IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

EDWARD BRAGGS, et al. Plaintiffs, v. JEFFERSON DUNN, in his official capacity as Commissioner of the Alabama Department of Corrections, et al. Defendants.	)	CIVIL ACTION NO. 2:14-cv-00601-MHT-GMB Judge Myron H. Thompson

NOTICE OF FILING OF SUICIDE PREVENTION ASSESSMENT REPORTS

Pursuant to the Parties' Agreement Regarding Process for Assessing Suicide Prevention (see Doc. 2014), Plaintiffs hereby provide notice of the filing of:

1) Report and Recommendations of Kathryn Burns, MD, MPH and Mary Perrien, PhD on Suicide Prevention in the Alabama Department of Corrections (Exhibit 1);

2) An appendix to the report, summarizing reviews of the 13 prisoners that committed suicide in Calendar Year 2018 through February 2019 (Exhibit 2);

3) A sample referral form (Exhibit 3); and

4) Supplemental Recommendations of Mary Perrien, PhD on Suicide Prevention in the Alabama Department of Corrections (Exhibit 4).

Defendants have confirmed that they do not believe any aspect of the documents provided by Drs. Burns and Perrien require redaction.

Dated: March 8, 2019

Respectfully Submitted,

/s/ Maria V. Morris

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I hereby certify that I have on this 8th day of March, 2019 electronically filed the foregoing with the clerk of court by using the CM/ECF system, which will send a notice of electronic filing to the following:

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IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

BRAGGS, et al., Case No. 2:14-cv-00601-MHT-GMB

v

JEFFERSON DUNN, et al.

REPORT and RECOMMENDATIONS OF KATHRYN BURNS, MD, MPH AND MARY PERRIEN, PhD on SUICIDE PREVENTION in the ALABAMA DEPARTMENT OF CORRECTIONS

March 8, 2019

In September 2018, we, Dr. Mary Perrien and Dr. Kathryn Burns, accepted an assignment to "assess Alabama Department of Corrections (ADOC) facilities and operations related to suicide prevention and provide a report with recommendations to resolve the constitutional violation determined by the Court in the Liability Opinion and Order as to Phase 2A Eighth Amendment Claim." (Joint Notice, Doc. 2014)

On September 28, 2018, we submitted our initial request for documents related to suicide watch and suicide prevention including policies, procedures and forms; count and location of suicide watch cells by major facility as well as approved overflow cells, if any; training materials; documentation related to placement, assessment, monitoring and treatment of inmates on watch; medical records of prisoners that completed suicide or made serious suicide attempts; and documentation reflecting any continuous quality improvement process or results related to suicide watch or suicide prevention, including documentation related to monitoring compliance with the terms of the Interim Agreement Regarding Suicide Prevention Measures (Doc. 11002-1). We received a large number of electronic documents that were poorly labeled without any accompanying narrative.

We made a second document request in mid-November requesting information be sent organized into folders and labeled with prisoner's name in the case of medical records or with the number of the request to which the information was responsive. Subsequent documents were somewhat better organized and labeled. We made additional document requests related to inmate suicides and continued to receive monthly generated logs and reports as well as documents responsive to earlier requests into early March, including the week this report was

due. Documents received March 5, 2019 included some documents related to a self-auditing process that started in February 2019. As such, there was insufficient sample size and audits on which to draw conclusions. However, as noted in prior discussions and testimony, issues remain with respect to the type of items audited (presence or absence of documents rather than any measure of quality, completeness or accuracy), items containing multiple components making the response unclear in terms of which portion of the item it pertains. It also appeared that ADOC developed an audit instrument as well, separate from that in use by the vendor. We recommend the vendor and ADOC headquarters staff jointly develop the audit instrument so that both parties are clear on expectations, prioritize important measures and include some assessment of quality, not just quantity.

Documents received March 6, 2019 included a 2-page document labeled "Suicide Attempts" that appeared to have been generated at Tutwiler Correctional Institution because the four individuals listed are confined there. Two of the four individuals were housed in segregation at the time of the suicide attempt; none of the attempts were lethal and all of the individuals were assigned to the stabilization unit following the incidents. The types of self-injury and dates of the self-injury are not included in the document, nor is any narrative explaining what this document is, who prepared it and why. We received no similar type of information from any of the other institutions.

Documents produced throughout this process were frequently poorly labeled with no accompanying description of why a particular document was provided or to which request it pertained; multiple files were identified only with Bates numbers and may have been inmate

records, monthly reports, crisis logs, training materials or any one of several other materials requested. In other words, production was poorly organized which we believe reflects a similar lack of organization and consistency across institutions that must be corrected to implement a suicide prevention program that provides clear instruction, clear expectations and consistent performance with standardization across facilities.

In addition to reviewing documents, we conducted tours at Kilby Correctional Facility, Holman Correctional Facility, Easterling Correctional Facility and Donaldson Correctional Facility in early January,2019. At those facilities we viewed suicide watch observation cells, mental health treatment space, medical units and segregation units inasmuch as the overwhelming majority of suicides occur in segregation or segregation-like settings. In the course of this project, ADOC adopted the terminology of "restrictive housing" in place of "segregation." In general, as well as specifically for this report, the terms "segregation" and "restrictive housing" are used interchangeably and refer to the exact same type of prison housing unit.

During tours, we interviewed Wexford mental health program managers, at times the site manager was present, and Alabama Department of Corrections (ADOC) management staff (e.g., Wardens, captains, lieutenants) about various aspects of the interim order and suicide prevention in general. We also interviewed prisoners and reviewed their medical records on site.

We have used the 2018 National Commission on Correctional Health Care (NCCHC) Suicide Prevention and Intervention Standard (P-B-05) as the guiding principal around which we

organized our findings and recommendations in the report that follows. The NCCHC considers suicide prevention as essential given its vital importance in preserving prisoner lives.

The NCCHC Suicide Prevention and Intervention standard: "Suicides are prevented when possible by implementing prevention efforts and intervention."

The key components of a suicide prevention program include the following:

Training. 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 annual training is provided.

Identification. The receiving screening form contains observation and interview items related to potential suicide risk. If a staff member identifies someone who is potentially suicidal, the inmate is placed on suicide precautions, and is referred immediately to mental health staff.

Referral. There are procedures for referring potentially suicidal inmates and those who have attempted suicide to qualified mental health professionals or facilities. The procedures specify a time frame for response to the referral.

Evaluation. An evaluation, conducted by a qualified mental health professional, determines the level of suicide risk, level of supervision needed, and need for transfer to an inpatient mental health facility or program. Patients are reassessed regularly to identify any change in condition indicating a need for a change in supervision level or required transfer or commitment. The evaluation includes procedures for periodic follow-up assessment after the individuals discharge from suicide precautions.

Treatment. Strategies and services to address the underlying reasons (e.g., depression, auditory commands) for the inmate's suicidal ideation are to be considered. The strategies

include treatment needs when the patient is at heightened risk for suicide as well as follow-up treatment interventions and monitoring strategies to reduce the likelihood of relapse.

Housing. Unless constant supervision is maintained, a suicidal inmate is not isolated but is housed in the general population, mental health unit or medical infirmary and located in close proximity to staff. All cells or rooms housing suicidal inmates are as suicide-resistant as possible (e.g., without protrusions that would enable hanging.)

Monitoring. There are procedures for monitoring an inmate identified as nonacutely suicidal. Unpredictable, documented supervision is maintained, with irregular intervals no more than 15 minutes apart. Although several protocols exist for monitoring suicidal inmates, when an acutely suicidal inmate is housed alone in a room, continuous monitoring by staff should be maintained. Other supervision aids (e.g., closed circuit television, inmate companions or watchers) can supplement, but never substitute for, direct staff monitoring.

Communication. Procedures for communication between mental health, medical and correctional personnel regarding inmate status are in place to provide clear and current information. These procedures include communication between transferring authorities (e.g., county facility, medical/psychiatric facility) and facility correctional personnel.

Intervention. There are procedure addressing how to handle a suicide attempt in progress, including appropriate first aid measures.

Notification. Procedures state when correctional administrators, outside authorities, and family members are notified or attempted or completed suicides.

Reporting. Procedures for documenting the identification and monitoring or potential or attempted suicides are detailed, as are procedures for reporting a completed suicide.

Review. There are procedures for mental health, medical and administrative review, including a psychological autopsy, for completed suicides. (NCCHC references the "Procedure in the Event of an Inmate Death" for details and definitions of clinical mortality review, administrative review and psychological autopsy. This information is incorporated into the Review section of this report.)

Debriefing. There are procedures for offering timely debriefing to all affected personnel and inmates. Debriefing is a process whereby individuals are given an opportunity to express their thoughts and feelings about an incident (e.g., suicide or attempt), develop an understanding of stress symptoms resulting from the incident, and develop ways to deal with those symptoms. Debriefing can be done by an in-house response team or outside consultants prepared to handle these highly stressful situations. When debriefing has been properly conducted, the rate of PTSD and other negative outcomes related to the suicide are significantly reduced.

Each of these 13 key components is discussed separately in the report that follows. Note that some discussions are broader than the name implied and defined by the NCCHC due to identified deficits. For example, our training discussion also includes recommendations for credentialing qualified mental health professionals (QMHP)[1] to conduct comprehensive initial and follow-up suicide risk assessments in addition to the more general training for all staff in recognizing verbal and behavioral cues indicating suicide potential. In the case of housing, the NCCHC definition discusses inmate location and suicide-resistant cells but our discussion will also incorporate the general environment and conditions of confinement including meals,

[1] QMHPs are defined as independently licensed clinicians; license mental health professionals that would be eligible to be credentialed initially to conduct comprehensive initial and follow-up suicide risk assessments include: LMSW, LISW, LPC, LPCS, in addition to CRNP, licensed psychologists and psychiatrists. The following are not eligible for this credential or to conduct these tasks: LBSW, ALC, LMFT. Any additional licensed professionals should first meet ADOC approval and then be reviewed for appropriateness by the court's external monitor. After 18 months of this process being implemented and existing staff achieving credentialed status, ALCs may be considered for credentialing with approval of the court-appointed monitor.

footwear, basic human hygiene items and a schedule and recommendations for cleaning safe cells based upon our observations on tours. There are other components in the report that are also more expansive than the NCCHC definitions as will be seen in the component discussions that follow.

A concise table summarizing reviews of the 13 prisoners that committed suicide in calendar year 2018 through February 2019 is appended to this report. Eleven of the prisoners were housed in segregation or segregation-like settings (e.g., death row or holding cells with limited out of cell time) at the time of their suicides, which exemplifies the harmful psychological effects of restrictive housing recognized by both the mental health and correctional communities. One prisoner was reported as being in general population housing, although recently released from segregation, and one man was in a Residential Treatment Unit (RTU) on a wait list for transfer to a stabilization unit at the time of his death. All of the completed suicides were men. As can be seen in the appendix as well as in findings and recommendations made in this report, there are very serious delays in the response time of custody and medical staff to begin CPR, first aid or to take other life-saving actions (such as cutting down an inmate discovered hanging and removing the noose from around his neck). Delays of 10 minutes or more to respond and take action were not uncommon in the cases reviewed and that is simply far too long for preservation of life. Perhaps even more disturbing than delayed response to suicide attempts in progress, was the lack of any documentation that ADOC or the vendor identified this very serious problem or took any steps to address it. Our

report contains recommendations for training, interventions in the event of a suicide in progress, documentation (reporting) and reviews to address this unacceptable problem.

In closing, we viewed our assignment as a call to assess and make recommendations for a comprehensive suicide prevention program overhaul within ADOC. In the midst of our project, an emergency suicide prevention motion was filed in January. In our view, the proposed emergency motion differs from our assignment in that it is designed to offer immediate relief while our recommendations will take a substantial period of time to implement fully. With that understanding, we are filing a supplemental document with recommendations for immediate implementation while our recommendations for a broader, more comprehensive program are being implemented. We also propose that if the parties accept our report and recommendations that we meet with them and the vendor to develop a plan together which prioritizes recommendations and sets a timeline for complete implementation of this comprehensive suicide prevention program.

TRAINING

Components: Several types of training are required based on staffs' role in the prevention of suicide:

- general training for all staff with inmate contact;
- training specific to medical and mental health staff;
- current emergency response plan (P-D-07, MH-A-07) that includes "man-down drills" for self-injury/suicide scenarios;
- training for mental health staff credentialed to conduct suicide risk assessments and level of watch determinations;
- inmate orientation.

Assessment:

A. It was unclear if the training materials provided to us were utilized in training for all facility staff who have any contact with inmates.

B. There was no evidence of regular emergency response drills.

C. Wexford staff reported during site visits that they had begun working and seeing inmates prior to receiving interim-agreement required training on completing suicide risk assessments, observation levels, the purpose of observation as well as what to monitor during observation.

    - In addition, it was reported that at least during the period between Dr. Woodley and Dr. Adams, this was provided by a non-clinical Wexford manager when the training was finally provided. The information provided to us by facility program managers was later contradicted by information provided in an unsourced document entitled "Responses to Questions and Document Requests Dated January 17, 2019" (Suicide Prevention Assessment Documents, file 2/28/19) in a section apparently attributed to Wexford. That same document indicated that documentation was maintained by Wexford regional office regarding who had taken the training, but not who had provided the training.
    - During site visits observers were also seen to be seated far removed from the crisis cell, further obscuring their view into the cell and of the inmate. This occurred even though the door and food/cuff port were closed and there was no apparent risk to the observer.

D. Vendor training materials were not consistent with terminology used by the ADOC (e.g., Level I and II watch instead of acute and non-acute watch).

E. Vendor suicide detection, prevention, and intervention training contains information that is not consistent with the most current statistics on correctional suicide. This information was not cited so it could not be determined if this was because it was data from a particular jail or prison while not reflective of national prison suicide data.

F. Additional training materials received 2/13/19 included two power point presentations: a brief training entitled "Specialized Suicide Prevention Training" (SPA_11507-SPA_11535) and a longer training labeled "Woodley Suicide Risk Assessment Training (MHM) (SPA_12930-SPA-13070). There was no accompanying narrative to explain how these trainings were or are used. Some of the content in the "Woodley Suicide Risk Assessment Training (MHM)" indicated that this training was used to train mental health professionals to perform risk assessments. However, neither training included any class activities such as discussion of scenarios, correlating risk level with suicide watch level nor was there any mention that the training included observation of suicide risk assessments or clinical supervision and credentialing.

G. None of the training materials provided had been approved by Plaintiffs' experts as required by the Interim Agreement Regarding Suicide Prevention Measures. (Doc 1102-01)

Recommendations:

A. All facility staff who may have inmate contact should receive pre-service and annual training in suicide prevention to recognize verbal and behavioral cues that indicate potential suicide and how to respond appropriately to those indicators. While biennial training is a minimum standard, given the ADOC history of suicide and serious suicide attempts, we *strongly* recommend annual training for all facility staff as well as annual training in CPR and first aid.
    - Ideally, the suicide prevention training would be provided concurrently with the general mental health training, but would not have to occur at the same time as CPR certification training.

B. Suicide prevention trainers should be QMHPs at minimum.
    - Because of their role in assessing risk of self-harm, determination of watch level, discharge from watch, and role in interacting with security and medical staff, we recommend that approved trainers for suicide prevention include at least one mental health treatment provider so that participant questions can be appropriately answered. The ADOC may wish to include a certified custody instructor with the mental health provider.
        - Further, we recommend that each trainer, custody and mental health, first be required to complete a "train the trainer" program to become "certified" prior to providing any mental health training including suicide prevention.

- To facilitate pre-service training, a trainer may be designated at each facility. We would recommend that the standards outlined above apply to designated facility trainers as well.

C. As part of ongoing training and emergency preparedness, each ADOC facility should implement quarterly emergency drills on each watch that include self-injury/suicide scenarios as a part of those drills. These should be tracked as part of the training and continuous quality improvement process by ADOC custody and healthcare management as well as vendor management.

D. Wexford clinical staff (QMHPs, psychologists, psychiatrists, and CRNPs) should be trained prior to assessing inmates. We recommend the use of a **mentoring model** for a credentialing or certification process. The specifics of the model should be approved by the court-appointed monitor (or plaintiffs' and defendants' experts prior to such a monitor) but would generally follow a model of the provider observing a credentialed provider conducting a suicide risk assessment initial or discharge interview on three separate occasions, conducting such an interview under supervision on three separate occasions, and submitting three completed suicide risk assessments for clinical review and approval. This provider would be considered credentialed and allowed to independently complete suicide risk assessments once all steps had been completed. This training should be repeated every two years though providers could be referred back to the mentoring program for remedial training by their supervisor as needed. This credentialing/certification model would replace the current process of consultation outlined in the interim agreement.[2]

- Clinical staff should receive training in safety planning (see Treatment for further details)
- Observers should also receive training prior to conducting any suicide watch. This training should address where the observer is expected to stand and sit during an active observation session.
- Until the mentoring model has been fully implemented, non-credentialed mental health staff should adhere to the process outlined in the "interim agreement regarding suicide prevention" (filed 1/12/2017).

E. ADOC and the agreed-upon monitor or Plaintiffs' experts should approve all vendor training materials. Those training materials should be consistent with ADOC administrative directives, policies, memoranda, and court orders. Training materials should reinforce that there are only two acceptable levels of observation for an inmate at risk of self-injury: acute and non-acute watch. Mental health observation should be reserved for inmates not at risk of harming themselves but who require monitoring for

[2] ADOC may consider developing a similar type credentialing and certification process to include Associate Licensed Counselors (ALC) after 18 months of successful implementation of the suicide prevention program with credentialed QMHPs.

other reasons (e.g., pending transfer to a higher level of care, during medication changes).

- Ensure that training for observers includes areas that are of most concern for them such as what to specifically watch for during their shift, how to access custody staff if an inmate begins to self-injure, how to properly monitor during toileting, addressing conflicts with custody, how to handle difficult inmate behaviors such as intentional genital exposure, requesting a break, and similar.
- Because there are physical plant differences as well as staffing differences between facilities – Kilby O dorm has officers assigned to the unit while Holman does not – the standard observer training should have facility-specific addendums for observers that address at minimum: accessing assistance in the midst of an emergency, accessing backup/relief for observer breaks (particularly between the hours of 2000-0600), and accessing supervisory staff during non-typical work hours.

F. Vendor training should be updated for consistency with evidence on national prison suicide. When possible, statistics from ADOC should be used to supplement that information to assist all staff in understanding the population that they are working with and treating. If necessary, a national correctional suicide expert (e.g., Lindsay Hayes) should be considered as a resource to review vendor materials.
    - As possible training material options, ADOC and vendor may wish to consider:
        - The Training Curriculum and Program Guide on Suicide Detection and Prevention in Jail and Prison Facilities by the National Center on Institutions and Alternatives. It is a complete and comprehensive training ready to be delivered. It is available at http://www.ncianet.org. That training can be purchased for $225, comes with a complete PowerPoint presentation and instructor binder (Training Curriculum and Program Guide on Suicide Detection and Prevention in Jail and Prison Facilities).

        - Another is a resource package available on nicic.org (https://nicic.gov/library/package/suicide) that provides multiple training materials and a complete eight-hour training curriculum, copyrighted by the Tennessee Department of Corrections. Use of these materials would require ADOC obtain copyright permission from Tennessee Department of Corrections and then tailor the training package for ADOC staff.

G. Prisoners received into ADOC must receive information during inmate orientation regarding mental illness, suicide risk and how to ask for help for themselves and/or to let staff know about concerns for any of their peers. Facility specific information must also be provided when prisoners are transferred from one institution to another within ADOC.

IDENTIFICATION

Components: Identification is done primarily through screenings, referrals and whenever mental health have a clinical contact with prisoners. This includes receiving intake screenings; screenings conducted when inmates transfer between institutions; staff referrals; inmate self-referrals; pre-placement screening for restrictive housing; restrictive housing rounds and all mental health clinical contacts.

The intake and referral practices described in the "Intake Order" (Docs. 1794, 1794-1), the "SMI and Coding Order" (Docs. 1792, 1792-1), and "Referral Order" (Docs. 1821, 1821-1 and 1821-2) address the screening and referral components related to identification. The "Segregation Order" (Docs. 1815, 1815-1), described processes related to identification when prisoners enter and remain in segregation/restrictive housing. These include pre-placement screening, rounds and periodic evaluations.

Assessment:

A. For the most part, the intake process at reception is in place and appears to be effective in identification of inmates entering the system at risk for suicide.

B. The referral process is discussed in the next suicide prevention component: Referral.

C. With regard to restrictive housing unit (RHU) procedures, a review of documents and observations during site visits raise concern that the practices of pre-placement screening, rounds and periodic evaluations are not being consistently implemented, documented nor well-understood in terms of their purpose. No instances of prisoners being diverted from RHU or placed on watch as a result of pre-placement screening were found despite multiple subsequent placements on suicide watch and mental health observation from RHU.
    - Mental health rounds appear to be brief and ineffective in terms of identifying prisoners needing follow-up. Many documents indicate that mental health staff misunderstand the initial segregation mental health evaluation, instead thinking it to be an assessment of the prisoner's capacity to participate in disciplinary proceedings. Mental health evaluations conducted at later intervals have infrequently recommended a prisoner's removal from segregation though it was not possible from the records provided to determine whether the recommendation was implemented. From the records reviewed, there were no instances in which mental health treatment interventions were increased in terms of frequency, duration, or type of contact when prisoners were placed or maintained in segregation.

D. Prisoners removed from segregation for suicide watches are returned to segregation, regardless of their continued level of risk of self-harm. Based on the information provided to us for the completed suicides from 2018 and February 2019, 11 of the 13

completed suicides occurred in segregated or segregation-like housing, the area of highest risk for suicide in correctional facilities.

Recommendations:

A. We recommend training for the nursing staff completing pre-placement screenings. While the forms indicate when crisis watch should be considered, training should provide greater detail about indicators to look for as well as include how to place someone on immediate watch after hours and how to initiate an emergent referral.

B. Monitor and track completion of pre-segregation screening forms and diversion from RHU as well as placement on suicide watch.

C. Provide additional training to QMHPs regarding the purpose of the initial and subsequent mental health evaluations in restricted housing.

D. Provide training to QMHPs on the purpose and proper procedure for conducting adequate restricted housing rounds. We recommend that this training include not only didactic materials but that QMHPs be required to job "shadow" or observe a more senior QMHP for one week prior to conducting such rounds independently.

REFERRAL

Components: This is related to identification as noted and includes staff referral process (administration, officers, medical and other institutional staff) and inmate self-referral. It also includes referrals at potentially high risk times such as following prisoner returns from being out to court, post parole board hearings and parole violators being returned to prison.

Assessment:

A. There were concerns noted with inmates interviewed not believing that they could report suicidal ideation to officers for fear of punishment or because officers would not provide them with access to medical or mental health staff for appropriate care post-self-injury. There were repeated examples of custody staff intrusions into the provision of mental health contacts through their presence during clinical encounters and pressure on clinical staff that minimized inmate concerns and reports of suicidality. This information was provided by inmates and staff as well as observed during the site visits.

B. There are currently procedures in place for staff and self-referrals, but they require improvement. The staff referral form (ADOC MH-008, 2005; found in file entitled "MH Forms," SPA 0001-0075) calls for the non-mental health staff person making the referral to do an overly-invasive questioning assessment rather than to providing observational information and also contains non-mental health information.

C. The facilities that we visited had some form of written self-referral system, though we observed some difficulties with compliance with that process. There did appear to be some confusion regarding staffs' responsibilities when inmates requested mental health services and needed those services on a more urgent basis. For example, a female inmate who had attempted to hang herself (11/28/18) and was found unconscious had previously requested to see mental health via custody staff. According to documentation, custody did not contact mental health with her request and she was later found hanging unconscious.

Recommendations:

A. Correctional line, supervisory, and management staff should receive focused suicide prevention training with emphasis on their role in the *referral* process and the role of mental health staff in the *evaluation* of risk.

B. Correctional staff should not triage inmate requests or engage in behaviors that discourage information sharing.

C. Revise the current written staff referral form to include observational data (see example provided from New York Department of Corrections). The referral form should also

include a portion to be completed by mental health staff that includes when the inmate was seen and by whom with an associated progress note filed in the medical record on that date.

D. Mental health clinical contacts should be confidential without the presence of custody staff unless there is a significant security reason as determined by the clinician.

E. Clinicians should receive refresher training with emphasis on the importance of correctional risk factors such as safety concerns and recent disciplinary actions. While there are inmates who may attempt to utilize suicide watch for some secondary gain, the fact that those same factors can elevate actual risk is the reason a thorough clinical evaluation must occur.

F. Mental health should utilize the ADOC MH-009 tracking log or similar to track inmate self-referrals and compliance with emergent, urgent, and routine referrals. In addition, we recommend that progress notes document the reason for contract was due to referral to allow for verification in the continuous quality improvement and peer review processes.

EVALUATION

Components: Includes the mental health evaluations and standardized suicide risk assessments conducted by psychiatry, mental health nurse practitioners, psychologists and independently licensed mental health practitioners that have been credentialed to do so.

Assessment:

A. There are standardized forms for initial and subsequent risk assessments.

B. There were multiple examples of inmates displaying very high numbers of risk factors but then being placed on a low level of watch. Staff reported during interviews that at times they determined the level of suicide watch based on the availability of observers rather than the level of risk assessed.

C. Currently, prisoners are re-evaluated at intervals to assess the degree of risk they present but even when the level of risk is assessed as having been reduced, they receive no additional property or privileges.

D. Mental health observation (MHO) is being used at many institutions as a level of watch in suicide prevention though it is not part of the Interim order, suicide prevention policy (AR 629), or mental health watch policy (AR 630) – nor should it.

Recommendations:

A. QMHPs conducting these suicide risk assessments must undergo training to be credentialed to do so. The credentialing process is outlined in the Training component section of this report (see Component 1: Training).
    - Clinicians should receive refresher training with emphasis on the importance of correctional risk factors such as safety concerns and recent disciplinary actions. While some inmates may attempt to utilize suicide watch for secondary gain, the fact that those same factors can elevate actual risk is the reason a thorough clinical evaluation must occur.
    - The level of watch must be based on the level of risk.

B. Evaluations must be conducted by a credentialed QMHP and take place in person, out of cell and in a place offering sound confidentiality. The credentialing process includes observation of assessments, being observed conducting assessments and clinical review/supervision of assessments conducted without observation.

C. As part of clinical supervision and the quality assurance/continuous quality improvement and peer review processes, watch placement should be monitored to ensure that inmates' level of risk is consistent with the level of watch ordered, property

and conditions permitted and frequency and types of subsequent contacts. The level of watch (acute or non-acute) should correlate closely with the degree of risk presented; the higher the risk, the higher the level of observation and intensity of treatment provided.

D. Eliminate MHO as part of the suicide prevention program (See Monitoring component *infra*.) Mental Health Program Managers should monitor the crisis utilization log and QMHPs' placement of inmates on watch to ensure that inmates at risk of self-injury are not placed on MHO.

TREATMENT

Components: Mental health treatment before, during and after suicide watch placement. Rounds and cell front contacts are not treatment per se. Treatment may be individual or group clinical contacts which take place out of cell in an area that affords sound privacy.

Assessment:

A. Treatment is occurring at cell front in many situations.

B. There is a requirement for treatment planning. Documentation of these plans reveals them to be generic rather than individualized with no objectively quantifiable measures to assess goal attainment.

C. Although follow-up assessments are to be completed in accordance with clinical judgment, we didn't see clinical judgment exercised; follow-up assessments are completed at the minimal intervals dictated by the interim order rather than based on clinical need. Inmates sent to Kilby for suicide watch are maintained at Kilby following watch discontinuation until after the 7-day follow-up and then transferred back to their sending institution. This created an additional transition and stressor during a high risk time for the inmate. Consequently, the "clock" setting minimum intervals for follow-up should be re-set upon their transfer to the sending institution to fulfill the original intention to provide support and assistance during this transition time.

D. No treatment other than individual MHP contacts, and perhaps a psychotropic medication consult (which will yield results in 4-6 weeks) appear to be occurring during crisis watch. MHP contacts are brief, occur mainly at cell front offering no sound privacy and thus, do not actually represent treatment.

E. It was not clear from the records observed that recent suicide watches were addressed in treatment planning and mental health follow-up upon watch discontinuation. It was also unclear when inmates had actually been placed on the caseload or if they were receiving services while not formally placed on the caseload. In at least one case that resulted in suicide, the inmate was seen on 8/22/18, 9/4/18, 9/19/18, 10/10/18 while another three scheduled appointments in November and one in December were canceled due to space and security staff shortage but the inmate was never formally placed on the mental health caseload. This individual had been receiving "mental health follow-ups due to reported depression."

F. There are a number of suicide watch placements and continuations due to prisoners' legitimate concerns about their safety in general population and the extremely limited or lack of any protective custody placement or status in ADOC. At most facilities, staff reported to us that they have no real options to address inmates with genuine safety concerns. Inmates repeatedly reported to us that they have been pressured by custody

to return to housing units where they have been threatened, pressured, and attacked. Mental health staff reported multiple watch episodes where inmates later recanted suicidality but stated that they needed housing changes because they were fearful and could not get custody staff to address their genuine safety concerns. In one case, the inmate we interviewed had clear bruises and cuts and we requested medical attention for him. We were told he was later sent out from the facility to receive medical care not available at the facility. There was at least one other inmate interviewed with a similar story and observable injuries though not as severe.

Recommendations:

A. Mental health staff must receive training in developing and implementing safety plans for prisoners at risk of suicide that address both short and long term individualized interventions. Suicide "safety contracts" have little to no clinical utility in this environment and should rarely, if ever, be used.

B. Individual counseling and group treatment should occur out-of-cell in a place that affords sound privacy and is focused on addressing the dynamic risk factors that were identified during the suicide risk assessment(s).

C. After completing the minimum follow-up assessments conducted through transitions[3] from being on watch to being off watch, subsequent follow-up intervals must be based on an assessment of clinical condition and not dictated by minimum contact intervals recommended for outpatient services (e.g., every 60 or 90 days). Treatment post-suicide crisis must occur more frequently (e.g., weekly) until the crisis has resolved and the inmate has stabilized.

    - We recommend that upon release from suicide watch, each person will have at least four standard follow-up examinations by mental health. The first three follow-up examinations will occur upon release from watch and upon return to the sending facility or expected housing; these examinations will occur on the three consecutive days upon release. The fourth follow-up examination will occur on the tenth day following release from watch. If the inmate is placed in temporary housing (e.g., housed at Kilby for days one through three post-watch and then moved to the sending facility; moved to SLU for days one through three post-watch then moved to RHU), that will be noted as a significant post-watch transition impacting the inmate's post-watch adjustment and risk level, requiring the post-watch follow-up examination schedule to be reset; another round of the four follow-up examinations will take place starting the day following movement.

[3] Transitions include movement from one level of care to another, such as being taken off watch, but also any changes in bed/housing assignment within or between prisons.

- We recommend that inmates who are determined to have been suicidal, engaged in a suicidal gesture, or demonstrated self-injurious behavior be placed on the mental health caseload and monitored in accordance with the degree of suicide risk. The behavior should be addressed in the treatment plan and specify the frequency of contacts with a clinical rationale.

D. Policy and procedure must include requirements for referrals to higher levels of care for prisoners remaining on watch status for extended periods. We recommend compliance with existing policy requiring inmates on watch for 72 hours be considered for referral to higher levels of care. If not referred, the clinical rationale should be documented in the medical chart, at minimum, and tracked in the crisis utilization log or similar. If the inmate remains on watch for 168 hours, the treatment team should meet to review a referral to a higher level of care. If the inmate is not referred to a higher level of care, the rationale should be documented in the medical chart, at minimum, and tracked in the crisis utilization log. If the inmate remains on watch for 240 hours or longer, referral to a higher level of care shall occur with notification of referral to OHS and vendor regional mental health management. In addition, inmates who are returned to watch status within 30 days of release from a watch and/or who have three watch placements within six months shall be referred to a higher level of care; OHS should be immediately notified of any inmates who meet these criteria but are not referred and provided with the clinical rationale.

E. We recommend a multi-pronged approach to RHU inmates who have been placed on suicide watch. Inmates who have been placed on watch should be evaluated not only for suicide risk, but also re-evaluated for the presence of a serious mental illness. If found to have a SMI, they should be evaluated for referral to a higher level of care (RTU or SU). If not referred to RTU or SU, the clinical rationale should be documented in the medical record and the inmate transferred on an expedited basis to a SLU. If the inmate is not on the mental health caseload but is determined to be at or above moderate acute or chronic risk of self-harm, the inmate should be placed on the mental health caseload to provide increased clinical monitoring and intervention. Finally, we recommend the ADOC consider a stepdown program for inmates determined to have moderate acute risk until they can be stabilized so that their acute risk level is low.

F. Inmates who remain on a suicide watch for 120 hours or more should be placed on the mental health caseload to allow for enhanced monitoring and clinical interventions. The inmate may be removed from the caseload once there have been 120 days in general population, outpatient level of care without a crisis placement if there is no SMI and chronic and acute risk levels are determined to be low.

HOUSING

Components: Suicide-resistant safe cells. Cells offering clear visibility into all areas of the cell, furnishings and architecture which do not provide any protrusions or structures that would permit a place to tie-off material used to create a noose.

Housing also includes consideration of other physical conditions such as ambient temperature, blankets, smocks, beds, mattresses, personal hygiene items, underwear, footwear, meals including access to fluids in addition to water from the sink at mealtimes.

Assessment:

A. Crisis cells varied in the type of door, combination (combi toilet/sink) units, lighting, venting, window grating, floor tile, sprinkler, beds, and electrical outlet covers that existed. Some of these cells had greater environmental risks while others had greater health hazards (e.g., more difficult to maintain cleanliness between inmates).

B. The operation of the crisis cell varied across facilities. For example, one facility may allow low lighting at night for an inmate on acute watch to sleep while still being monitored while another facility may require lights to be fully lit at all times even when an inmate was on mental health observation.

C. The facilities were not consistent in maintaining appropriate health and safety standards. Most facilities visited did not allow the inmate to keep his own shower slides or other footwear near the crisis cell, forcing inmates to walk barefoot around a housing unit or throughout the prison (i.e., Holman) or to share shower shoes for appointments and showers. This is clearly unacceptable and presents a health and safety risk. In addition, inmates were only allowed to brush their teeth when showering, at most every other day.

D. The meals provided to all inmates on watch of any type, regardless of risk assessment, were sack meals consisting of the same meal for all three daily meals – two peanut butter (PB) sandwiches in some facilities and in others two biscuits with egg for breakfast and the PB sandwiches for lunch and dinner. In all facilities visited, only two of these same "meals" were provided on Sundays. There was no variation and this exact same meal was served at every mealtime irrespective of the duration of the watch. This practice is not nutritionally sound and appeared punitive.

Recommendations:

A. We recommend that the ADOC establish comprehensive and specific policy guidelines for what constitutes a "suicide resistant" cell. These policy guidelines should be approved by

the court monitor or plaintiffs' and ADOC experts and include doors, electrical outlets, combi (toilet/sink) units, windows, ceiling grates, sprinklers, and beds. Policy should require every facility come into compliance with the appropriate number of suicide resistant cells for each facility.

- This should be regularly verified by facility management and headquarters operational management staff with quarterly physical inspections.
- Establish a hierarchy of less preferred but acceptable areas/cells that an inmate may be temporarily placed into when no crisis cell is available immediately. Inmates must receive constant observation when placed in these alternative cells.
- Some factors to consider in standardized suicide resistant cells:
    - Vents, ducts, and light fixtures should be free from protrusions and covered so that the covers are flush with the wall. Covers or screens should have holes that are ideally 1/8 inches wide but no more than 3/16 inches wide or 16-mesh per square inch (e.g., http://www.capecodsystemscompany.com/store/-ccs_seg-4p3,Product.asp; http://www.securinghospitals.com/shopexd.asp?id=33143).
    - Beds should be made of heavy molded plastic or single poured concrete slabs with rounded corners. The plastic molded beds can be found online (e.g., http://www.furnitureconcepts.com ; http://besafeprod.com/product-catalog/furniture/item/suicide-resistant-attenda-floor-mount-bed).
    - Suicide resistant cells should have stainless steel toilet- sink combination units where the flushing mechanism is outside of the cell. The sink should have no accessories or anti-squirt slit (e.g., https://www.grainger.com/product/1JZL9&AL!2966!3!50916757677!!!g!82128209637!?gclid=CLWW8bqo1dQCFQJrfgodaV4CVQ&cm_mmc=PPC:+Google+PLA?campaignid=175663197&s_kwcid=AL!2966!3!50916757677!!!!82128209637!&ef_id=UpysegAAAWeOXgmK:20170624012052:s; http://www.capecodsystemscompany.com/store/ccs_wi1806,Product.asp).
    - If a cell is on CCTV, the camera should be anchored in a manner that does not allow it to be used for self-injury. It should not provide an anchoring point and have no sharp edges. It is also important that staff realize that cameras can only be used to *supplement* human observation, not *supplant* that observation.

B. ADOC should establish policy guidelines that include minimum property and personal hygiene standards at each level of watch. These should be approved by the court monitor or parties' experts. Inmates could be allowed to use flexible thumbprint, flexible finger or similar toothbrushes that can be returned after each use twice daily or No-Shank fingertip toothbrushes which are then maintained in individual Ziploc bags. Consideration needs to be given to shampoo, hair combs or brushes, hair grease, and lotion; feminine hygiene products must be available. ADOC should also maintain each

inmate's shower shoes or other footwear outside of the cell for movement outside of the cell and consider providing socks for inside of the cell.

- Cells must be terminally cleaned between inmate admissions; at minimum crisis cells should be pressure-washed from ceiling to floor on all walls and the interior of the cell door and allowed to dry thoroughly. Cleaning measures consistent with biohazard elimination/disposal must be adopted to address control of infectious diseases due to exposure to bodily fluids and fungal infections (tinea pedis).

C. A regular meal offering can be provided on a pressed cardboard tray with a thumb-handle mini spork or a paper eating utensil (e.g., eco security utensil) if the inmate has misused regular cutlery while on suicide watch. If sack lunches are necessary, they should be provided only for the period of time necessary to manage that level of extreme risk. A registered dietician should be enlisted to prepare a menu of meal items of appropriate nutritional content and variation for brief instances when sack lunches are necessary. The dietician can provide a menu list of multiple finger food items so that a variety of finger foods can be provided at each meal rather than the same two sandwiches for every meal, every day while on watch.

D. Inmates on crisis watch should be afforded all privileges (e.g., visits, phone calls, mail) they were receiving in the setting that they came from (e.g., population, RHU) unless there is a documented clinical reason to withhold a specific privilege. These three privileges, in particular, maintain stability in many inmates and form the basis of the protective factor of support when positive in nature.

MONITORING

Components: ADOC has determined there are two levels of suicide watch: acute suicide watch and non-acute suicide watch.

Acutely suicidal inmates are monitored by facility staff via constant observation.
Non-acutely suicidal inmates are monitored at unpredictable intervals with no more than 15 minutes between checks.

Mental Health Observation (MHO) is *NOT* a component of the suicide prevention program as clearly stated in ADOC AR 638; nor is MHO a "security" intervention or placement.

Assessment:

A. In none of the facilities visited were the "watchers" positioned appropriately to permit full visibility into the safe cells or constant visibility of the inmates being observed.

B. Observation intervals reviewed during the site visits indicated that there has been significant progress (at least in those 4 institutions) with respect to interval documentation being staggered, irregular and without times (or signatures) written in advance of the observation.

C. Mental health observation is not part of the suicide watch continuum. It is not part of the ADOC suicide prevention administrative regulation (AR) nor is it part of the mental health watch AR; it is a separate policy (AR 638) for use with non-suicidal inmates. It must be considered a separate entity which is initiated and continued for specific *mental health* reasons such as observations during psychotropic medication adjustments, closer observation required to monitor/assess changes in mental status, and housing for mental health prisoners awaiting transfer to a higher level of care (such as RTU or SLU placement). As stated in AR 638, it is not a form of punishment or protective custody. Because inmates on MHO are not at risk of harm to self or others, they do not require the same level of property restrictions and should be granted their own clothing and belongings unless there are strong clinical indications to justify any limited restriction which are clearly documented in the medical record. All of these levels of observation should be limited to the least amount of time necessary to achieve stabilization or transfer to the appropriate clinical setting.
Use of MHO as a proxy for suicide prevention is inappropriate. Neither placement nor discontinuation require an assessment of risk. In the case of the prisoner that committed suicide on 2/14/19, he was sad, depressed and hopeless but only placed on mental health observation. His level of risk was never assessed. He was released from MHO after three days - with no assessment of risk, and no documentation by the CRNP that released him. He was placed directly into segregation where his pre-placement screening also identified his depressive symptoms. He completed suicide by hanging within 12 hours of being sent to segregation. MHO is NOT a level of suicide watch and

must not be used as a substitute for conducting the necessary assessment(s). In this case, the use of MHO was inappropriate, discharge to segregation without a risk assessment was inappropriate and the failure to make an emergent mental health referral was inappropriate in light of his symptoms during the pre-placement screening process. (Note that an "urgent" mental health referral was made but that does not call for an immediate response.)

D. Record reviews and interviews conducted during the site visits suggested that there were times when inmates reported suicidality to staff and those inmates were left unattended while waiting to be seen by mental health staff. Those inmates were left in their cells or sent on their own to the mental or medical clinic.

Recommendations:

A. All facilities should immediately assess the equipment available to observers or "watchers" to ensure that they can easily observe the entirety of the crisis cell and inmate within the cell as they sit or stand throughout their shifts. Mental health administrators and supervisors should also regularly observe "watchers" and view the line of sight in order to correct any improper practices and ensure that prisoners on watch are being observed in accordance with acute and non-acute watch requirements.

B. All facilities should have their observation logs reviewed to ensure that the progress observed during the site visits extends beyond those facilities. This should also be a target of continuous quality improvement monitoring to maintain the progress and identify any deficiencies in the future.

C. Suicide Prevention Policy must make clear that there are only two (2) levels of observation and that mental health observation (MHO) is not an acceptable form of suicide watch; acute and non-acute watch are the only appropriate placements for inmates deemed at risk of suicide. We recommend the use of these terms on all forms including crisis cell utilization logs to maintain consistency and adherence to policy. For example, "precautions" should not be used on any forms. We also recommend review of the separate policy on Mental Health Observation and refresher training on that policy to include the procedure for placing an inmate on MHO, the specific circumstances under which it can be used, the property permitted for the inmate, the level of observation of the inmate, and the frequency of clinical contacts.

D. Inmates who have reported thoughts of suicidality to staff should be maintained under constant observation until they can be evaluated by a QMHP. This should not result in a delay accessing medical care when there has been an injury (e.g., cut to wrist leaving open, bleeding wound).

COMMUNICATION

Components: Procedures for communication between and among correctional staff, medical and mental health staff in a single institution as well as between institutions when prisoners are transferred.

Assessment:

A. There is a medical intra-system transfer form. Mental health staff at Kilby reported that they also called and/or emailed when an inmate was transferred back to the "home" facility. Holman mental health staff confirmed that they were either called or received an email.

B. There were also forms on crisis cell doors indicating what level of watch the inmate was on and the property allowed to assist in communication with custody.

C. Mental health staff reported that they were called when persons were put on watch on weekends or overnight when mental health staff were not on site. However, record review indicated that mental health staff (i.e., on-call or program manager) were not notified timely when a serious suicide attempt or suicide occurred.

D. It was unclear as to the degree of medical staff involvement for inmates on watch. Multiple inmates reported that they experienced difficulty accessing medical care while on watch status. While record review suggested that at least some inmates received pre-placement body scan charting, there was no documentation of regular nursing rounds beyond medication administration for those prescribed medication. While at Kilby, one inmate interviewed while on watch had clearly been assaulted but reported that he had not been seen by a physician. Following our request that he be seen by medical, we were informed that he was seen later that day and sent out for further treatment that could not be provided at the facility.

E. Based on staff interviews, crisis cells were tracked as segregation or restricted housing cells. This causes confusion amongst staff as to what status the inmates inside of these cells actually are (custody and security level). It may have been because of this that all crisis inmates interviewed were cuffed with belly chains and cuffed at the ankles even when they were not max custody status. Staff could not indicate why these inmates would be cuffed other than the classification of the cell

Recommendations:

A. Formalize the transfer communication process in policy/procedure to ensure all are handled in the same manner. When an inmate on suicide watch is transferred to another facility (inmates on some level of watch or MHO were frequently transferred to

make room for another inmate), staff at the sending facility should make telephone contact with mental health staff at the receiving facility and follow-up with an email. This contact should include a notification that the inmate is coming, expected arrival, and include a transfer progress note via email.

B. All inmates placed on watch should continue to have pre-placement body scans charted in their medical records. They should also receive medical screens within 24 hours of placement. While on crisis watch, medical staff should monitor the need for medical referral.

C. There must be an established method of communication at all facilities between the observer and custody so that when an inmate begins to self-harm while on watch the observer can immediately alert custody to initiate the emergency response.

D. Also recommend that crisis cells not be designated as segregation or restricted housing cells regardless of their location so that inmates in crisis cells are not routinely cuffed. Suicidal inmates should only be cuffed if their security level requires it. If they would not have been cuffed prior to being placed on suicide watch, they should not be cuffed while on suicide watch unless the inmate is engaging in serious disruptive and dangerous activity that makes it unsafe to bring the inmate out of cell without mechanical restraints.

E. Recommend a statewide database that exists in "real time" that is accessible from all facilities, ADOC headquarters, and vendor regional office. This statewide database should, at minimum, have inmate's basic demographic information, track an inmate's placement on watch from initiation to termination regardless of the change in level of watch (acute, nonacute) or housing, location prior to watch and discharge location[4], mental health code and SMI flag, level of care, follow-up compliance, date of readmission (to permit calculation of number of admissions, time between crisis watches, etc.)

[4] Location as used in this recommendation refers to a limited number of choices such as general population, restrictive housing, residential treatment unit, stabilization unit, structured living unit, medical hospitalization or psychiatric hospitalization, rather than an institution's specific dorm, bed assignment which would have no meaning to providers working in other institutions. There could also be an "other" location with a drop down to provide the location information. For example, in the unfortunate event of a completed suicide while on a watch status, the "other" narrative would be "death – completed suicide."

INTERVENTION

Components: This component includes clear procedures to be followed when an inmate is or has engage in self-harm and how to handle a suicide attempt in progress, including rendering immediate first aid. Medical must respond to the scene timely and function within their scope of practice. Neither correctional staff nor nursing staff should presume that an inmate is dead; nor shall a nurse pronounce an inmate dead and obstruct efforts to resuscitate the inmate.

Assessment:

A. Record review revealed that there were delays in responding and providing life-saving interventions in cases of apparent suicide. For example, in one case while it appeared that at least two security staff were on scene, no one began CPR until nursing staff arrived. On another occasion, nursing staff did not arrive on scene for 10 minutes during which no life-sustaining efforts were taken including in at least one case of leaving the inmate hanging for 30 minutes on the order of an LPN's determination that the inmate was dead (outside scope of practice).

Recommendations:

A. Policy and practice must be revised to include IMMEDIATE response as soon as two security staff are present. Preservation of life supersedes crime scene preservation and all inmates are considered to be rescuable unless a physician has declared them to be deceased. CPR should be immediately initiated while whatever method of suicide is eliminated.

B. As noted in the Training component, all shifts must conduct timed response drills quarterly.

C. Facilities should maintain easily accessible appropriate cut-down kits (not scissors) in housing units.

D. Medical at each facility should have a standard emergency response kit. This kit should include an AED and ambu bag.
    - ADOC may want to consider purchasing multiple AEDs to locate throughout the facility for rapid access in responding to staff and inmate emergencies.

E. We recommend moving inmates to medical area via gurney following suicide attempt for medical intervention. CPR should continue during transport. The medical area provides access to appropriate medical equipment and personnel as well as privacy.
    - Life-saving measures should not cease until a physician has declared death.
    - We strongly recommend that deceased inmates not be locked into cells but instead be moved to a private area. Moving inmates into a cell and leaving them

there for other inmates in the unit to see can have a chilling effect on the rest of the inmate population and their perception of the staff. Inmates frequently believe that the staff did little or nothing to safe an inmate and actions such as these serve to reinforce that perception. Beliefs such as that can destabilize the inmate population in a way that can create an unsafe environment for inmates and staff.

F. Every person (ADOC and contractors) witnessing or participating in the intervention must write an incident report from his/her individual perspective without prior to the end of their shift. These reports should be individualized and not the result of "group"

G. Medical staff must document in the medical record consistent with the standard of care: a timeline documenting when they were notified, when they responded, the examination/condition of the inmate, medical and other interventions provided and the inmate's response to the interventions.

NOTIFICATION

Components: Procedures state when correctional administrators, outside authorities and family members are notified of attempted or completed suicide.

Assessment:

A. No procedure could be identified in ADOC administrative regulations or provided policies for notification of next of kin in the case of suicide.

B. Inconsistent documentation in records reviewed of notice of family regarding deaths which does not necessarily reflect that notice was not given, only that documentation was inconsistent. No documentation in records reviewed of notice regarding serious suicide attempts.

Recommendations:

A. The Suicide Prevention Policy/AR must address notification of next of kin in addition to internal and external stakeholders. This should then be tracked and evaluated as part of the suicide/mortality review process.

REPORTING

Components: Reports regarding serious incidents and completed suicide must be written by all staff involved in or witnessing the incident.

Assessment:

A. Medical response is not documented in the medical records. It is the standard of care that medical staff responding document the notice they received, the condition of the patient, interventions attempted and the patient's response as well as the timeline. It is inexplicable why this is not being done.

B. All involved/responding/observing staff do not write incident reports.

C. Currently, inmate suicidal behaviors are inappropriately being reported via the disciplinary system which serves to discourage suicidal inmates from disclosing their suicidal actions or asking for help. Inmates engaging in self-harm or attempting suicide continue to receive or be threatened with receiving a disciplinary report. This includes disciplinary reports for destruction of state property (tearing a bed sheet), failing to follow a direct order (continuing to hang) or intentionally creating a security/safety/health hazard. As a result, the prisoner will not have telephone, commissary or visitation privileges suspended or serve disciplinary detention time.

Recommendations:

A. Reports regarding serious incidents and completed suicide must be written by all staff involved in or witnessing the incident.

B. Every person (ADOC and contractors) witnessing or participating in the intervention must write an incident report from his/her individual perspective prior to the end of their shift. These reports should be individualized and not the result of "group" report writing or copying from other one official report.

C. Medical staff must document in the medical record consistent with the standard of care. This includes a timeline documenting when they were notified, when they responded, the examination/condition of the inmate, medical and other interventions provided and the inmate's response to the interventions.

D. Inmates should not receive disciplinary action for engaging in suicidal behaviors, reporting suicidal behaviors, or reporting suicidal thoughts. This has a chilling effect on help-seeking behaviors by inmates. In the event a disciplinary report is issued in error, the disciplinary should be dismissed immediately and the inmate notified that it will have no effect on the inmate's record.

REVIEW

Components: Medical, mental health and correctional administrative reviews must occur in instances of serious self-injury and suicide attempts as well as completed suicides. Each discipline (medical, mental health and corrections) must complete an independent review of their area of expertise and there shall also be a discussion among them of positive findings as well as any areas requiring improvement. There are standard items to be reviewed and documented for each area.

Per NCCHC standard: Procedure in Event of an Inmate Death, there are three types of reviews to be completed:

1. **Clinical mortality review** – an assessment of the clinical care provided and the circumstances leading up to a death.

2. **Administrative review** – an assessment of correctional and emergency response actions surrounding an inmate death

3. **Psychological autopsy** – sometimes referred to as psychological reconstruction or postmortem, is a written reconstruction of an individual's life with an emphasis on factors that lead up to and may have contributed to the death. It is usually conducted by a psychologist or other QMHP.

All deaths are reviewed to determine the appropriateness of clinical care; to ascertain whether changes to policies, procedures or practices are warranted; and to identify issues that require further study.

Assessment:

A. We received QI Program reviews (MH004) and some psychological autopsies.

B. While improvements are needed, it should be acknowledged that mental health did complete reviews. We received no reviews completed by custody or medical addressing the clinical mortality and administrative reviews necessary for suicides. We received documentation that there were disciplinary sanctions issued to correctional staff in two cases of suicide which indicates that a custody review was completed, at least in these two cases, but we did not receive the actual reviews, just the apparent steps taken as a result of this type of review. There was also no documentation that any formal discussion occurred between custody, medical, and mental health (ADOC and their vendor) to review the review by mental health and identify improvements for implementation.

C. In general, QI program reviews were cursory and summarized personal and correctional history but didn't look at or critique the mental health care provided. Even when medical response was untimely (or non-existent), the conclusion was that medical and security responded "according to policy and standards" and there were no recommendations.

D. While we were greatly appreciative to have been provided the psychological autopsies/reconstructions, there were significant areas for improvement. The psychological reconstructions in at least one case were completed by the deceased inmate's provider which is inconsistent with the standard for reconstructions. These documents were also completed in a cursory manner, did not contain a summary narrative, and contained no findings.

Recommendations:

A. Develop or revise instruments to conduct the mental health, medical and administrative reviews so that the same types of information is gathered in every instance and data analyzed to identify any trends or patterns in order to improve processes and performance.

B. We recommend that the ADOC and its vendor refer to the American Association of Suicidology for training in the completion of suicide autopsies/reconstructions. As an example of a comprehensive, well-developed suicide reconstruction, the ADOC may want to refer to the California Department of Corrections and Rehabilitation.

C. Findings that result from these reviews must include recommendations need to be shared across the state to improve safety, response time, assessment, and other suicide prevention factors.

DEBRIEFING

Components: Procedures for offering timely debriefing to all affected personnel and inmates. "Affected" staff and inmates are those witnessing and/or responding to the incident.

Assessment:

A. Requested documents did not indicate that debriefing of inmates was a standard component of the suicide prevention program. One mental health program manager who was interviewed indicated that inmates were told to complete a health care request if they wanted services and reported that some inmates did so. This program manager spoke directly to a deceased inmate's neighboring inmates.

B. The current suicide prevention policy does not address any debriefing component.

Recommendations:

A. The Suicide Prevention Policy/AR must include a debriefing component for affected staff and inmates.

B. The NCCHC standard includes a statement that practical guidelines are available from organizations such as the International Critical Incident Stress Foundation. Outside community organizations may be available to conduct staff debriefings. Mental health staff may be trained to debrief the inmate population. Facility mental health staff are generally not recommended to debrief staff, particularly as they may be impacted by the suicide themselves.

L name	F name	AIS#	Incident	Institution, location	Date	Additional information	Assessment of reviews
Barker	John	222010	Observed by CO in cell to be hanging from vent cover over toilet at 6:30 PM. No actions taken until 6:36 PM when medical arrived at which time, entered cell, cut prisoner down and began CPR. Dr. Wilson "verified" death at 7:00 PM.	St Clair - GP	9/26/18	Barker had been housed in segregation for several months due to disciplinary reports. He was on a suicide watch at the end of August and returned to segregation. 9/1/18 - MH recommended adminstrative removal from segregation due to SMI diagnosis. It is not clear whether or not that was acted upon from the records. The psychological autopsy indicates Mr. Barker was released from RHU only 2 days before committing suicide. (Records unclear whether this release was a result of the 9/1/18 recommendation or whether he had been released, re-admitted and then released again 9/24/18.) Psychological autopsy also documents that several other prisoners stated that Mr. Barker was murdered and then placed in a cell to appear as if he committed suicide.	Security emergency response inadequate - must intervene and begin life-sustaining efforts rather than waiting for medical. Medical emergency response time inadequate - took 6 minutes to arrive. No clarity in records received regarding whether physician actually examined inmate or basis for declaring death. No medical review received. No security review received. Mental health review was cursory and found no problems and no areas for improvement. No indication that other inmate allegations were reported to administration or investigated.
Borden	Jeffery	Z593	Observed hanging from cell bars by tier runner serving breakfast trays at 2:40 AM. Mr. Borden was cut down and placed on bed.	Holman DR	6/3/18	At 2:50 AM, nurse arrived and said he was dead; called physician who pronounced Mr. Borden dead. No medical interventions provided.	No medical review provided but a 10 minute response time is unacceptable and will not save lives. No life-saving efforts or medical interventions were attempted. No security review provided.
Chumney	Timothy	223948	Within 1 day of being released from MHO to a housing unit where he expressed concern for his safety from other inmates, he was discovered hanging in his cell having tied a bed sheet to a cell window and then around his neck.	Limestone seg	5/12/18	No CPR, actual medical assessment or life-sustaining measures attempted. LPN responding to the emegency said to leave him in the cell on the unit and called the physician to pronounce the death. Hours later, the deputy coroner arrived and "confirmed inmate Chumney deceased."	Mental health QI program review had no criticisms or recommendations for anyone. No transitional care planned; treatment plan called only for a monthly contact with treatment coordinator and quarterly appointment with CRNP. No plan to follow more closely (or intervene to prevent placement in RH based on his anxiety and paranoia). Psychological autopsy revealed no additional or substantive information. No medical review received. No security review received.
Martinez	Robert	213158	Nurse and CO doing pill call in segregation at 12:25 PM and discovered Mr. Martinez "unresponsive" and hangingfrom a vent by a sheet tied around his neck.	St Clair seg	3/31/18	Mr. Martinez had a lengthy segregation stay. Mental health notes indicate seeing him in segregation since at least mid-2017 and the last mental health note was earlier in March 2018. Inmate discoved "unresponsive" at 12:25 PM. Medical arrived 12:35 PM, but he was not cut down at 12:58 PM.	No reviews received. Medical emergency response time of 10 minutes is unacceptable. Failure to cut the inmate down for more than 30 minutes after discovery is inexcusable and inhumane.
Thornton	Billy Lee	271763	Observed in process of attempting to hang himself in segregation cell. Officer opened door and the shoe string Mr. Thornton was using to hang himself broke as the officer was "assisting." Mr. Thornton fell and struck his head on floor, sustaining a severe closed head injury that lead to his death.	Holman seg	2/26/18	All of this literally happened as officer watched him tie string around neck and step off bed. They opened the door to assist and the string broke and the inmate allegedly fell and struck head on the floor. Officers put him in a wheelchair and took him to medical rather than calling a medical for an emergency response. Mr. Thornton previously attempted suicide by hanging at Holman in December 2017 and was transferred out to Fountain where he was placed on MHO - rather than Acute Suicide Watch. He returned to Holman and was seen once by mental health. Mr. Thornton was again transferred to Fountain for crisis watch 2/22/18 and released and returned to Holman 2/23/18. He was not seen again by mental health staff prior to his death.	No medical or security reports received. No outside hospital records received for review. Security decision to place him in wheelchair after sustaining head/neck injury rather than a back board and/or calling for medical to respond requires further review and supports need for additional and on-going first aid training for correctional staff. Entire incident requires investigation which if completed, was not provided. The narrative reports received and reviewed make it difficult to understand how a head injury serious enough to cause death was sustained in this situation where staff was in the cell to assist and the inmate did not fall from a great height. The mental health QI review indicates inmates should be taken to HCU for assessment when making statements of self harm but did not identify any issues with mental health's failure to provide any follow-up to Mr. Thornton after crisis placements.

Wolfinger	Ross	273245	Discovered hanging in segregation unit cell at 12:57 AM by CO and nurse doing pill call.	Fountain seg	8/22/18	Discovered hanging at 12:57 AM, no intervention except to call for assistance which arrived at 1:03 AM. No intervention until others arrived and then he was cut down and taken to HCU, arriving there at 1:08 AM. LPNs attempted CPR and ambulance was called. Death pronounced by physician 1:32 AM.	No medical review provided. Mr. Wolfinger was on the MH caseload. The QI Program review was provided 1/2/19: recently placed on MH caseload & prescribed medication but potential contributing factor was only drug debt and fear for safety as a result of the debt. There were no recommendations made. Psychological autopsy provided no additional analysis or information. Information from ADOC indicates CO assigned to segregation did not walk down the tier until accompanying the nurse at pill call or conduct rounds during his shift but recorded them as having been completed.
Rust	Ryan	301646	Inmate was transferred to Holman 12/21/18 after being captured during escape attempt from Fountain. He was placed in segregation. Discovered later that day sitting on floor with one end of belt around his neck and the other end tied to a bar in the window of the cell.	Holman RH	12/21/18	History of swallowing razor blade 11/15/18 when in county jail, but he denied it was a suicide attempt stating that it was accidental; he was using the razor blade to get an infection out of his teeth and accidentally swallowed it. He was on the mental health caseload and prescribed Trazodone and Clonidine for Anxiety NOS, MH code 1b. He had three pre-placement RH screenings after his escape attempt: 12/20/18 at 0040 (SPA_9472), 12/20/18 at 0205 (SPA_9470) and 12/21/18 at 1543 (SPA_9464), none of which indicated a need for an urgent or emergent mental health referral.	No medical review recieved. Psychological Autopsy limited, does not contain any psychological information. THe mental health QI program review does indicate that post crisis follow-ups were missed after the razor blade ingestion, adding him to caseload was missed, and proposed that he may have benefitted from closer observations in segregation following his capture. The reason for three pre-placement screenings was not clear. At best, the three completed screenings raise questions about inefficiencies in the system regarding redundant work and/or poor communication among nursing staff; at worst, they raise concerns regarding the authenticity and validity of the screenings. We also received a sort of chronology of Mr. Rust's ADOC confinement and contacts with medical/mental health that was labeled only "Ryan Chas Rust". The authorship and purpose of this document was not indicated though it does identify deficiencies in mental health follow-ups, treatment planning and diagnostics.
Chatter	Kendall	296876	Prisoner was discovered hanging when meals distributed. He had previously been banging on cell and "yelling intensely" about temperature in cell.	Staton temp holding unit	11/28/18	Records indicate he was on ASW after cutting his wrist 11/16/18 "due to security issues and allegations of PREA", and reduced to MHO 11/17/18. MHO was discontinued 11/20/18. He was not placed on the mental health caseload. He does not appear to have been seen by MH after watch discontinued. (8 days). (THe (The "security issues and PREA" appear to have been related to Mr. Chatter's reports that his "ex" was at Staton and he could not remain there and needed to be transferred to another institution.)	The mental health QI review contained little information and no recommendations for improvement in spite of failing to provide follow-up after watch placement and failure to provide an actual mental health assessment after referral from security 11/14/18. Mr Chatter then cut his wrist, requiring sutures and was placed on ASW. The Psychological Autopsy states both that the treatment plan was up to date and included goals that were implemented but also states that there were no goals on the treatment plan becasuse he wasn't on the mental health caseload. No medical review was provided. No security review was provided though ADOC did provide information indicating written reprimands were issued to two ADOC staff in this case for policy violations.
Araujo	Mark	201188	Mr. Araujo used a sheet to make a noose and was discovered hanging from inmates' door. He had been returned to prison on an Escape Charge for leaving a Work Release program and was pending a close custody classification.	Limestone seg	11/23/18	At 6:13 PM, the inmate didn't respond verbally when called and security saw that he had a noose around his neck but door wasn't opened until 6:19 PM. Cut down at 6:22 PM and CPR was started at 6:23 PM. Medical arrived 6:24 PM. Ambulance was not called until 6:34 PM. Mr. Araujo asked to be put on the metnal health caseload and be seen by psychiatry when seen for his segregation pre-placement screening and mental health assessment at Limestone 10/29/18. He was not seen as requested at Limestone prior to his death. (He had been seen by Dr. Crawford at Kilby prior to his being sent to Limestone segregation, but she did not add him to the mental health caseload at that time.)	Security emergency response untimely - 6 minutes from discovery to opening cell and 9 minutes to cut down are not acceptable time frames and will not save lives. The QI review contains no recommendations but it does note that facing more time for the escape charge may have been a contributing factor and concluded there were no recommendations because "security and medical responded according to policy and standards." Psychological Autopsy contained little information - and neglected to note that he wanted MH help and asked for it 10/29/18 when seen in seg.

Ford	Paul	147711	Inmate discovered hanging in his segregation cell when store items were being distributed at 1:10 PM. , responded 1:15 & cut sheet from around neck	Kilby seg	1/16/19	Discovered hanging 1:10 PM; entered cell and cut down 1:15 PM. Medical staff arrived and started CPR 1:16 PM. Physician arrived 1:30 PM and pronounced death at 1:42 PM. Mr. Ford had attempted suicide at Holman in April 2018 when he was housed in segregation by setting fire to the contents of his cell and trying to hang himself. He made another suicide attempt at Holman in July 2018 and was transferred to Donaldson for suicide watch. He was transferred to Kilby in August 2018. He attempted to harm himself again when in segregation at Kilby and was on suicide watch 12/12/18 - 12/21/18. He was released back into segregation where he remained until his suicide less than a month later.	The QI program review notes that Mr. Ford was discharged from a crisis cell and returned to segregation 12/21/18. It records the last mental health contacts were 12/12/18 and 1/15/19. The 1/15/19 contact appears to be a segregation round note as it was done at the cell fron and the inmate was lying on his bed with his head covered and did not interact with the mental health staff. THe review identified "schedule follow-up with LMHP" and "increase in staffing" as areas for improvement. No medical or security reviews were received. Notably, Mr. Ford received a disciplinary report for creating a disturbance when he cut his wrist 12/12/18.
Abrams	Roderick	220360	Discovered hanging from grate in cell with a piece of blanket during a security round. He had been on crisis watch from 12/21/18 until 12/26/18, but was not placed on the mental health caseload.	St Clair seg	1/2/19	Discovered hanging at 7:00 PM; cut down 7:11 PM and medical initiated CPR. Time of death called at 7:55 PM. Body locked in cell until 12:40 AM when taken to infirmary for release for transport to coroner. Mr. Abrams was on ASW 12/21/18 and changed to NASW 12/22/18. A nursing encounter note 12/21/18 indicates he said he planned to cut or hang himself (SPA 10382) but it is not clear what was done with this information initially though later in file there are watch logs. Appears to have been on watch until 12/26/18. He was seen 1/2/19 as 7-day follow-up after release from watch - complaining that he was in segregation after a hacksaw which was not his, was found in his locker box.	Emergency response times are inadequate to save life - 11 minutes from discovery to cut down is more than enough time for death to occur. No medical review recieved. QI review says he was not on MH caseload "but had been receiving mental health follow-ups due to reported depression." He was seen for 1:1 mental health appointments 8/22/18, 9/4/18, 9/19/18, and 10/10/18. There is also documentation (SPA_10428) that he could not be pulled for his appointments 11/20/18, 11/27/18, 11/30/18 or 12/4/18 due to space and security shortage. QI program review found no areas for improvement or recommendations. It is not clear why an inmate receiving regular mental health counseling was not considered to be on the mental health caseload.
Gentry	Daniel	272837	Mr. Gentry was discovered hanging from a light fisture inside his cell during a routine security check. He was on a wait list for transfer to the Bullock Stabilization Unit.	Donaldson RTU	2/6/19	Mr. Gentry was discovered at 10:43 PM, cut down at 10:44 PM. Nurses arrived at 10:47 PM and told security to remove the sheet from around the inmate's neck and place him on his back. CPR initiated at 10:48 PM. He was pronouned dead by a physician 7 minutes later after an EKG revealed no cardiac activity. The body was locked into the cell and security placed at the door until released later. Inmate was SMI and had a history of crisis placements and suicide attempts. He was on MHO 1/24/19 - 1/31/19 after asking CO to kill him and subsequently returned to the cell block while awaiting transfer to SU. He was also on suicide watch in August 2018. He was on a wait list since 1/30/19 to be transferred to the Bullock SU, but was not on any sort of increased level of observation or more frequent mental health contacts in spite of having been identified as needing a higher level of care.	The mental health QI review (MH004) found MH services "appropriate" which is hard to reconcile with the documentation that he recieved no increased level of observation or mental health contacts while on a wait list for transfer to a higher level of care. The medical record contains an appropriate medical response chronology. No medical or security reviews were received. Medical emergency response was more timely in this case. Security staff need additional training and drills regarding first aid and responding to hanging attempts.

Holmes	Matthew	253447	Mr. Holmes was discovered hanging from overhead light fixture in his cell by security performing count at 10:43 PM.	Limestone seg	2/14/19	Discovered 10:43 PM and cut down within a minute or two. LPNs arrive and begin CPR in the cell at 10:46 PM and advise custody to call for ambulance. Sgt. does not order call for ambulance ntil 10:50 PM. Ambulance arrives and paramedics enter cell 11:18 PM. Mr. Holmes was pronounced dead by a physician at the outside hospital after review of EKG. Mr. Holmes body is thereafter locked in the cell until the coroner and others arrive. Inmate had been on MHO in infirmary 2/11/14 and released to segregation 2/14/19. He completed suicide less than 12 hours later.	MH code "B" - per problem list with diagnoses Depressive disorder NOS, history of polysubstance,and antisocial personality disorder traits listed 2/12/19. He was placed on MHO 2/11/19 but given suicide smock, blanket and sack lunch which is more indicative of a suicide watch placement but without risk assessment and less frequent monitoring. Documentation at a treatment plan review on 2/13/19 signed by all treatment team members, indicates Mr. Holmes was not making progress towards treatment goals. However, the very next day, the treament plan review states he completed goals. He was released from MHO to segregation (SPA_13577, SPA_13576) per the order of CRNP Grace wrote no note in the chart explaining the rationale for this decision or the level of risk assessed. On MHO watch in infirmary he was seen "inside his cell" rather than in a confidential area out of cell. The pre-placement segregation screen completed 2/14/19 at 11:45 AM documents that Mr. Holmes is SMI and there are 3 Yes responses (SPA 13571). He was not diverted from segregation placement and an "urgent" rather than "emergent" referral to mental health was made. Case represents illustrates the problems with use of MHO rather than approved suicide watch levels, poor documentation of rationale for release from watch, failure to generate an emergency referral to mental health in response to a positive pre-placement screen, and releasing SMI inmates from watch directly into segregation.

FORM 3150 (7/16) STATE OF NEW YORK - DEPARTMENT OF CORRECTIONS AND COMMUNITY SUPERVISION

DOCCS - MENTAL HEALTH REFERRAL

This form may be completed by any employee to request mental health services for an inmate. Please press hard - you are making four (4) copies.

INMATE NAME: _____ DATE: _____

DIN: _____ FACILITY: _____ CELL LOCATION: _____ TIME: _____ AM / PM

REFERRED BY: _____ TITLE: _____ EXT.: _____

1. Refer to the checklist below and check each item which applies for the inmate. Please be as complete and accurate as possible.

A. IMMEDIATE PHONE REFERRAL

KNOWLEDGE OF BASIC FACTS
Does not know:
- ☐ Own name
- ☐ Where he/she is
- ☐ Day of week

(*If any of the above boxes are checked, please refer the inmate to DOCCS Medical immediately. Inmate must be seen by Medical prior to Mental Health.*)

POSSIBLE SUICIDE RISK
Talks about or writes:
- ☐ Feeling hopeless
- ☐ Giving up
- ☐ Feeling helpless
- ☐ Being worthless
- ☐ Life not being worthwhile
- ☐ Killing self
- ☐ Cutting self
- ☐ Hanging self
- ☐ Overdosing
- ☐ Swallowing foreign objects
- ☐ Starting fires
- ☐ Harming self in other ways

NON-VERBAL /UNUSUAL BEHAVIORS
- ☐ Appears very fearful or nervous for no apparent reason
- ☐ Cries often for no apparent reason
- ☐ Appears sad
- ☐ Handles own urine or feces
- ☐ Suddenly refuses to leave cell most of the time

B. REGULAR REFERRAL

NON-VERBAL /UNUSUAL BEHAVIORS
- ☐ Does not speak
- ☐ Significant change in program attendance
- ☐ Significant change in visiting habits

VERBAL BEHAVIORS
- ☐ Significant change in communicating
- ☐ Suddenly begins to yell and scream

VERBAL/UNUSUAL THINKING
Talks about:
- ☐ People being out to get "Me"
- ☐ Grandiose plans or schemes
- ☐ Unusual religious preoccupations
- ☐ Hearing voices

APPEARANCE AND HYGIENE
- ☐ Sudden change in appearance, has poor hygiene, has an offensive odor, etc.

EATING AND SLEEPING HABITS
- ☐ Significant change in sleeping habits
- ☐ Significant change in eating habits

SEXUAL ABUSE
- ☐ Possible victim of sexual abuse

SELF REFERRAL
- ☐ Inmate requesting to see OMH - note reason in Section C below.

C. FOR ANY OTHER REASON: _____

_____

_____

Actions:
- **Any box checked in Section A, make an immediate phone referral to Mental Health and notify the Watch Commander**
- **Any box checked in Section B, make a regular referral to Mental Health**
- **If for any other reason you feel there is a significant problem with the inmate, notify Mental Health and call the Watch Commander.**

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3. Type of Mental Health Notification: ☐ Regular Referral ☐ Immediate Phone Referral

If immediate referral, name and title of clinician contacted is required. In addition, at a facility with no Mental Health clinician, print the name of the Watch Commander notified:

_____

NAME & TITLE OF OMH CLINICIAN OR WATCH COMMANDER CONTACTED

TO BE COMPLETED BY MENTAL HEALTH UNIT:

Inmate: _____ was seen on _____ by OMH staff.

COMPLETED BY: _____ _____ _____

Clinician Name | Title | Phone Extension

The source of a mental health referral and information provided on the referral may be protected from disclosure under Sections 33.13 and 33.16 of the Mental Hygiene Law, if such disclosure could be detrimental to the referral source, the patient, or other persons.

Distribution: Take off Goldenrod copy for the referral source. Notify your immediate supervisor and forward the referral form to OMH. In an facility without OMH staff on site forward the referral form to Medical.

If inmate is placed on a suicide watch in RCTP by DOCCS, this form must be hand delivered to the Mental Health Unit so OMH will have it upon return to duty.

After completion by OMH submit: White - OMH Canary - Referral Source: Security send to DSS; Civilian send to DSP Pink - Medical

H: Harassment / Threats
O: Overwhelmed by Prison / Commitment
T: Transfer / Fear Of Transfer

F: Family Estrangement
L: Loss / Rejection
A: Adverse Court / Parole Outcome
G: Gang - Related Fears
S: Sanctions (SHU/KL)

I: Ideation
S: Substance Abuse

P: Purposelessness
A: Anxiety
T: Trapped
H: Hopelessness

W: Withdrawal
A: Anger
R: Recklessness
M: Mood Changes

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

BRAGGS, et al., Case No. 2:14-cv-00601-MHT-GMB

v

JEFFERSON DUNN, et al.

SUPPLEMENTAL RECOMMENDATIONS OF KATHRYN BURNS, MD, MPH AND MARY PERRIEN, PhD REGARDING SUICIDE PREVENTION in the ALABAMA DEPARTMENT OF CORRECTIONS

March 8, 2019

This brief document is being sent as a supplement to our larger comprehensive report and recommendations for suicide prevention in the Alabama Department of Corrections. (ADOC) It contains our prioritization of recommendations for immediate implementation while our recommendations for a broader, more comprehensive program are being implemented.

We recommend the following:

- No Mental Health Observation (MHO) as a component of suicide prevention. It is not such in ADOC policy and adhering to ADOC policy would require that no one with any risk of self-harm, referred for self-harm, and/or related issues (e.g., suicidal ideation) be placed on MHO status. The only acceptable watches for people with issues related to suicide and/or self-harm are acute and non-acute watch.

- Additional mental health contacts following watch discontinuation as spelled out in our report:

    - We recommend that upon release from suicide watch, each person will have at least four standard follow-up examinations by mental health. The first three follow-up examinations will occur upon release from watch and upon return to the sending facility or expected housing; these examinations will occur on the three consecutive days upon release. The fourth follow-up examination will occur on the tenth day following release from watch. If the inmate is placed in temporary housing (e.g., housed at Kilby for days one through three post-watch and then moved to the sending facility; moved to SLU for days one through three post-watch then moved to RHU), that will be noted as a significant post-watch transition impacting the inmate's post-watch adjustment and risk level, requiring the post-watch follow-up examination schedule to be reset; another round of the four follow-up examinations will take place starting the day following movement.

    - Policy and procedure must include requirements for referrals to higher levels of care for prisoners remaining on watch status for extended periods. We recommend compliance with existing policy requiring inmates on watch for 72 hours be considered for referral to higher levels of care. If not referred, the clinical rationale should be documented in the medical chart, at minimum, and tracked in the crisis utilization log or similar. If the inmate remains on watch for

168 hours, the treatment team should meet to review a referral to a higher level of care. If the inmate is not referred to a higher level of care, the rationale should be documented in the medical chart, at minimum, and tracked in the crisis utilization log. If the inmate remains on watch for 240 hours or longer, referral to a higher level of care shall occur with notification of referral to OHS and vendor regional mental health management. In addition, inmates who are returned to watch status within 30 days of release from a watch and/or who have three watch placements within six months shall be referred to a higher level of care; OHS should be immediately notified of any inmates who meet these criteria but are not referred and provided with the clinical rationale.

- We recommend a multi-pronged approach to RHU inmates who have been placed on suicide watch. Inmates who have been placed on watch should be evaluated not only for suicide risk, but also re-evaluated for the presence of a serious mental illness. If found to have a SMI, they should be evaluated for referral to a higher level of care (RTU or SU). If not referred to RTU or SU, the clinical rationale should be documented in the medical record and the inmate transferred on an expedited basis to a SLU. If the inmate is not on the mental health caseload but is determined to be at or above moderate acute or chronic risk of self-harm, the inmate should be placed on the mental health caseload to provide increased clinical monitoring and intervention.

- We recommend training for all nursing staff completing RHU pre-placement screenings. While the forms indicate when crisis watch should be considered, training should provide greater detail about indicators to look for as well as include how to place someone on immediate watch after hours and how to initiate an emergent referral. The model should be “easy in;” this means that it should not be difficult to place an inmate on watch. An example would be if nursing is uncertain in any way about a case, the inmate is placed on watch.

- 30-minute custody rounds in segregation must be enforced consistent with existing policy.

- Adhere to confidentiality requirements. Mental health clinical contacts should be confidential without the presence of custody staff unless there is a significant security reason as determined by the clinician. Evaluations must be conducted in person, out of cell and in a place offering sound confidentiality. Documentation (e.g., suicide risk assessment, progress note) should clearly indicate that the contact was in a confidential space, conducted at cell front, or other specific non-confidential setting.

- IMMEDIATE intervention (upon appropriate number of security staff present; this should be two officers) in the event of suicide in progress – cut down, remove noose, and begin life-saving measures and continue until a physician declares death.

These recommendations may be implemented immediately with existing correctional and vendor staff and do not conflict with existing policies or administrative rules.