Chapter 16

Reducing Inmate Suicides Through the Mortality Review Process

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Suicide continues to be a leading cause of death in jails across the country, where well over 400 inmates take their lives each year (Hayes, 1989). The rate of suicide in county jails is estimated to be approximately four times greater than that of the general population (Mumola, 2005). Overall, most jail suicide victims were young white males who were arrested for nonviolent offenses and intoxicated on arrest. Many were placed in isolation and dead within 24 hours of incarceration (Hayes, 1989; Davis & Muscat, 1993). The overwhelming majority of victims are found hanging by either bedding or clothing. Research specific to suicide in urban jail facilities provides certain disparate findings. Most victims of suicide in large urban facilities are arrested for violent offenses and are dead within 1 to 4 months of incarceration (DuRand, Burtka, Federman, Haycox, & Smith, 1995; Marcus & Alcabes, 1993). Due to the extended length of confinement prior to suicide, intoxication is not always the salient factor in urban jails as it is in other types of jail facilities. Suicide victim characteristics such as age, race, gender, method, and instrument remain generally consistent in both urban and nonurban jails.

While suicide is well recognized as a critical problem within jails, the issue of prison suicide has not received comparable attention, perhaps because the number of jail suicides far exceeds the number of prison suicides. Suicide ranks third, behind natural causes and AIDS, as the leading cause of death in prisons (Mumola, 2005). Although the rate of suicide in prison is considerably lower than in jail, it still remains slightly greater than the general population (Mumola, 2005). Most research on prison suicide has found that the vast majority of victims were convicted of personal crimes, housed in single cells (often either administrative or disciplinary segregation), and have histories of prior suicide attempts and/or mental illness (Daniel & Fleming, 2006; He, Felthous, Holzer, Nathan, & Veasey, 2001; Kovasznay, Miraglia, Beer, & Way, 2004; Salive, Smith, & Brewer, 1989; White, Schimmel, Frickey, 2002).

The precipitating factors of suicidal behavior in jail are well established (Bonner, 1992, 2000). It has been hypothesized that two primary causes for jail suicide exist: (1) jail environments are conducive to suicidal behavior and (2) the inmate is facing a crisis situation. From the inmate's perspective, certain features of the jail environment may enhance suicidal behavior: fear of the

unknown, distrust of authoritarian environment, lack of apparent control over the future, isolation from family and significant others, shame of incarceration, and the dehumanizing aspects of incarceration. In addition, certain factors are prevalent among inmates facing a crisis situation that could predispose them to suicide: recent excessive drinking and/or use of drugs, recent loss of stabilizing resources, severe guilt or shame over the alleged offense, current mental illness, prior history of suicidal behavior, and an approaching court date. Some inmates simply are (or become) ill-equipped to handle the common stresses of confinement. As the inmate reaches an emotional breaking point, the result can be suicidal ideation, attempt, or completion. During initial confinement in a jail, this stress can be limited to fear of the unknown and isolation from family, but over time (including stays in prison) stress may become exacerbated and include loss of outside relationships, conflicts within the institution, victimization, further legal frustration, physical and emotional breakdown, and problems of coping within the institutional environment (Bonner, 1992). Precipitating factors in prison suicide may include new legal problems, marital or relationship difficulties, and inmate-related conflicts (White et al., 2002).

Despite a declining rate of suicide in county jails throughout the country, there remains the lingering problem of too many preventable suicides occurring alongside the feeble attempt to comprehensively review the deaths through a mortality review process. The thorough examination of an inmate death, encompassing both a mortality review and psychological autopsy, is cited in most national standards. For example, according to National Commission on Correctional Health Care (NCCHC) standards, "a clinical mortality review is an assessment of the clinical care provided and the circumstances leading up to a death" (NCCHC, 2003). In many cases, however, the clinical mortality review is simply a review of the inmate's chart by a physician. A national survey of suicide prevention practices in state prison systems found that only 14% of departments of correction addressed the issue of administrative or mortality reviews in their suicide prevention policy or other administrative directive (Hayes, 1995).

NCCHC standards also recommend a "psychological autopsy," in which a psychologist or other qualified mental health professional conducts "a written reconstruction of an individual's life with an emphasis on factors that may have contributed to the individual's death" (NCCHC, 2003). Although there are various references to psychological autopsies for inmate suicides in the literature (Aufderheide, 2000; Sanchez, 2006), the process is often misunderstood and misused within the correctional environment. Finally, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) offers guidance through policies and procedures for the "root cause analysis," but it too is rarely found within the correctional facilities (JCAHO, 2005). According to JACHO:

> Root cause analysis is a process for identifying the basic and causal factors that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event. A root cause analysis focuses primarily on systems and processes, not on individual performance. It progresses from special causes in clinical processes to common causes in organizational processes and identifies potential improvements in processes or systems that tend to decrease the likelihood of such events in the future, or determines, after analysis, that no such improvement opportunities exist. (p. 2)

In order to fully understand why an inmate committed suicide, as well as whether the correctional facility was in the best possible position to prevent the incident, every suicide and serious suicide attempt (i.e., requiring hospitalization) should be examined through a comprehensive mortality review process. The process is separate and apart from other formal investigations that may be required to determine the cause of death (e.g., medical examiner's autopsy, departmental investigation, state police inquiry, coroner's inquest).

The primary purposes of a mortality review are: What happened in the case under review and what can be learned to help prevent future incidents? Unlike NCCHC requirements which stress only a clinical perspective, 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. Exclusion of one or more disciplines will severely jeopardize the integrity of the review. The multidisciplinary review should include: (1) critical review of the circumstances surrounding the incident; (2) critical review of facility procedures relevant to the incident; (3) synopsis of all relevant training received by involved staff; (4) review of pertinent medical and mental health services/reports involving the victim; (5) review of possible precipitating factors (i.e., circumstances which may have caused the victim to engage in self-injury/suicide) resulting in the incident; and (6) recommendations, if any, for change in policy, training, physical plant, medical or mental health services, and operational procedures (Cox & Hayes, 2003).

Most jail and prison facilities do not embark on a comprehensive and multidisciplinary mortality review process. Why? There are concerns about liability. There is the inherent awkwardness of discussing the circumstances surrounding an inmate's death across various disciplines within an agency. But inevitably, mortality reviews are not conducted because key actors in the process (i.e., the administrators) are afraid of what they may find. Take, for example, the suicide of Edward Vaughn.

According to available records, 45-year-old Edward Vaughn (a pseudonym) was first confined in the Lincoln County Jail on February 8, 2002, for various charges, including alleged criminal attempt at kidnapping, unlawful restraint, and aggravated assault.[1] He was assessed as being both mentally ill and suicidal soon after his confinement. During the intake process, Mr. Vaughn became incoherent and it was determined that he had suffered from an overdose of his psychotropic medication. A razor blade was later found in his clothes. Mr. Vaughn was placed on suicide precautions with the requirement of observation at 15-minute intervals. Two days later on February 10, he was observed to be bleeding from self-inflicted lacerations on his right wrist. He was provided treatment by nursing staff and remained on suicide precautions with observation at 15-minute intervals. The following day, Mr. Vaughn was observed with a noose around his neck and tied to the cell bars. The ligature was removed and he remained on

[1] In order to ensure complete confidentiality, certain identifying information regarding the victim, facility, and staff have been changed. No modifications to the facts of the case have been made.

suicide precautions until February 25. On March 30, he was again placed on suicide precautions with the requirement of observation at 15-minute intervals for self-injurious behavior. He was also stripped naked and not provided with any protective clothing (e.g., safety smock, paper gown). Mr. Vaughn was released from the Lincoln County Jail on April 2, 2002.

Mr. Vaughn was again confined in the Lincoln County Jail on October 27, 2002 for charges that included alleged aggravated assault and reckless endangerment. At the scene of arrest, he threatened suicide by placing a knife to his throat. He also appeared depressed ("feeling so bad") and threatened suicide ("can't live anymore") during the intake process. Mr. Vaughn self-reported a history of mental illness, psychiatric hospitalization, and psychotropic medication. He also had observable scars from previous self-inflicted injuries. He was placed on suicide precautions in the reception unit with the requirement of observation at 15-minute intervals. Several hours later, Mr. Vaughn began to engage in self-injurious behavior by repeatedly throwing himself on the floor and wall of his cell causing head trauma, and was placed in a restraint chair and received psychotropic medication. He continued to be observed as "quite tearful and depressed." Mr. Vaughn was subsequently removed from the restraint chair but remained on suicide precautions with the requirement of observation at 15-minute intervals. The following day (October 28), he was found hanging from the cell bars by a blanket that he had torn into strips. Although the arriving nurse declared that "he's gone," Mr. Vaughn remained conscious and was placed in a restraint chair after continuing to threaten suicide. He was subsequently released from the restraint chair, stripped naked without any protective clothing, and remained on suicide precautions. On November 4, Mr. Vaughn was relocated to the mental health unit and remained on suicide precautions until November 14. Although Mr. Vaughn remained housed in the mental health unit, as a result of his suicidal behavior, as well as assaultive behavior to staff, he was punished by receiving a sanction of disciplinary segregation.

During the evening of December 4, 2002, Mr. Vaughn was requested to change cells in the mental health unit. He refused, became very agitated, and was forcefully removed from the unit and relocated in the segregation unit at approximately 8:50 PM. After placement in his segregation cell, Mr. Vaughn remained agitated and began to engage in various forms of self-injurious behavior, including banging his head against the floor, bunk, and wall; climbing on the top bunk and purposely falling off to the concrete floor; attempting to flush his head down the toilet; and trying to hang himself by tying his underwear around his neck and to the towel bar in the cell. He was again placed in a restraint chair.

A few hours later at approximately 12:30 AM on December 5, 2002, Mr. Vaughn was released from the restraint chair and placed on suicide precautions with the requirement of observation at 15-minute intervals. For unexplained reasons, he was reportedly observed at 30-minute intervals during the next several hours. Beginning at approximately 7:30 AM, the officers' logs reflected observation at exact 15-minute intervals. The last documented observation of Mr. Vaughn on suicide precautions occurred at 4:00 PM on December 5, 2002. At approximately 4:16 PM, a correctional officer found Mr. Vaughn hanging from the cell bars by a strip of bed sheet. (According to the videotape recording of the housing unit and the suicide

attempt, the last time that an officer was in the housing unit was approximately 3:45 PM and that officer did not walk past Mr. Vaughn's cell. The inmate was seen on the videotape to be tying the sheet to the cell bars at 3:56 PM and the sheet was visible from that time forward until he was found hanging 20 minutes later at 4:16 PM.) The officer called for backup personnel and several correctional staff arrived shortly thereafter and assisted in cutting the sheet away from the bars. The cell door was opened and Mr. Vaughn was placed on the floor. Other correctional personnel arrived in the housing area and stood around the victim. Approximately 3 minutes later at 4:19 PM, medical staff arrived and initiated cardiopulmonary resuscitation (CPR). At approximately 4:29 PM, emergency medical services personnel arrived and continued life-saving measures. Mr. Vaughn was then transported to a local hospital and subsequently pronounced dead.

Why did Edward Vaughn commit suicide? What really happened? Was he ever considered a high risk for suicide? Was he ever considered for hospitalization? Was he on the correct level of observation? Why was he stripped naked without any protective clothing? How was he able to gain access to both a sheet and blanket? Was staff aware that Mr. Vaughn had attempted suicide in the facility several months earlier? Why did correctional officers wait until medical personnel arrived before assisting with CPR? Had any personnel received suicide prevention training prior to the incident? Was Mr. Vaughn's suicide preventable? Were there any similarities between his death and the other prior suicides in the facility? These and many other lingering questions were left unanswered in this case, as well as in several hundred other suicides that occur in correctional facilities each year, simply because many agencies choose not to address them. While verifying the cause of death and ruling out foul play remain the staples of routine investigations, correctional agencies remain reluctant to comprehensively review an inmate suicide, determine whether or not it was preventable, and take corrective action to reduce the opportunity for similar deaths in the future.

What a Mortality Review Would Have Found

A departmental investigation was conducted following Edward Vaughn's suicide and concluded that he was at low to moderate risk for suicide and, based on the facility's adequate policies and procedures, the death was not preventable. Although an NCCHC-accredited facility, a mortality review was not conducted in Mr. Vaughn's case. If a comprehensive mortality review had been conducted, the following issues would have been raised.

First, there was overwhelming evidence to show that Edward Vaughn was at a continuing high risk for suicide in the Lincoln County Jail, and that continuing high risk was known to various medical, mental health, and correctional personnel. This much was known: (1) he had a history of mental illness, psychiatric hospitalization, and psychotropic medication; (2) he was observed to be depressed, agitated, incoherent, "quite tearful" and crying, and displaying numerous self-inflicted injuries and scars; (3) he self-reported both depression ("feeling so bad") and suicidal ideation ("can't live anymore"), as well as requested to remain in the restraint chair when feeling the impulse to engage in suicidal behavior; and (4) he

engaged in self-injurious behavior on at least seven separate occasions (immediately prior to or) during his confinement:

- on intake on February 8 when it was suspected that he overdosed on psychotropic medication,
- on February 10 when he was observed to be bleeding from lacerations on his right wrist,
- on February 11 when he was observed with a noose around his neck and tied to the cell bars,
- on March 30 when he was observed engaging in self-injurious behavior,
- on October 27 when he repeatedly threw himself on the floor and wall of his cell causing head trauma,
- on October 28 when he was found hanging from the cell bars by a blanket that he had torn into strips, and
- on December 4 when he observed banging his head against the floor, bunk, and wall; climbing on the top bunk and purposely falling off to the concrete floor; attempting to flush his head down the toilet; and trying to hang himself by tying his underwear around his neck and to the towel bar in the cell.

Despite Mr. Vaughn's continuing high risk for suicide during his confinement in the Lincoln County Jail, the response from staff was the following: placement on 15-minute suicide precautions in various unsafe cells, periodic assessment by contracted medical and mental health staff, psychotropic medication, and periodic placement for a few hours in a restraint chair. These responses were inadequate because Mr. Vaughn was permitted to continue to engage in self-injury and ultimately committed suicide in the facility.

The Lincoln County Jail also had inadequate policies and practices in the area of suicide prevention (particularly levels of observation and safe housing) that were the proximate causes of Mr. Vaughn's suicide. A written suicide prevention policy is a prerequisite for running a correctional facility. The importance of written policy in suicide prevention is clearly stated in the American Correctional Association standards (2004): "A suicide-prevention program is approved by the health authority and reviewed by the facility or program administrator. It includes specific procedures for handling intake, screening, identifying, and supervising of a suicide-prone inmate and is signed and reviewed annually" (p. 64). In addition, the National Commission on Correctional Health Care standards (2003) requires each jail to have a written suicide prevention plan that includes the following components: training, identification, referral, evaluation, housing, monitoring, communication, intervention, notification, reporting, review, and critical incident debriefing.

The Lincoln County Jail's suicide prevention policy stated that the facility will "provide special, housing, increased levels of observation, and medical restraint to those inmates who display self-destructive behavior." Although the policy referenced both ACA and NCCHC standards, it was not consistent with those standards. For example, although national correctional standards required an option for *constant observation* for actively suicidal inmates, the Lincoln County Jail's suicide prevention policy provided two levels of observation for suicidal inmates: *suicide precaution* and *close observation*. A review of the policy indicated little discernible difference between the two supervision levels. In practice, inmates on *suicide precaution* status were stripped naked of their clothing, all items (with the exception of a blanket)

were removed from the cell, and they were observed "at irregular 15-minute intervals (no more than 15 minutes between checks). The checks are staggered so that there is no predictable pattern for the inmate to use in planning suicide." Of course, allowing an inmate to be stripped naked without any protective clothing (e.g., safety smock, paper gown) is contrary to all national standards, as well as human decency. Inmates on *close observation* status were allowed to retain their clothing and other possessions and were observed at staggered 15-minute intervals. Thus, the only difference between the two levels was the issue of clothing and possessions. Contrary to Lincoln County Jail policy, Mr. Vaughn was observed for several hours on December 5 at 30-minute intervals, and was rarely observed at staggered or "irregular" 15-minute intervals while on either close observation or suicide precaution status. Instead, the officers' logs were recorded at exact 15-minute intervals.

Despite his continuing high risk for suicide, Mr. Vaughn was never placed on constant observation. Although observation at 15-minute intervals is routinely reserved for inmates assessed as being either at low or moderate risk for suicide, it should never be utilized for a highly suicidal individual. In fact, Lincoln County Jail staff was emphatically warned of Mr. Vaughn's high-risk suicidal behavior when, on his discharge from the emergency room of a local hospital on October 27, 2002, the physician stated: "Be absolutely watchful of his behavior. Consider this patient high-risk for repeated self-injury. Must have someone watching him at all times." A review of the records in this case indicated that facility staff never placed Mr. Vaughn on constant observation nor considered psychiatric hospitalization for his continuing high-risk suicidal behavior.

Further, interviews with jail staff revealed that even the alleged observation of Mr. Vaughn at 15-minute intervals was not always performed by an officer physically walking past his cell, but rather by an officer stationed inside the control booth which was estimated to be between 30 and 40 feet from Mr. Vaughn's cell and partially obstructed by a stairway. A consulting psychiatrist at the Lincoln County Jail later stated it would be improper for a control booth officer to be responsible for the observation of suicidal inmates, and that he was unaware that such a practice was occurring at the Lincoln County Jail. In fact, the last time that an officer was in Mr. Vaughn's housing unit on December 5 was at approximately 3:45 pm, and that officer did not walk past Mr. Vaughn's cell. The inmate was seen on a videotape to be tying the sheet to the cell bars at 3:56 pm and the sheet was visible from that time forward until he was found hanging 20 minutes later at 4:16 pm. It was obvious that none of the officers assigned to the housing unit (including the control officer) adequately observed Mr. Vaughn prior to his death, the proximate cause of which was his ability to successfully commit suicide. In essence, had jail staff followed standard correctional practices and national correctional standards, Mr. Vaughn would have been observed on constant observation following his most recent high-risk self-injurious behavior on December 4 and not had the ability to successfully commit suicide the following day.

With regard to housing of suicidal inmates, consistent with national correctional standards and standard practices in correctional facilities throughout the country, housing assignments should be based on the ability to maximize staff interaction with the inmate, avoiding assignments that

heighten the depersonalizing aspects of incarceration. Ideally, suicidal inmates should be housed in the general population, mental health unit, or medical infirmary, located close to staff. All cells designated to house suicidal inmates should be suicide-resistant, free of all obvious protrusions, and provide full visibility. These cells should contain tamperproof light fixtures and ceiling air vents that are protrusion-free. No cell housing a suicidal inmate should have open-faced bars. Rather, each cell door should contain a heavy gauge Lexan (or equivalent grade) glass panel that is large enough to allow staff a full and unobstructed view of the cell interior. Cells housing suicidal inmates should not contain any electrical switches or outlets, bunks with holes and ladders, towel racks on desks and sinks, radiator vents, corded telephones of any length, clothing hooks (of any kind), or any other object that provides an easy anchoring device for hanging (Hayes, 2003). As reiterated in the NCCHC standards, "All cells or rooms housing suicidal inmates are as suicide-resistant as possible (e.g., without protrusions of any kind that would enable the inmate to hang himself/herself)" (p. 102).

Although Lincoln County Jail's suicide prevention policy required "special housing" for suicidal inmates, the policy did not contain any description as to the specific type of housing provided to such inmates. As such, suicidal inmates could be placed in a variety of housing units, each of which contained open-faced bars, shelves with clothing hooks, metal bunks with holes, and towel racks attached to desks. In Mr. Vaughn's case, he was placed on suicide precautions in the reception, mental health, and segregation units, and he was able to attempt suicide in each of these units. For example, he was found hanging from the cell bars in the reception unit on October 28, tried to hang himself from the towel bar attached to the desk in his cell in the segregation unit on December 4, and successfully committed suicide by hanging himself from the cell bars on December 5. For inexplicable reasons, Mr. Vaughn was also able to attempt (and commit) suicide with ligatures that were prohibited from being in his cell, including a blanket and sheet. The communication between corrections, medical, and mental health personnel at the facility was so poor that an officer gave Mr. Vaughn a blanket and sheet because he did not realize the inmate was on suicide precautions.

Given the fact the inmates have historically attempted and/or committed suicide in the Lincoln County Jail utilizing a variety of dangerous anchoring devices (including a successful suicide by hanging of an inmate utilizing a shelf with clothing hooks in July 1995 and a hanging attempt of an inmate utilizing the open-faced bars in February 2000), it is particularly troubling that Mr. Vaughn was placed in a cell on suicide precautions that contained protrusions that were obvious and previously known to be dangerous by jail officials. In fact, the Lincoln County Jail had a policy that required a suicidal inmate to be placed in a dangerous cell (i.e., "Suicide Precaution: This involves the inmate in an open-barred cell").

Although heavy gauge Lexan (or equivalent grade) glass paneling is commonly known and utilized in jail and prison facilities throughout the country to cover bars of cells housing suicidal inmates, when Lincoln County Jail officials were subsequently asked why Lexan paneling was not installed on the barred doors of cells in the facility, they offered inadequate responses, ranging from not having heard of Lexan paneling to the belief that inmates would smear feces on the paneling thus obstructing visibility.

Jail officials had several options to safely house suicidal inmates, including the placement of Lexan (or equivalent grade) glass paneling on selective cells, housing suicidal inmates in cells that did not have open-barred doors, and ensuring that actively suicidal inmates were provided with constant observation of a correctional officer who was stationed directly outside the cell. Instead, jail officials chose none of these or other options and simply continued to allow these obviously dangerous cells to be utilized for housing suicidal inmates.

Finally, although the Lincoln County Jail's 4-hour "In-Custody Suicide Prevention" training lesson plan appeared comprehensive, a review of personnel files revealed that the workshop was offered at 1-hour (not 4-hour) durations and, contrary to both ACA and NCCHC standards, most personnel who interacted with Mr. Vaughn either never received suicide prevention training or received it infrequently from 1995 through 2002.

Conclusion

Although national standards address the issue of mortality reviews in varying degrees, practical guidelines for conducting meaningful reviews are absent. Based on the critical components of a comprehensive suicide prevention program (Hayes, 2005), detailed below is a recommended format and areas of inquiry for conducting a morbidity–mortality review.

1. Training
   - Had all correctional, medical, and mental health staff involved in the incident received both basic and annual training in the area of suicide prevention prior to the suicide?
   - Had all staff who responded to the incident received training (and were currently certified) in standard first aid and cardiopulmonary resuscitation (CPR) prior to the suicide?

2. Identification/Referral/Assessment
   - Upon this inmate's initial entry into the facility, were the arresting/transporting officer(s) asked whether they believed the inmate was at risk for suicide? If so, what was the response?
   - Had the inmate been screened for potentially suicidal behavior on entry into the facility?
   - Did the screening form 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.); and history of suicidal behavior by family member/close friend?
   - If the screening process indicated a potential risk for suicide, was the inmate properly referred to mental health and/or medical personnel?
   - Had the inmate received a postadmission mental health screening within 14 days of his/her confinement?
   - Had the inmate previously been confined in the facility/system? If so, had the inmate been on suicide precautions during a prior confinement in the facility/system? Was such information available to staff responsible for the current intake screening and mental health assessments?

3. Communication
   - Was there information regarding the inmate's prior and/or current suicide risk from outside agencies that was not communicated to the correctional facility?
   - Was there information regarding the inmate's prior and/or current suicide risk from correctional, mental health, and/or medical personnel that was not communicated throughout the facility to appropriate personnel?
   - Did the inmate engage in any type of behavior that might have been indicative of a potential risk of suicide? If so, was this observed behavior communicated throughout the facility to appropriate personnel?

4. Housing
   - Where was the inmate housed and why was he/she assigned to this housing unit?
   - If placed in a "special management" (e.g., disciplinary and/or administrative segregation) housing unit at the time of death, had the inmate received a written assessment for suicide risk by mental health and/or medical staff on admission to the special unit?
   - Was there anything regarding the physical design of the inmate's cell and/or housing unit that contributed to the suicide (e.g., poor visibility, protrusions in cell conducive to hanging attempts)?

5. Levels of Supervision
   - What level and frequency of supervision was the inmate under immediately prior to the incident?
   - Given the inmate's observed behavior prior to the incident, was the level of supervision adequate?
   - When was the inmate last physically observed by correctional staff prior to the incident?
   - Was there any reason to question the accuracy of the last reported observation by correctional staff?
   - If the inmate was not physically observed within the required time interval prior to the incident, what reason(s) was determined to cause the delay in supervision?
   - Was the inmate on a mental health and/or medical caseload? If so, what was the frequency of contact between the inmate and mental health and/or medical personnel?
   - When was the inmate last seen by mental health and/or medical personnel?
   - Was there any reason to question the accuracy of the last reported observation by mental health and/or medical personnel?
   - If the inmate was not on a mental health and/or medical caseload, should he/she have been?
   - If the inmate was not on a suicide watch at the time of the incident, should he/she have been?

6. Intervention
   - Did the staff member(s) who discovered the inmate follow proper intervention procedures, i.e., surveyed the scene to ensure the emergency was genuine, called for backup support, ensured that medical personnel were immediately notified, and initiated standard first aid and/or CPR?

- Did the inmate's housing unit contain proper emergency equipment for correctional staff to effectively respond to a suicide attempt, i.e., first aid kit, gloves, pocket mask, mouth shield, or Ambu bag, and rescue tool (to quickly cut through fibrous material)?
- Were there any delays in either correctional or medical personnel immediately responding to the incident? Were medical personnel properly notified as to the nature of the emergency and did they respond with appropriate equipment? Was all the medical equipment working properly?

7. Reporting
   - Were all appropriate officials and personnel notified of the incident in a timely manner?
   - Were other notifications, including the inmate's family and appropriate outside authorities, made in a timely manner?
   - Did all staff who came into contact with the inmate prior to the incident submit a report and/or statement as to their full knowledge of the inmate and incident? Was there any reason to question the accuracy and/or completeness of any report and/or statement?

8. Follow-Up/Morbidity–Mortality Review
   - Were all affected staff and inmates offered critical incident stress debriefing following the incident?
   - Were there any other investigations conducted (or that should be authorized) into the incident that may be helpful to the morbidity–mortality review?
   - As a result of this review, were there any possible precipitating factors (i.e., circumstances which may have caused the victim to commit suicide) offered and discussed?
   - Were there any findings and/or recommendations from previous reviews of inmate suicides that are relevant to this morbidity–mortality review?
   - As a result of this review, what recommendations (if any) are necessary for revisions in policy, training, physical plant, medical or mental health services, and operational procedures to reduce the likelihood of future incidents?

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