional personnel. If the sole criteria remains that inmates are maintained on the list when they are determined to be “at risk to themselves or others because of mental illness,” then those inmates should be observed more frequently by correctional staff (e.g., at documented 30-minute intervals) and assessed more frequently by mental health staff (e.g., at least three times per week). In addition, inmates on the List should be stronger candidates to be excluded from designation to segregation. Simply stated, if there is increased concern regarding an inmate, then DOC and UMCH must demonstrate increased attention to that inmate.

### **Housing**

- 11) It is strongly recommended that the DOC ensure that all cells designated to house suicidal inmates are as reasonably “suicide-resistant” as possible. For example, wall and ceiling ventilation grates should contain holes that are ideally 1/8 inches wide, and no more than 3/16 inches wide or 16-mesh per square inch; clothing hooks should be removed; gaps between window bars and glass should be closed; and bed rails and bunk holes should be removed. This writer’s complete recommended guidelines for removing obvious cell protrusions can be found in Appendix A.
  
- 12) It is strongly recommended that the DOC work collaboratively with UMCH to completely revamp the use of the Health Services Unit for suicide precautions. The revised policy should include, but not be limited to, the following procedures:
  - The removal of an inmate’s clothing and issuance of safety garment shall be commensurate with the level of suicide risk as determined by mental health staff;
  - All inmates on suicide precautions shall be allowed all routine privileges (e.g., family visits, telephone calls, recreation, etc.) unless the inmate has lost those privileges as a result of a disciplinary sanction;
  - All inmates on suicide precautions shall have unimpeded access to their attorneys at any time;
  - All inmates on suicide precautions shall have shower access commensurate with their security level; and
  - To every extent possible, mental health staff should avoid conducting daily assessments through the food slot of the inmate’s cell door. In addition, prior to discharging an inmate from suicide precautions, the inmate must be provided with an out-of-cell mental health assessment.

- 13) It is strongly recommended that the clinical decision regarding placement of an inmate on any level of suicide precautions should not be dictated by the availability of bed space and staff; rather it should be based upon the specific needs of the identified suicidal inmate. As such, the DOC should ensure that it provides sufficient staff to the HSU and any other unit housing suicidal inmates to ensure proper observation at constant or 15-minute intervals, as well as to allow adequate out-of-cell time for the inmate. In addition, placement and length of stay on suicide precautions should be based solely upon the clinical judgment of mental health staff, and DOC officials and staff should refrain from interfering with, and/or unduly influencing, that judgment.
- 14) Given the increase in suicides in the HSUs, it is strongly recommended that correctional staff conduct documented observation at 15-minute intervals within these units.
- 15) It is strongly recommended that no inmate (regardless of their mental status) should receive a punitive sanction (i.e., disciplinary report) based solely upon self-injurious behavior.
- 16) Given the increase in the number of “open” mental health cases within the DOC during the past several years, it is strongly recommended that additional suicide-resistant cells be identified for the housing of suicide inmates. *These cells need not be necessarily located in the HSUs.*
- 17) It is strongly recommended that the DOC work collaboratively with UMCH to create a transitional housing unit and/or step-down process following an inmate’s discharge from mental health watch in the HSU. On a trial basis, it might be beneficial to identify beds in the DOC’s residential treatment units to begin this initiative.

### **Levels of Supervision**

- 18) It is strongly recommended that both the DOC and UMCH suicide prevention policies be revised to include a better description of the type of behavior and/or circumstances that necessitates a specific level of observation. A proposed revision is offered as follows:
- ***Close Observation*** is reserved for the inmate who is not actively suicidal, but expresses suicidal ideation and/or has a recent prior history of self-destructive behavior and would be considered a low risk for suicide. In addition, an inmate who denies suicidal ideation or does not threaten suicide, but demonstrates other concerning behavior (through actions, current circumstances, or recent history) indicating the potential for self-injury, should be placed under close observation. This inmate should be observed by staff at

staggered intervals not to exceed every 15 minutes, and should be documented as it occurs.

- ***Constant Observation*** is reserved for the inmate who is actively suicidal, either by threatening or engaging in self-injury and would be considered a high risk for suicide. This inmate should be observed by a staff member on a continuous, uninterrupted basis. The observation should be documented at 15-minute intervals.

- 19) It is strongly recommended that reference to 30-minute observation for suicidal inmates be deleted from DOC Policy 650.07. While this level of observation would be appropriate for an inmate discharged from suicide precautions and transferred to a transitional housing unit, it is not appropriate for an inmate in suicidal crisis in the HSU.
- 20) The DOC should ensure that all facilities are utilizing the “Correction Officer Observation Check Sheet” (DOC 650, Attachment B-4) that does not contain pre-printed 15-minute time intervals. In addition, a “Mental Health Watch Form” (DOC 650, Attachment C), completed by the assigned mental health clinician, should be attached to the door of each cell housing a suicidal inmate. The report provides a daily listing of the inmate’s level of observation, and personal items and privileges that are allowed/prohibited. It is also strongly recommended that the DOC develop and enforce a policy that prohibits its officers from allowing inmates on suicide precautions to cover their heads with blankets or other bedding.
- 21) It is strongly recommended that correctional officers conduct documented 30-minute rounds of all special housing units, including residential treatment units. As previously recommended, documented 15-minute rounds should be conducted in the Health Services Units. In addition, to ensure compliance with these directives, it is strongly recommended that DOC officials conduct more frequent audits (via review of closed circuit telephone monitors) of these units, as well as the segregation units.
- 22) It is strongly recommended that UMCH revise its suicide prevention policy to ensure that an inmate is not discharged from suicide precautions until their case was reviewed during the daily clinical team meeting. In addition an inmate placed on constant observation should always be downgraded to close (i.e., 15-minute) observation for a reasonable period of time prior to being discharged from suicide precautions. Further, progress notes regarding inmates on suicide precautions should always reflect a thorough suicide risk assessment and justification for a particular level of observation. UMCH should embark upon a quality assurance process to audit selective health care charts on a regular basis and take corrective action when appropriate.

- 23) In order to safeguard the continuity of care for suicidal inmates, all inmates discharged from suicide precautions should remain on mental health caseloads and receive regularly scheduled follow-up assessments by mental health staff until their release from DOC custody. As such, unless an inmate's individual treatment plan directs otherwise or they are on the Mental Health Risk List and receive recommended visits from mental health personnel three times per week, it is recommended that the current reassessment schedule following discharge from suicide precautions be revised as follows: daily for 5 days, once a week for 2 weeks, and then once a month until release from the DOC custody.
- 24) It is strongly recommended that administrative or security watches should not be utilized in cases in which staff is concerned enough about an inmate's behavior that increased observation is necessary. These inmates, regardless of their diagnoses, should be placed on mental health watch. And as previously stated, these mental health watches need not necessarily be conducted in the HSUs.

### **Intervention**

- 25) Both DOC and UMCH policies should be slightly revised to better ensure a proper response of both correctional and medical personnel to a suicide attempt. At a minimum, policies should reiterate that CPR should be initiated immediately (on a flat, hard surface) and the victim should not be carried away from the cellblock area during the emergency. This writer's complete recommended guidelines for intervention following a suicide attempt can be found in Appendix A.
- 26) It is strongly recommended that the DOC ensure that *all* housing units contain an emergency response bag that includes a first aid kit; pocket mask, face shield, or Ambu-bag; latex gloves; and emergency rescue tool. All staff who come into regular contact with inmates should know the location of this emergency response bag and be trained in its use.
- 27) It is strongly recommended that the health services administrator at each facility ensure that all equipment utilized in the response to medical emergencies (e.g., Code 99 bags, code cart, oxygen tank, AED, etc.) is inspected and in proper working order on a daily basis.
- 28) It is strongly recommended that the DOC review and revise its "mock drill" training at each facility to ensure that correctional and medical staff review specific instructions regarding the proper role in responding to suicide attempts and providing first aid/CPR. The mock drill training should occur on an annual basis for all correctional and medical personnel.

### **Reporting**

None

**Follow-up/Mortality Review**

29) It is strongly recommended that in order to ensure that all mortality review recommendations are processed in a timely manner, a “corrective action plan” (CAP) should be developed in response to each recommendation. Each CAP should include, but not be limited to, the following: 1) the recommendation, 2) whether it has been accepted or rejected by the DOC Commissioner and UMCH program medical director (or their designees), 3) the corrective action, 4) target date for completion, 5) completion date, and 6) the mechanism for periodically monitoring continued compliance. In addition, it is suggested that the recommendations contained within this report be subject to the corrective action format described above.

## **D. CONCLUSION**

It is hoped that the assessment provided by this writer, as well as the recommendations contained within this report, will be of assistance to the Massachusetts Department of Correction. During this assessment process, this writer met numerous DOC and UMCH officials and supervisors, as well as officers, nurses and clinicians, who were genuinely concerned about inmate suicide and committed to taking whatever actions were necessary to reduce the opportunity for such tragedy in the future. And based upon a pro-active approach and high caliber management and line staff, this writer is confident that implementation of the various recommendations contained within this report will result in successful efforts to reduce the likelihood of future inmate suicides within the Massachusetts Department of Correction.

In conclusion, this writer would be remiss by not extending sincere appreciation to Kathleen M. Dennehy, DOC Commissioner, and Terre K. Marshall, DOC Health Services Director. Special thanks goes to Lawrence Weiner, DOC Mental Health and Substance Abuse Coordinator, for his assistance in scheduling the tours and interviews, fulfilling document requests, and providing valuable insight to this assessment. Without the total candor, cooperation and assistance from these individuals, as well as from all correctional, medical, and mental health personnel that were interviewed, this writer would not have been able to complete this technical assistance assignment.

Respectfully Submitted By:

Lindsay M. Hayes  
Project Director

January 31, 2007



## **APPENDICES**

- A) Checklist for the “Suicide-Resistant” Design of Correctional Facilities
- B) Model Intervention Procedures for Suicide Attempts

**APPENDIX A**  
**CHECKLIST FOR THE “SUICIDE-RESISTANT” DESIGN OF CORRECTIONAL FACILITIES**

The safe housing of suicidal inmates is an important component to a correctional facility’s comprehensive suicide prevention policy. Although impossible to create a “suicide-proof” cell environment within any correctional facility, given the fact that almost all inmate suicides occur by hanging, it is certainly reasonable to ensure that all cells utilized to house potentially suicidal inmates are free of all obvious protrusions. And while it is more common for ligatures to be affixed to air vents and window bars (or grates), *all* cell fixtures should be scrutinized, since bed frames/holes, shelves with clothing hooks, sprinkler heads, door hinge/knobs, towel racks, water faucet lips, and light fixtures have been used as anchoring devices in hanging attempts. As such, to ensure that inmates placed on suicide precautions are housed in “suicide-resistant” cells, facility officials are strongly encouraged to address the following architectural and environmental issues:

1) Cell doors should have large-vision panels of Lexan (or low-abrasion polycarbonate) to allow for unobstructed view of the entire cell interior at all times. These windows should *never* be covered (even for reasons of privacy, discipline, etc.) If door sliders are not used, door interiors should not have handles/knobs; rather they should have recessed door pulls. Any door containing a food pass should be closed and locked.

Interior door hinges should bevel down so as not to permit being used as an anchoring device. Door frames should be rounded and smooth on the top edges. The frame should be grouted into the wall with as little edge exposed as possible.

In older, antiquated facilities with cell fronts, walls and/or cell doors made of steel bars, Lexan paneling (or low-abrasion polycarbonate) or security screening (that has holes that are ideally 1/8 inches wide and no more than 3/16 inches wide or 16-mesh per square inch) should be installed from the *interior* of the cell.

Solid cell fronts must be modified to include large-vision Lexan panels or security screens with small mesh;

2) Vents, ducts, grilles, and light fixtures should be protrusion-free and covered with screening that has holes that are ideally 1/8 inches wide, and no more than 3/16 inches wide or 16-mesh per square inch;

3) Wall-mounted corded telephones should *not* be placed inside cells. Telephone cords of varying length have been utilized in hanging attempts;

4) Cells should *not* contain any clothing hooks. The traditional, pull-down or collapsible hook can be easily jammed and/or its side supports utilized as an anchor;

5) A stainless steel combo toilet-sink (with concealed plumbing and outside control valve) should be used. The fixture should *not* contain an anti-squirt slit, toothbrush holder, toilet paper rod, and/or towel bar;

6) Beds should ideally be either heavy molded plastic or solid concrete slab with rounded edges, totally enclosed underneath.

If metal bunks are utilized, they should be bolted flush to the wall with the frame constructed to prevent its use as an anchoring device. Bunk holes should be covered; ladders should be removed. (Traditional metal beds with holes in the bottom, not built flush to the wall and open underneath, have often been used to attach suicide nooses. Lying flat on the floor, the inmate attaches the noose from above, runs it under his neck, turns over on his stomach and asphyxiates himself within minutes.);

7) Electricity should be turned off from wall outlets outside of the cell;

8) Light fixtures should be recessed into the ceiling and tamper-proof. Some fixtures can be securely anchored into ceiling or wall corners when remodeling prohibits recessed lighting. All fixtures should be caulked or grouted with tamper-resistant security grade caulking or grout.

Ample light for reading (at least 20 foot-candles at desk level) should be provided. Low-wattage night light bulbs should be used (except in special, high-risk housing units where sufficient lighting 24 hours per day should be provided to allow closed-circuit television (CCTV) cameras to identify movements and forms).

An alternative is to install an infrared filter over the ceiling light to produce total darkness, allowing inmates to sleep at night. Various cameras are then able to have total observation as if it were daylight. This filter should be used only at night because sensitivity can otherwise develop and produce aftereffects;

9) CCTV monitoring does *not* prevent a suicide, it only identifies a suicide attempt in progress. If utilized, CCTV monitoring should *only* supplement the physical observation by staff. The camera should obviously be enclosed in a box that is tamper-proof and does not contain anchoring points. It should be placed in a high corner location of the cell and all edges around the housing should be caulked or grouted.

Cells containing CCTV monitoring should be painted in pastel colors to allow for better visibility. To reduce camera glare and provide a contrast in monitoring, the headers above cell doors should be painted black or some other dark color.

CCTV cameras should provide a clear and unobstructed view of the entire cell interior, including all four corners of the room. Camera lens should have the capacity for both night or low light level vision;

10) Cells should have a smoke detector mounted flush in the ceiling, with an audible alarm at the control desk. Some cells have a security screening mesh to protect the smoke detector from vandalism. The protective coverings should be high enough to be outside the reach of an inmate and far enough away from the toilet so that the fixture could not be used as a ladder to access the smoke detector and screen. Ceiling height for new construction should be 10 feet to make such a reasonable accommodation. Existing facilities with lower ceilings should carefully select the protective device to make sure it can not be tampered with, or have mesh openings large enough to thread a noose through.

Water sprinkler heads should not be exposed. Some have protective cones; others are flush with the ceiling and drop down when set off; some are the breakaway type;

11) Cells should have an audio monitoring intercom for listening to calls of distress (only as a supplement to physical observation by staff). While the inmate is on suicide precautions, intercoms should be turned up high (as hanging victims can often be heard to be gurgling, gasping for air, their body hitting the wall/floor, etc.);

12) Cells utilized for suicide precautions should be located as close as possible to a control desk to allow for additional audio and visual monitoring;

13) If modesty walls or shields are utilized, they should have triangular, rounded or sloping tops to prevent anchoring. The walls should allow visibility of both the head and feet;

14) Some inmates hang themselves under desks, benches, tables or stools/pull-out seats. Potential suicide-resistant remedies are: (a) Extending the bed slab for use as a seat; (b) Cylinder-shaped concrete seat anchored to floor, with rounded edges; (c) Triangular corner desk top anchored to the two walls; and (d) Rectangular desk top, with triangular end plates, anchored to the wall. Towel racks should also be removed from any desk area;

15) All shelf tops and exposed hinges should have solid, triangular end-plates which preclude a ligature being applied;

16) Cells should have security windows with an outside view. The ability to identify time of day via sunlight helps re-establish perception and natural thinking, while minimizing disorientation.

If cell windows contain security bars that are not completely flush with window panel (thus allowing a gap between the glass and bar for use as an anchoring device), they should be covered with Lexan (or low-abrasion polycarbonate) paneling to prevent access to the bars, or the gap, should be closed with caulking, glazing tape, etc.

If window screening or grating is used, covering should have holes that are ideally 1/8 inches wide, and no more than 3/16 inches wide or 16-mesh per square inch;

17) The mattress should be fire retardant and not produce toxic smoke. The seam should be tear-resistant so that it cannot be used as a ligature;

18) Given the fact that the risk of self-harm utilizing a laundry bag string outweighs its usefulness for holding dirty clothes off the floor, laundry bag strings should be removed from the cell;

19) Mirrors should be of brushed, polished metal, attached with tamper-proof screws;

20) Padding of cell walls is prohibited in many states. Check with your fire marshal. If permitted, padded walls must be of fire-retardant materials that are not combustible and do not produce toxic gasses; and

21) Ceiling and wall joints should be sealed with neoprene rubber gasket or sealed with tamper-resistant security grade caulking or grout for preventing the attachment of an anchoring device through the joints.

NOTE: A portion of this checklist was originally derived from R. Atlas (1989), "Reducing the Opportunity for Inmate Suicide: A Design Guide," *Psychiatric Quarterly*, 60 (2): 161-171. Additions and modifications were made by Lindsay M. Hayes, and updated by Randall Atlas, Ph.D., a registered architect. See also Hayes, L.M. (2003), "Suicide Prevention and "Protrusion-Free Design of Correctional Facilities," *Jail Suicide/Mental Health Update*, 12 (3): 1-5. Last revised in January 2004.

**APPENDIX B**  
**MODEL INTERVENTION PROCEDURES FOR SUICIDE ATTEMPTS**

- 1) All staff who come into contact with inmates will be trained in standard first aid and cardiopulmonary resuscitation (CPR). All staff who come into contact with inmates will participate in annual “mock drill” training to ensure a prompt emergency response to all suicide attempts.
- 2) All housing units will contain an emergency response bag that includes a first aid kit, pocket mask, microshield or face shield, latex gloves, and emergency rescue tool. All staff who come into regular contact with inmates will know the location of this emergency response bag and be trained in its use. The emergency response bag will be inspected by correctional staff each shift to ensure all equipment is accounted for and in proper working order.
- 3) Any staff member who discovers an inmate attempting suicide will immediately respond, survey the scene to ensure the emergency is genuine, alert other staff to call for the facility’s medical personnel, and bring the emergency response bag to the cell. If the suicide attempt is life-threatening, Central Control personnel will be instructed to immediately notify outside (“911”) Emergency Medical Services (EMS). The exact nature (e.g., “hanging attempt”) and location of the emergency will be communicated to both facility medical staff and EMS personnel.
- 4) The first responding officer will use their professional discretion in regard to entering the cell without waiting for backup staff to arrive. With no exceptions, if cell entry is not immediate, it will occur no later than four minutes from initial notification of the emergency. (Should the emergency take place within the Special Housing Unit and require use of the Cell Entry Team, the Team will be assembled, equipped and enter the cell as soon as possible, and no later than four minutes from initial notification of the emergency.) Correctional staff will *never* wait for medical personnel to arrive before entering a cell or before initiating appropriate life-saving measures (e.g., first aid and CPR).
- 5) Upon entering the cell, correctional staff will *never* presume that the victim is dead, rather life-saving measures will be initiated immediately. In hanging attempts, the victim will first be released from the ligature (using the emergency rescue tool if necessary). Staff will assume a neck/spinal cord injury and carefully place the victim on the floor (not mattress or other soft surface). Should the victim lack vital signs, CPR will be initiated immediately. All life-saving measures will be continued by correctional staff until relieved by medical personnel. If cell space is limited for CPR initiation, the victim may be carefully carried out onto the tier, ensuring protection of both the neck and spinal cord. The victim should *not* be carried to the infirmary or satellite nursing station.
- 6) The shift supervisor will ensure that both arriving facility medical staff and EMS personnel have unimpeded access to the scene in order to provide prompt medical services to, and evacuation of, the victim.

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

8) An Automated External Defibrillator (AED) is located in the Special Housing Unit. All medical staff, as well as designated correctional personnel, will be trained (both initial and annual instruction) in its use. The facility medical director will provide direct oversight of AED use and maintenance. (See also policy on “Automated External Defibrillator Use.”)

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

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