JAIL SUICIDE/MENTAL HEALTH UPDATE

(A joint project of the National Center on Institutions and Alternatives and the National Institute of Corrections, U.S. Department of Justice)

Fall 2008 **Volume 17 • Number 2**

The Tragic and Preventable Death of David Thomas

David Thomas[1] was born into a life of turmoil and discord in Atlanta, Georgia on November 3, 1987. His mother, Anne, gave birth to her son at age 18 after many years of institutionalization for incorrigibility and mental illness. She was reportedly raped at age 13 in one of many institutional placements. David's father left the family early on in his life, but not before sexually and physically abusing both he and his younger sister. Anne Thomas was in and out of her son's life for much of the early years, debilitated by both substance abuse and mental illness. As a troubled young adult, she was self-described as an irresponsible parent. During this time, David was cared for by his grandmother, Barbara Mitchell, herself a victim of childhood sexual abuse. Ms. Mitchell tried to become a stabilizing factor in his life. However, as a result of his unsettled and dysfunctional early years, David experienced learning difficulties at school that were associated with delinquent behavior.

The family moved to Florida in 1991 and soon thereafter, when his wrongful behavior escalated, David was sent to the first in a long series of mental health professionals. In April 1993, six-year-old David was diagnosed with Attention Deficit Disorder and Oppositional Defiant Disorder. The following year, he was taken to the hospital on two occasions for possible Clonidine overdoses. In July 1995, David was admitted to the psychiatric unit of a local hospital with diagnoses of Attention Deficit Disorder, Oppositional Defiant Disorder, and Conduct Disorder. The following year, he was placed in a residential substance abuse and mental health treatment program. When his behavior deteriorated and he became aggressive and uncontrollable, David spent time in the program's crisis stabilization unit and was diagnosed with a Psychotic Disorder. He would returned to the same crisis unit two years later in April 1997.

Later in 1997, it was disclosed that David's aggressive behavior now included multiple incidents of sexually acting-out behavior, inappropriate sexual comments, and inappropriate sexual gestures. He was only 10-years-old. David admitted to having inappropriate sexual contact with his younger sister, as well as a neighborhood child, on two occasions. When asked during a May 1998 evaluation whether he needed sex offender treatment, David responded that "I would be willing to go to the hospital for help….I know I need sex offender treatment. I don't want to be in any sex offender program, but I guess that is where I belong right now." David's grandmother told the clinician that "there is no way we can control David. He needs 24-hour a day supervision and structure that we cannot provide him. You turn your back for a second and he jumps the fence and is gone. We are afraid of what David might do to someone or himself." The clinician concluded the obvious, that David had experienced multiple incidents of sexual and physical abuse as a child, felt abandoned by his mother, and presented with symptoms of Posttraumatic Stress Disorder. Based upon this traumatic history, additional placement failures could be expected. "David has already begun a pattern of compulsive reenactment of his own sexual trauma and his trauma of abandonment, by acting out sexually on others and by creating situations in which he is likely to be rejected," the clinician concluded.

Three Springs of Daytona

Despite a recommendation for an out-of-home residential program for sex offender treatment, such a placement was not immediately forthcoming. Stranded on a waiting list for placement and unable to return home, David began a long odyssey in Florida's juvenile justice system. On November 10, 1999, he entered the Marion Regional Juvenile Detention Center, an 88-bed facility in Ocala. The youth, seven days removed from his 12th birthday, would spend almost nine months in the facility while awaiting a residential placement. The superintendent of the facility would later admit that David never received any mental health care during his confinement. On July 14, 2000, David was admitted into Three Springs of Daytona, a 33-bed residential treatment program for adolescent sex offenders operated under contract with the Florida Department of Juvenile Justice and located in Daytona Beach. The transition into the program did not go smoothly. David received two doses of Thorazine (50 and 100 milligrams, respectfully) on the first day as a result of assaultive behavior.

[1]In order to avoid any further embarrassment to those cited in this article, all individual names have been changed. No other alterations have been made.

Inside. . .

Ten days later, he received another dose of Thorazine for self-injurious and assaultive behavior, then two more daily doses in late July 2000. David began averaging three incidents per month of assaultive and self-injurious behaviors. In August, a psychiatrist at the facility thought David might be suffering from Bipolar Disorder and began to prescribe Depakote. David refused to eat for several days in October. In November 2000 and February 2001, David was placed on suicide precautions for self-injurious scratching and cuts to his arms. On March 11, he attempted to assault a Three Springs staff member. Two weeks later on March 24, he was again placed on suicide precautions for self-injurious behavior. The next day, David became angry and again tried to assault staff. He also reportedly tried to cut his wrists.

After more than nine months of disruption, Three Springs officials had seen enough. David was charged with assault and discharged from the program on March 26. The discharge clinical evaluation stated that David came to "treatment with significant emotional and mental health interventions that appear to have had little impact on his behavior and thought processes. Since his arrival, he is minimally invested in treatment and more interested in how to avoid the treatment process." His diagnoses at discharge were Sex Abuse of a Child (perpetrator), Conduct Disorder (childhood onset), Oppositional Defiant Disorder, and Posttraumatic Stress Disorder (acute).

Volusia Regional Juvenile Detention Center

On March 26, 2001, David was escorted to the Volusia Regional Juvenile Detention Center (VRJDC) in Daytona Beach, located a little more than 400 yards from the Three Springs facility. The VRJDC was a 90-bed secure detention facility operated by the state Department of Juvenile Justice. The length of stay normally averaged 13 days. Upon arrival, David was processed and subsequently assessed by Cathy Dalton, a mental health clinician from Act Corporation, a community agency providing limited mental health services at the VRJDC. Ms. Dalton's initial screening found that the youth was moderately depressed and feeling hopeless with some suicidal ideation. David was placed on "sight and sound" suicide precautions which, although not specified in policy, meant that facility staff were required to both see and hear the youth at all times. Youth on suicide precautions at the VRJDC were also on lockdown status and prohibited from inclusion into regular programming. Ms. Dalton next saw David eight days later on April 2 "at his request." The youth pleaded with the clinician to "get me out of Room 15. I can't sleep and I'm not going to hurt myself." He was then placed on regular supervision in a single room. David met with Ms. Dalton four days later on April 6, again at his request because he was anxious regarding the uncertainty of his legal status. The following week, David complained to the clinician about being assigned to a single room and was told it was due to the nature of his (sex offense) charge.

On April 27, David met with Ms. Dalton "at his request." He again complained of being housed alone, stating that "I've had all I can take from being in room alone" and threatened to commit suicide in order to gain a room change. The clinician viewed his behavior as manipulative, but placed David back on "sight and sound" suicide precautions. Ms. Dalton issued a written warning to VRJDC staff: "Client is manipulative, but has issues severe enough to make it very possible that he will make an attempt that could be more than superficial." The following week, the youth saw Ms. Dalton again after he began biting himself and banging his head against the wall. The clinician recommended continued suicide precautions and "counseling," although no counseling had occurred or was forthcoming.

On May 15, 2001, David requested to speak with Ms. Dalton because "I heard I might be going home and I'm pretty anxious about it. I haven't been home for two years, and I don't know what to expect." He remained on suicide precautions. On May 21, David attended a court hearing regarding the March 25 battery charge (reduced from assault) and the judge ordered a psychiatric evaluation based upon his escalating behavior. Not surprisingly, the evaluation found that David was significantly depressed and felt hopeless about his current confinement. The diagnoses of Conduct Disorder and Oppositional Defiant Disorder were confirmed, and the psychiatrist opined that the youth might also be suffering from Bipolar Disorder and/or Major Depression. Back at the VRJDC, David continued to engage in self-injurious behavior and was observed banging his head against the wall, then loosely tying part of his uniform around his neck on May 24. VRJDC failed to notify Ms. Dalton of the self-injurious behavior, but David remained on "sight and sound" observation. The following week, there were more suicidal threats and superficial cutting of his arms. Suicide precautions continued. Ms. Dalton's last session with David was on June 11 when the youth lamented that "I don't know why sometimes I try to hurt myself." The youngster remained on "sight and sound" observation and the clinician gave David "some affirmations to use when he's feeling like he wants to die." Cathy Dalton left the VRJDC on July 1, 2001 when the Department of Juvenile Justice (DJJ) discovered she was unlicensed (see below). With no Act Corporation mental health staff available, the VRJDC was unable to provide any on-site mental health services during the month of July 2001.

Beginning on April 23, an audit team from DJJ's Bureau of Quality Assurance had spent five days at the VRJDC. Areas of inspection included the physical plant, security and safety operations, education services, food services, and health care services. The audit team found numerous deficiencies in the provision of mental health services. In fact, inspectors found that, due to limited funding, the provision of mental health services by Act Corporation was generally limited to intake screening. For example, comprehensive mental health evaluations were not being performed on all youth who scored in the high range for suicide risk during the initial screening process. Intake screening was performed by an unlicensed mental health worker. Treatment planning was virtually non-existent and often limited only to youth detained for over 30 days. Youth admitted to the facility on psychotropic medications were not always referred for further assessment and "there appears to be no single point of contact at the facility to arrange for psychiatric appointments and follow-up." The inspectors also found little, if any, communication between medical and mental health staff. With regard to suicide prevention, the audit team found that "the Suicide Prevention Plan does not address suicide risk screening….On-going staff communication is unclear. The Notifications [section] does not clearly instruct staff on timeframes for making notifications"

Back to Three Springs

On July 16, 2001, David underwent another court-ordered psychiatric evaluation. He was again diagnosed with

Attention Deficit Disorder and Oppositional Disorder, and was probably also experiencing Bipolar Disorder. According to the psychiatrist, David continued to be in great danger to himself and others, and was in need of long-term treatment. Two days later on July 18, the youngster was escorted across the VRJDC grounds and back to Three Springs of Daytona. Within a month, David was again engaging in out-of-control behavior and was cycling in and out of the facility's isolation room. In one incident captured on videotape on August 11, he was observed biting himself and cutting his arms, and then continuously kicking the window of the isolation room door. He tied a sheet around his neck and staffed enter the room and removed the sheet, as well as his clothes. David eventually calmed down and his clothes were returned, but he remained on suicide precautions. In another memorable incident, David was seen continuously banging his head on the isolation room door for several minutes. Staff was seen observing the behavior but appeared uncertain and frustrated as to how to respond. David eventually collapsed from exhaustion and staff entered the room. He was restrained and later assessed by the nurse for injuries. According to a Three Springs psychological evaluation, the youngster had elevated scores for depression, hopelessness, anger, sexual conduct, and anxiety. His mental health was rapidly deteriorating. On August 23, David cut his arms with glass and again was placed in the isolation room on suicide precautions. Almost a month later on September 17, David reportedly swallowed glass and was escorted back to the isolation room. He then became angry and held a folding metal chair in the air, threatening to throw it at staff. He was subdued and began kicking staff. David was once again charged with battery and discharged from the program.

The Final Transfer: David Meets Rachel Manning

David was transferred back to the Volusia Regional Juvenile Detention Center on September 17, 2001. During the intake process, VRJDC staff noticed that the youth had fresh cuts on his arms and he reported a past history of self-injurious behavior. He was placed on "sight and sound" supervision and referred to an Act mental health clinician for further assessment. The clinician determined that although David was now denying any suicidal ideation, based upon his recent history, he was still at moderate risk for self-harm and would be downgraded to "close watch," requiring staff to observe David at 5-minute intervals.

The following day, David met with Rachel Manning, a new unlicensed mental health clinician at the facility. Ms. Manning began employment with Act Corporation in August and was immediately assigned to the VRJDC. During the session, David confided that his prior self-injurious behavior was, for the most part, related to "getting rid of emotional pain." He denied any current suicidal ideation. Ms. Manning concluded that the youth was "attention seeking" and that his history of self-mutilation was not related to suicidal intent. The clinician would later admit that she was unaware of the extent of David's mental health history. She also had never reviewed the VRJDC medical files, Three Springs records, nor even available Act Corporation mental health records from the youth's previous VRJDC confinement. She would also later state requesting records "was not a major concern at the time" and probably "something I had planned on doing, but had not gotten to that stage yet." Ms. Manning then discharged David from suicide precautions.

A week later on September 24, David got into an altercation with three VRJDC staff and yelled "I have nothing to live for." He was placed on suicide precautions and referred to Ms. Manning. In the interim, David found a piece of metal and began cutting his wrists. He later told the clinician "I tried to cut my wrists. I should go right instead of left." Ms. Manning concluded that the youth had "self-mutilation with suicidal ideation," but was again "attention seeking." She recommended that David be placed on constant observation (with continuous supervision from an assigned VRJDC staff) until 6:00pm, then "sight and sound" supervision for 72 hours. The recommendation was unclear as to what level of observation, if any, David would receive after 72 hours. The clinician said she would assess the youth again in three days, but the follow-up assessment never occurred..

Seven days later on October 1, David was observed hitting his head against the table and biting his wrist and leg. When seen by Ms. Manning, the youth was in the fetal position on the floor. He was placed under medical seclusion for 24 hours and continued on sight and sound observation. When Ms. Manning saw David again the following day, he appeared calm and stable. The clinician warned the youth that any further acts of self-mutilation would result in *permanent* medical seclusion status. David signed a "no-harm contract" agreeing not to engage in self-injurious behavior, and remained on sight and sound observation.

For the next few weeks, David was seen by the nursing staff on numerous occasions for somatic complaints (including stomach aches, loss of appetite, sore throat, and back ache) and was involved in a fight with another youth. Although he also complained of "increased stressors," David was not seen by any mental health staff until October 24. On that date, David's behavior was seen as "calm and stable" by Ms. Manning, who said that he "had not had any significant incidents in a whole month." The clinician later admitted that she had not reviewed the youth's medical chart nor conversed with any medical staff. Ms. Manning recommended that David be downgraded to close watch status, requiring observation at 5-minute intervals. She also initiated a treatment plan with the following goal: "David will not cut or attempt suicide while in the VRJDC Detention Center." Ms. Manning would later admit the document was not really a treatment plan and that she was untrained to perform treatment planning. She also stated that, although at the VRJDC every day, "there was no reason to talk with David on suicide precautions. No one brought any concerns to me."

On October 29, 2001, Module C had several youth on suicide precautions. David and another youth were each confined in separate cells (No. 1 and No. 2) on close watch status. Three other youth were assigned to sight and sound observation in Cell No. 15. They were being supervised by Detention Officer Paul Charles. It was his first day of employment at the VRJDC. One of the youth under his supervision, James Farrier, was allowed out into the dayroom area and, contrary to policy, was often unobserved. James was a large, older youth with an intimidating demeanor. Throughout the day, James would periodically walk up to Cell No. 1 and threaten David with "You're mine, boy" and he would "get him" the next day. The last encounter occurred at approximately 10:00pm.

Detention Officer Timothy Hanson was working the 3:00pm to 11:00pm shift in Module C on October 29. Although responsible

for supervising up to 24 youth in the unit, Officer Hanson left Module C without authorization several times during the shift. He conducted some, but certainly not all, cell checks at roughly 10-minute intervals that day. At approximately 10:38pm, Officer Hanson conducted a cell check and observed David Thomas sitting on the cement slab in his cell. Ten minutes later, the officer left the unit prior to the end of his shift. At approximately 11:00pm, 22 minutes after the last cell check, Detention Officer Jake Holder entered Module C to begin his shift. He walked up to Cell No. 1 and could only observe David's legs stretched out on the floor. The officer assumed the youth was sitting with his back against the door. The officer passed by the cell eight minutes later at 11:08pm and became suspicious when he observed the youth in the exact same position. Officer Holder opened the cell door and David's body fell into the dayroom. One end of a torn bed sheet was tied around his neck, the other end attached to the hinge of his cell door. The officer untied the ligature and placed the youth in a supine position on the floor. An emergency was called, other VRJDC staff arrived, and cardiopulmonary resuscitation (CPR) was started by Officer Holder. According to observers, the victim's body appeared stiff, an indication he had been hanging unobserved for a considerable period of time. David Thomas was later transported to the hospital by ambulance and pronounced dead several hours later — four days short of his 14th birthday.

The Aftermath

Almost immediately after David's death, the Office of Inspector General (OIG) within the Florida Department of Juvenile Justice initiated an investigation. Four months later in March 2002, the OIG investigation was complete and investigators found that:

- Detention Officer Timothy Hanson improperly supervised youth when, while working the 3:00 to 11:00pm shift, failed to consistently conduct 10-minute checks of the housing unit; failed to conduct 5-minute checks of David's room; allowed a television to be turned on in the dayroom after the detainees were secured in their rooms; allowed a youth who was on constant observation to exit his room, roam unsupervised around the unit where he threatened and intimidated David; and departed the unit without permission prior to the end of his shift.

- Detention Officer Hanson engaged in improper conduct when he submitted false reports by documenting in the housing unit logbook that both the 10-minute and 5-minute checks were performed as required; and called in a false report to master control reporting that he conducted a master count when, in fact, he had not. Officer Hanson later engaged in improper conduct when he did not provide truthful information, while under oath, during an interview with OIG investigators.

- Detention Officer Paul Charles failed to properly supervise a youth on constant observation by allowing him to exit his room and roam unsupervised around the unit where he threatened and intimidated David.

- Detention Officer Jake Holder, who was working the 11:00pm to 7:00am shift, improperly supervised youth when he failed to check the housing unit log to ascertain which youth were on special watch status. As a result, Officer Holder failed to realize that David was on close watch status requiring observation at 5-minute intervals.

- Senior Detention Officer Harold Jacobs failed to properly supervise his housing unit staff.

- Nurse Margaret Gillespie failed to notify VRJDC officials and the mental health clinician when she observed that David had made numerous sick call requests regarding frequent stomach aches, "feeling stressed," and not eating for several days. She also did not notify Dr. William Wayne, the facility physician, that David complained of stomach aches for five consecutive days.

- Dr. William Wayne failed to have David evaluated by a psychiatrist after renewing his prescription for Depakote.

- Rachel Manning, the mental health clinician, did not contact Nurse Gillespie in order to gain insight into David's medical condition prior to reducing his observation status from sight and sound to close watch. Ms. Manning also failed to discuss David's case with her clinical supervisor. She also failed to request any records from Three Springs, Inc. and/or converse with that program's psychologist regarding David's mental health treatment. She was unlicensed and had never previously worked with detained youth.

- Alan Monahan, VRJDC Assistant Superintendent, was administratively responsible for medical services provided by a local hospital and mental health services provided by Act Corporation. He was unfamiliar with the scope of services required from these health care providers. As a result of poor communication between providers, as well as his unfamiliarity with the required services, David did not receive the required medical and mental health services.

- Peter Forest, VRJDC Superintendent, failed to ensure the coordination of medical and mental health services, resulting in David receiving inadequate health care services. He also failed to address any of the deficiencies previously identified in the April 2001 Department of Juvenile Justice's Quality Assurance Review.

Both before and following issuance of the OIG report, numerous corrective actions occurred in the Volusia Regional Juvenile Detention Center as a result of David Thomas's death. First, there were several personnel actions: Detention Officer Timothy Hanson resigned three days after the death in lieu of being fired; Rachel Manning later obtained a "provisional" license to provide mental

health care," but was laid off from Act Corporation in 2002; Detention Officer Paul Charles received a written reprimand for his actions on October 29, but was later fired from the VRJDC when his probationary period of employment ended in September 2002; and Peter Forest, VRJDC Superintendent, received a three-day suspension for failure to coordinate the provision of medical and mental health services to David. The superintendent would later state that "I think almost all employees involved with David's case received some type of disciplinary action."

In January 2002, mental health services began to improve at the VRJDC. A new contractor was hired to provide full-time mental health, substance abuse, and crisis intervention services. Youth detained over 21 days received a thorough mental health assessment. A psychiatrist was contracted to be on-site four hours per week to provide evaluations and monitor youth receiving psychotropic medication. Act Corporation was retained to provide full-time suicide risk screening, as well as on-call crisis services. However, the Act clinician working at the VRJDC was still unlicensed.

With regard to suicide prevention, close watch status was temporarily eliminated and all suicidal youth were placed on "sight and sound" observation. Each suicidal youth was seen daily by mental health staff. Communication was improved with regular debriefings scheduled between each shift. Supervisors were required to spend more time in the modules conversing with both youth and staff; cell checks sheets and logs were scrutinized more carefully. However, according to Bureau of Quality Assurance review of the VRJDC conducted in June 2002, record sharing remained a problem. Auditors found that "clinical records are not available on-site and therefore, not part of the treatment record at the facility. In lieu of this, referrals are made….if treatment services are needed, but usually with only limited information and often without a clinical summary."

The Lawsuit

In April 2002, the family of David Thomas filed a lawsuit against the Florida Department of Juvenile Justice, Act Corporation, Three Springs, Inc., and numerous individuals employed by each agency. The lawsuit alleged that the defendants were both negligent and deliberately indifferent to David Thomas, the result of which was the proximate cause of his suicide. The case spanned more than five years and thousands of pages of documents. The defendants paraded more than 10 experts through the process to opine that their respective clients were neither negligent nor deliberately indifferent "to the health, safety and welfare" of David. Some defense experts, however, had little hesitation in pointing fingers at other defendants. For example, the expert for Act clinician Rachel Manning opined that she and her employer "acted within the appropriate standard of care at all relevant times," and the suicide would have been prevented had VRJDC staff performed proper rounds. The expert for three VRJDC officers believed Ms. Manning "acted improperly in removing David Thomas for sight and sound observation." Another VRJDC expert opined Ms. Manning provided grossly inadequate assessments and her decision-making was poor, whereas the required close watch observation at 5-minute intervals should have been staggered at 10- to 15-minute intervals. Another expert for Rachel Manning stated that she was exempt from both licensure and clinical supervision because she was working under a state contract for Act, and DJJ did not provide enough mental health resources at the VRJDC. An expert for the VRJDC superintendent opined that the facility's suicide prevention was adequate and the lack of mental health services was not the administrator's fault.

The plaintiff also had their share of experts to opine that David Thomas's death was preventable and caused by the negligence and deliberate indifference of various defendants. One plaintiff expert organized their opinion into the following eight categories:

Training

The pre-service suicide prevention training curriculum utilized at the VRJDC was barely adequate. Developed by the DJJ and 2.5 hours in length, the manual lacked discussion of close watch, manipulative/attention-seeking behavior, reasons why youth engage in self-injurious behavior, or effective communication. The poor training was exemplified by statements from several personnel. For example, Detention Officer Paul Charles, who had just graduated from the training academy and was working his first day at the VRJDC when David died, believed that observation of suicidal youth could be either sight *or* sound, and that only mental health personnel could authorize suicide precautions. Detention Officer Jake Holder, who discovered David hanging in his cell after only observing his legs stretched out on the floor, believed the requirement for cell checks was only to observe a youth's body, not his face. Officer Holder had worked at the facility for five years and only remembered post-academy suicide prevention training being offered following David's death. Nurse Margaret Gillespie dismissed David's somatic complaints and self-injurious behavior as "manipulative," and had never received training on the relationship between perceived manipulative behavior and suicide.

Most staff was unfamiliar with the VRJDC suicide prevention policy. Superintendent Peter Forest was not even sure there was such a policy. The suicide prevention policy, eight pages in length, was descriptive of both constant and sight and sound observation, but little else. The policy stated that "each year every officer will receive two (2) hours of training from the Mental Health Agency." Such training was never provided on an annual basis, nor by the Act Corporation. Rachel Manning was also unfamiliar with the facility's suicide prevention policy, and had no specialized training in conducting suicide risk screening — her primary responsibility at the VRJDC.

Screening/Assessment

David Thomas was on sight and sound observation almost continuously from October 1 through October 24. Per DJJ policy, he should have been transferred to a local hospital for stabilization. Yet David was only taken to the hospital to be pronounced dead. Also contrary to DJJ policy, David never received a mental health evaluation at the VRJDC. Despite receiving psychotropic medication (Depakote) for over a year, he was never assessed by a psychiatrist during nearly six months of confinement in the VRJDC on two occasions, and the facility physician simply renewed the prescription with a telephone order. An incredibly flawed policy prohibited unlicensed Act personnel from diagnosing and

providing treatment and individualized therapy, while allowing them to downgrade and discharge youth from suicide precautions.

Communication

Contrary to both DJJ and VRJDC policies, a "mini treatment team" comprising detention, mental health, and medical personnel was not operational at the facility. Although Ms. Manning completed a one-page form entitled "treatment plan" for David on October 24, she later admitted that the document was not a treatment plan, and she was untrained to perform treatment planning. Personality conflicts between Nurse Gillespie and Ms. Manning prevented effective communication between medical and mental health staff. In fact, these two individuals never discussed David Thomas. According to Ms. Manning, "we really had no occasion to speak to each other." Medical and mental health records at the VRJDC were not integrated and there was confusion as to whether medical and mental health personnel had access to each other's file. Ms. Manning never talked to her Act supervisor or David's family (his mother and grandmother visited him on a weekly basis) about his care, and never accessed his prior mental health records from either Three Springs or Act, her employer. Finally, there were no shift briefings between detention staff at the VRJDC, and several officers claimed to be unaware that David was on close watch status on October 29, the day of his death.

Housing

Contrary to DJJ policy that required rooms housing suicidal youth to "be as suicide-proof as possible," Cell No. 1 in Module C of the VRJDC was unsafe. The door hinges were not beveled, thus allowing for the attachment of a ligature. A few years earlier, another youth had attempted to commit suicide by hanging himself from a door hinge. The small dimensions of the door window created blind spots and an obstructed view of the cell interior. David was subjected to prolonged lockdown in his cell for nearly six months on two occasions, and often subjected to intolerable conditions (e.g., prohibited from routine programming, water turned off in cell, and harassment from an older youth).

Supervision

The DJJ and VRJDC policy calling for three levels of observation (constant 1:1, sight and sound, and close watch at 5-minute intervals) was adequate; the supervision of David Thomas on October 29 was grossly inadequate in that he was unobserved for 30 minutes (from 10:38pm to 11:08pm). Officer Hanson failed to consistently check David's cell at 5-minute intervals throughout the shift, and Officer Holder failed to determine if the youth was breathing during the 11:00pm check. Another officer allowed a youth on sight and sound status to leave his room and walk freely unobserved throughout the unit. An observation log sheet with pre-printed 10-minute time intervals was utilized to record 5-minute observations. Shift supervisors provided inadequate supervision of line staff and rarely verified observation logs. Although Ms. Manning complained to VRJDC officials that detention officers had historically not observed suicidal youth as required, she still downgraded David to close watch status several days before his death.

Ms. Manning and other Act mental health staff failed to provide daily assessments of David's continued risk for suicide. During his most recent 44-day confinement in the VRJDC — a period in which he was on suicide precautions nearly every day — Ms. Manning saw the youth on six occasions. When asked why daily assessments were not provided, Ms. Manning responded that "there was no reason to talk with David on suicide precautions. No one brought any concerns to me."

Intervention

Not all VRJDC staff were certified in CPR and first aid at the time of David's suicide. CPR was conducted on the youth by only one officer, with other personnel appearing uncertain as to their roles. That officer, Jake Holder, was not certified in CPR. The April 2001 audit by the DJJ's Bureau of Quality Assurance found that the VRJDC policy regarding emergency response was vague, and the rescue tool (utilized to cut a ligature) referenced in the policy was not available to staff at the time of David's suicide attempt.

Reporting

Detention Officer Hanson submitted false reports by documenting in the housing unit logbook that both the 10-minute and 5-minute checks were performed as required. He called in a false report to master control reporting that he conducted a master count when, in fact, he had not. Officer Hanson later engaged in improper conduct when he did not provide truthful information, while under oath, during an interview with OIG investigators. More than eight months following David's death, Rachel Manning changed his Act Discharge Summary on June 11, 2002 to include the following: "Suicide assessment found youth to be at moderate risk. Youth was recommended for close watch supervision. Supervision was not conducted as recommended and youth completed suicide by hanging himself from a door hinge in his cell at DJJ."

Review/Follow-up

The VRJDC suicide prevention policy did not address the issue of the review/follow-up process that should be initiated following any serious suicide attempt or suicide. Assistant Superintendent Walter Bennett was responsible for quality assurance at the facility and he, as well as Superintendent Peter Forest, failed to initiate any corrective action following the April 2001 audit from the Bureau of Quality Assurance. There was no reasonable explanation as to why any of the corrective actions (e.g., increased staff training; regularly scheduled staff debriefings; implementation of daily suicide risk assessments, mental health evaluations, and treatment planning; multidisciplinary staff meetings; review of psychotropic medication; etc.) taken following David's suicide could not have been implemented prior to his death.

Closure

The civil trial to determine which defendants, if any, were liable for the suicide of David Thomas's suicide was scheduled to begin on January 29, 2008. The trial date, however, was postponed when attorneys for both sides started to negotiate a settlement in the case. Several weeks later on February 25, 2008, the case was officially closed when the various defendants (for the VRJDC and Act Corporation) agreed to pay the family of David Thomas the sum of approximately $1.2 million in settlement of the lawsuit. ❑

Review of Completed Suicides in the California Department of Corrections and Rehabilitation, 1999 to 2004

by
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***Objective*:** The purpose of this extended review is to assist health care managers, clinicians, prison administrators, and custody staff in identifying and responding effectively to prisoners who present a substantial risk of suicide in the foreseeable future. ***Methods*:** The California Department of Corrections and Rehabilitation (CDCR) is the largest state-operated prison system in the country, with a census range of 155,365 to 163,346 prisoners between 1999 and 2004. The authors conducted a review of all 154 suicides that occurred in CDCR during this period and examined several factors related to the suicide, including demographic characteristics of the inmate, health care information, suicide method, custody information, and emergency response. ***Results*:** The analysis of trends in this six-year review reveals that prisoners who completed suicide were similar to those who took their lives in the community in age distribution and mental health factors. The analysis also found that this group of prisoners who committed suicide had other characteristics or commonalities related specifically to their incarceration. In this review 60 percent of the suicides were judged to have been foreseeable, preventable, or both. ***Conclusions*:** Although suicide is not predictable, the terms "foreseeable" and "preventable" are used to indicate cases in which the risk of suicide was elevated or events occurred that should have triggered clinical or custodial reactions that would have reduced the likelihood of completed suicide. This review provides clues to recognize inmates at elevated risk and identifies some of the health care practices and conditions of confinement to consider for provision of an adequate suicide prevention program.

This review examines prisoner suicides that occurred in the California Department of Corrections and Rehabilitation (CDCR) from 1999 to 2004. The review was conducted pursuant to *Coleman v. Schwarzenegger*, a federal district court case decided in late 1995 in which the plaintiffs, a certified class of state prison inmates, successfully challenged the adequacy of mental health services available to them. The litigation culminated in the appointment of a special master and a deputy master to oversee the development and implementation of a constitutionally sound mental health services program in CDCR. These persons were appointed by the court to remedy constitutionally inadequate mental health care and to promote other constitutional requirements in the program.

CDCR's mental health services delivery system is intended to provide reasonable access to screening, assessment, and treatment for prisoners with serious mental illness. The mental health services delivery system comprises several levels of care, including the correctional clinical case management system (that is, an outpatient program for prisoners within the prison setting), the enhanced outpatient program (which consists of specialized housing units with enhanced mental health treatments), mental health crisis bed units with 24-hour nursing care (that is, an infirmary setting) for suicidal prisoners or prisoners in crisis, and acute and intermediate inpatient care in programs operated by the California Department of Mental Health located within two CDCR facilities and within hospitals run by the California Department of Mental Health that are outside CDCR.

This review is not intended to provide a comprehensive analysis of the mental health services and programs provided by CDCR. Rather, it focuses solely on the suicides that occurred in CDCR during the covered six-year span; on the recorded events before, during, and after each suicide that help facilitate an analysis of the potential suicide risk; and on the clinical and custodial factors relevant to each completed suicide.

Methods

The data on demographic characteristics, health care, and custody presented in this study are based largely on comprehensive reviews conducted at both institutional and central-office levels by CDCR mental health, custody, and administrative personnel. The compilation of the data collected originally occurred as part of CDCR's internal process for the review of individual suicides. At the direction of the special master in the *Coleman* case in 1999, two court-appointed psychiatric experts (the authors of subsequent annual installments and this six-year study) collaborated in the generation of the first annual suicide review.

The development of a more effective individual suicide review process became one of the early goals of the authors' annual suicide reviews, and the process was influenced by the National Commission on Correctional Health Care's standards and recommendations (1). Each annual review generated refinements in the compilation and analysis of collected data, which in turn contributed to substantive and procedural improvements in suicide prevention policies and practices. All of this took place in a state correctional system that has a design-rated capacity of 79,477 beds and an annual population average of 159,893 for the six-year review period, exceeding the rated capacity by approximately 200% (2).

In addition to the suicide review documents prepared by CDCR personnel, the authors also compiled data from prisoners' health and classification records, autopsy reports, and inmate suicide notes (when available). These data were further supplemented by the observations and reports of the mental health experts in the *Coleman* case and monitors at facilities where suicides occurred, as well as by insights and information provided by counsel for plaintiffs in the *Coleman* case.

The sifting of the available demographic data together with the circumstances surrounding each death that were discernible from the attendant records permitted the identification of some shared

[2]This article previously appeared in *Psychiatric Services*, Volume 59, Number 6, June 2008; 676-682. It is reprinted with permission of the authors and the American Psychiatric Association, Copyright © 2008 by the American Psychiatric Association.

characteristics that suggested a heightened potential risk of suicide for some categories of prisoners. Similarly, a close reading of the historical clinical and custody documentation surrounding each completed suicide helped identify some common clinical failures and conditions of confinement that seemed to contribute to the translation of the potential for suicide into reality.

Results

The third leading cause of death in U.S. prisons is suicide, exceeded by natural deaths and deaths from AIDS (3). At least six well-known demographic characteristics of persons who commit suicide are shared by the U.S. general population and the incarcerated subpopulation, including age, gender, ethnicity, drug and alcohol abuse, history of psychiatric treatment, and prior suicide attempts (4,5). For the community, more than 90% of people who die by suicide have a combination of those risk factors, such as male gender and increasing age (4,5). For the incarcerated population these risk factors are similar with the exception of the highest rates of suicide being in the 31 to 40 age range because of fewer numbers of inmates aged 41 and older. The rates for inmates older than 50 are 9%, similar to the 14% rate in the community (4). In prisons, such as the CDCR, younger inmates comprise the majority of inmates, with declines in numbers over time. The percentage of suicide reflects these declining numbers by age but is consistent with prevalence in the community (4,5). From 2000 to 2002 state prisoner suicide rates ranged from 13 to 14 suicides per 100,000 prisoners for every age group over 18 (6). Men are four times more likely than women to commit suicide (7). Non-Hispanic Caucasian males are the highest-risk group (7). The rate of suicide is highest among non-Hispanic Caucasian men, regardless of whether they are inside or outside of correctional facilities (5,7). Family conflict, bereavement, and loss of support are well-known risk factors. First incarceration, which usually takes place in a jail, is a widely known risk factor, as described by Metzner and Hayes (5,8) and others (6,9,10,11).

In contrast to society at large, where ready access to a handgun is identified as a risk factor and handguns are the most common method of suicide, hanging was the most frequently employed method of suicide in custody found in this and other studies. This was not surprising in view of the crucial role played by a readily accessible method. In the sample presented here, hanging was employed in 85% of cases. This finding was consistent with the literature on incarcerated populations (5,6,8) and with the Missouri samples of completed suicides in prisons (N=37) described by Daniel and Fleming (11), who found that hanging was the most frequent method of suicide, employed in 81% of cases.

Although the suicide rate in jails dropped more than 50% between 1983 and 2002 in the United States, from 129 per 100,000 down to 47 per 100,000, as described by Mumola (6), jails continue to have a much higher rate of suicide than prisons. Suicide rates in state prisons also dropped, from 34 per 100,000 in 1980 to 16 per 100,000 in 1990, with further decline to 14 per 100,000 by 2004 (5-7,9).

Recently there have been indications that suicide rates among Hispanics and suicide attempts among young African-American men are rising nationwide (6). Regarding the incarcerated population, non-Hispanic Caucasian inmates commit suicide at the highest rate (96 per 100,000), compared with rates of 30 per 100,000 among Hispanics in custody and rates of 16 per 100,000 among African Americans in custody (6). In the sample presented here, the number of Hispanic men who committed suicide approached that of non-Hispanic Caucasians, while the number of African Americans who committed suicide remained low.

The body of literature on suicide risk factors suggests hypotheses—some already codified in standards promulgated by the American Correctional Association and the National Commission on Correctional Health Care (1,12)—that should elicit keen interest among those charged with the care of incarcerated individuals.

The accompanying tables provide graphic representation of the demographic data collected during each of the six years covered in the study.

The number of annual suicides occurring during the covered period ranged from a low of 15 in 2000 to a high of 36 in 2003. On the basis of the institutional population of CDCR at the end of each of these respective years, the suicide rate ranged from 9.3 per 100,000 to 23.1 per 100,000. The variability in the annual rate of suicides is tracked for each of the covered years in Table1.

The wide range of variability illustrates the pitfalls of comparing annual rates of an event with a low base rate event in a small, fluctuating population. Even with large samples, a minimum of five years of data are needed for meaningful analysis because of year-to-year variability and other factors affecting mental health resources (10,11,13).

Table 1 also provides a breakdown of the annual end-of-year overall CDCR population and the annual number of suicides per year in each type of housing unit where prisoners resided at the time of their deaths. Three different types of housing units were examined: single cell, administrative segregation or secure housing, or mental health crisis bed. Single-cell units are defined as one inmate per cell and can be for the general population or for inmates with specialized needs. Administrative segregation and secure housing units can have one or two persons in a cell. Administrative segregation consists of housing units where inmates are generally locked in their cells 23 hours per day, for days to months at a time, and secure housing units are a “super maximum” security setting where inmates are typically locked in their cells for 23 hours per day for one to many years. Mental health crisis bed units or outpatient housing units have one person in a cell and have nursing and clinical staff on the units 24 hours per day. The breakdown of suicides occurring in single-cell housing in administrative segregation or secure housing units and in the general population (that is, nonspecialized housing units) is also included in Table 1. The data indicate that 73% of all suicides were completed in single cells, while 46% of completed suicides occurred in single cells in administrative segregation or secure housing units and 12% occurred in mental health crisis beds.

These findings regarding the importance of environmental stressors unique to prison conditions, such as isolation, punitive

Table 1

California Department of Corrections and Rehabilitation population, suicide rate, and housing and location of suicide

Variable	Population (at end of year)	Total suicides (N=154)	Suicide rate per 100,000	Single-cell housing		Administrative segregation or secure housing unit		Mental health crisis bed unit	
				N	%	N	%	N	%
Year									
1999	160,970	25	15.5	20	80	9	36	2	8
2000	160,855	15	9.3	12	80	8	53	0	—
2001	155,365	30	19.3	25	83	12	40	6	20
2002	158,099	22	13.9	15	68	6	27	1	5
2003	160,722	36	23.1	22	61	20	56	3	8
2004	163,346	26	15.9	22	85	19	73	3	12
Average	159,893	26	16.2	19	73	12	46	3	12

sanctions, severely restricted living conditions, and acquisition of new charges or imposition of an unexpected sentence were consistent with previous reports (11,14,15). We found that the conditions of deprivation in locked units and higher-security housing were a common stressor shared by many of the prisoners who committed suicide. Liebling (16) found that recent punishment, segregation, long or unexpected sentences, and high levels of reported distress, including symptoms of depression and anxiety, were reported by a sample of men who attempted suicide. In Liebling's (16) sample of 50 cases, 24% had recently experienced punishment or were in segregation and 22% had recently received a long or an unexpected sentence.

Among the 154 prisoners who committed suicide during the six-year period, 149 (97%) were male, and four (3%) were female. Sixty-two (40%) were Caucasian, 55 (36%) were Hispanic, 25 (16%) were African American, four (3%) were Asian, and eight (5%) were of another race or ethnicity. Seventy-three (47%) of the prisoners who completed suicide were aged 31-40 years, 42 (27%) were 18-30 years, 24 (16%) were 41-50 years, 14 (9%) were older than 50 years, and one (1%) was younger than 18 years.

The methods utilized by prisoners who completed suicide included hanging (N=131, or 85%), lacerations or exsanguinations (N=9, or 6%), overdose (N=5, or 3%), and other (N=9, or 6%).

Table 2

Mental health history of persons who committed suicide in the California Department of Corrections and Rehabilitation

Variable	Total suicides (N=154)	Mental health caseload at time of death		Previous mental health treatment		Previous suicidal activity	
		N	%	N	%	N	%
Year							
1999	25	16	64	18	72	17	68
2000	15	8	53	11	73	11	73
2001	30	16	53	22	73	19	63
2002	22	10	45	14	64	12	55
2003	36	23	64	27	75	18	50
2004	26	13	50	20	77	15	58
Average	26	14	54	19	73	15	58

Among prisoners who completed suicide during the six-year period, 73% had a history of mental health treatment, and 62% had a history of suicidal behavior or statements. The breakdown of these numbers for each year is provided in Table 2.

Among the 154 suicides completed during the covered period, 87 (56%) involved prisoners on the mental health caseload. Table 3 provides the breakdown. One caveat: prisoners housed in a mental health crisis bed unit or a Department of Mental Health inpatient program may have been at any level of care before their placement in those beds, including "none." The level of mental health care for the 87 prisoners included in the CDCR mental health caseload at the time of their suicides was as follows: five (3%) were at the Department of Mental Health inpatient (hospital) level of care; two (1%) were at a crisis level of CDCR care (in a mental health crisis bed unit, outpatient housing unit, or transitional care unit); 27 (18%) were in the enhanced outpatient program; and 53 (34%) were in the correctional clinical case management system program.

These findings are consistent with Daniel and Fleming's ten-year review (11) of prison suicides in Missouri. These findings point to the need for thorough suicide risk assessment of prisoners who appear to be relatively high functioning or who are found not to be in need of ongoing mental health treatment. In the group of suicides presented here, 59 (38%) were not in need of mental health treatment (as determined by the CDCR clinical treatment staff), a percentage that was higher than Daniel and Fleming's finding that nearly 30% of the prisoners who committed suicide over a ten-year period in Missouri presented with no mental health problems (11). For eight (5%) inmates, mental health treatment status was unknown because of missing data. In our California sample, like the Missouri sample, the prevalence of prior treatment was higher than current need for treatment. Both findings reflect a well-known indicator of elevated suicide risk in society at large—that is, history of psychiatric treatment. A total of 112 of 154 (73%) of the persons who committed suicide in our sample had a history of psychiatric treatment; however, 101 of the 112 (90%) had axis I diagnoses. Seventy-three percent of the total Missouri sample had been diagnosed as having an axis I disorder at some point in the past, and 66% of our total sample had a diagnosis of an axis I disorder at some point in the past (11).

Also reviewed were emergency responses to inmates who were unresponsive when they were discovered and who subsequently were determined to have committed suicide. The reviews focused on the timely initiation and continuation of cardiopulmonary resuscitation (CPR) by first responders. Policy requires that CPR be initiated and continued with very few exceptions, exceptions

Table 3

Level of care received by persons who committed suicide in the California Department of Corrections and Rehabilitation

Variable	Total suicides	Correctional clinical case management system		Enhanced outpatient program		Mental health crisis bed, outpatient housing unit, transitional care unit		Department of Mental Health		None		Unknown[a]	
		N	%	N	%	N	%	N	%	N	%	N	%
Year													
1999	25	10	40	6	24	0	—	0	—	8	32	1	4
2000	15	4	27	3	20	0	—	1	7	0	—	7	47
2001	30	7	23	6	20	0	—	3	10	14	47	0	—
2002	22	9	41	0	—	0	—	1	5	12	55	0	—
2003	36	16	44	6	17	2	6	0	—	12	33	0	—
2004	26	7	27	6	23	0	—	0	—	13	50	0	—
Total	154	53	34	27	18	2	1	5	3	59	38	8	5

[a] Unknown because of missing data.

such as the presence of rigor mortis, lividity, or obvious trauma, such as severe head injury or decapitation. For the six-year review period, CPR was performed in a timely and appropriate manner on 107 inmates who committed suicide (69%), CPR was not performed in a timely and appropriate manner on 42 inmates (27%), and it could not be determined on the basis of the available documentation whether CPR was performed in a timely or appropriate manner on five inmates (3%). These results are presented by year in Table 4.

Sixty percent of all the suicides covered in this six-year period were either foreseeable or preventable, and some were both. The term "foreseeable" refers to cases in which already known and reasonably available information about an inmate indicates the presence of a substantial or high risk of suicide that requires responsive clinical, custody, or administrative interventions to prevent self-harm. The term foreseeable is not to imply "predictable," because suicide is not predictable, but rather to refer to the presence of an elevated risk to substantial or high risk, which requires appropriate clinical or custodial intervention or monitoring.

The term "preventable" applies to situations where if some additional information had been gathered or some additional interventions had been undertaken, usually as required in existing policies and procedures, the likelihood of a completed suicide might have been substantially reduced. The concept includes, but is not limited to, situations where inmates report self-injurious behaviors or threats but do not receive appropriate evaluation or treatment, are not transferred to a more clinically appropriate or safe environment, or fail to receive appropriate lifesaving procedures, such as timely CPR. Table 5 shows the breakdown of foreseeable and preventable suicides by year. Major contributing factors in foreseeable or preventable deaths included inadequate clinical assessments, inappropriate interventions, incomplete referrals, missed appointments and appointments that were not rescheduled, unsupported diagnoses, failure to review records, assignments to inappropriate levels of mental health care, failure to provide protective housing, and the provision of inadequate or untimely resuscitation efforts. In numerous cases, multiple such factors contributed to the outcome.

Table 4

Cardiopulmonary resuscitation (CPR) performed on persons who committed suicide in the California Department of Corrections and Rehabilitation

Variable	Total suicides	CPR performed		CPR not performed		Unknown	
		N	%	N	%	N	%
Year							
1999	25	15	60	8	32	2	8
2000	15	11	73	4	27	0	—
2001	30	20	67	9	30	1	3
2002	22	16	73	6	27	0	—
2003	36	29	81	5	14	2	6
2004	26	16	62	10	38	0	—
Total	154	107	69	42	27	5	3

Table 5

Foreseeable or preventable suicides in the California Department of Corrections and Rehabilitation

Variable	Total suicides	Foreseeable or preventable		Not foreseeable or preventable		Unable to determine	
		N	%	N	%	N	%
Year							
1999	25	8	32	6	24	11	44
2000	15	11	73	3	20	1	7
2001	30	14	47	13	43	3	10
2002	22	10	45	12	55	0	—
2003	36	29	81	7	19	0	—
2004	26	21	81	5	19	0	—
Total	154	93	60	46	30	15	10

Discussion

During the period covered by this review, both the scope and quality of CDCR's review process improved significantly. In 1999 psychological autopsies were rarely included in reviews, and many of the psychological autopsies were conducted by personnel who were clinically involved directly or indirectly with the specific inmate who committed suicide. By 2004 clinicians not involved in specific inmates' care and treatment had performed psychological autopsies for all inmates who had committed suicide. In 1999 the special master's reports recommended improvements in the review process that included clarification of

the duties of local reviewers, mandated time frames for completion of reviews, and the development of corrective action plans. Subsequent procedural recommendations focused on specific timelines for the preparation of responsive corrective action plans by institutions.

The review process did not focus solely on procedural elements. From the beginning of the study period the annual review helped prompt substantive changes and improvements in suicide prevention policy and practices, including, for example, requirements for increased clinical monitoring of prisoners in high-security units, both for those who were and for those who were not on the mental health caseload; the development of clinical and custody follow-up monitoring regimens for suicidal prisoners discharged from mental health crisis beds and their alternatives; the effective provision of group therapy for prisoners on the mental health caseload in administrative segregation units; the development of routinely administered suicide risk assessments; efforts to keep suicidal prisoners out of cells with heating, ventilating, and air conditioning vents with large-mesh screens to facilitate hanging; a ban on the substitution of video monitoring for the personal observation of prisoners on suicide watch; and the development and implementation of improved CPR policies and practices.

The suicides by four female inmates and the sharp rise in the number of suicides in locked units, particularly administrative segregation, led to greater attention to both areas. Failure to use a suicide risk assessment instrument as required by departmental policy was a factor in the female suicides, and corrective measures were taken. The rising rate of suicide in administrative segregation initiated a two-year effort to analyze the causes and prescribe remedies. The latter have included, among other initiatives, custody monitoring of new arrivals at 30-minute intervals, preplacement mental health screenings, better tracking of history of suicidal behavior, easing of property restrictions for protective custody prisoners, and improved physical safety in cells for newly arrived prisoners. Several of these remedies were based upon data indicating that suicides occurred most often within three weeks of a prisoner's placement in an administrative segregation unit. In the California cases, 39 of 74 (53%) of the suicides that occurred in administrative segregation or secure housing units occurred within three weeks of placement. Individuals housed in administrative segregation and secure housing units are more isolated than those in the general prison population, and these housing changes may represent a very different and stressful environment for inmates as they are placed in these environments because they incurred charges or for safety and protective custody reasons (typically these environments involve 23 hours per day in cell confinement with some exceptions for out-of-cell time for yard activities and showers).

Conclusion

Over the six years of the study, the suicide review process has identified characteristics that ought to draw the attention of staff to certain categories of prisoners, including the following:

- Prisoners with a history of serious mental illness
- Prisoners with a history of suicide attempts
- Prisoners housed in a single cell, particularly in administrative segregation or a secure housing unit
- Prisoners expressing safety concerns with associated anxiety and agitation
- Prisoners with serious medical concerns
- Prisoners with both severe personality disorders and coexisting mental illness
- Prisoners whose legal status has undergone significant change—for example, individuals returning from court after denial of appeals and those receiving third-strike determinations or other additions to their sentences
- Caucasian prisoners, although the number of suicides among Hispanic prisoners increased rapidly during the six-year period.

The above categories may help identify prisoners who might warrant focused attention. CDCR's experience with completed suicides over the study period highlights both clinical practices and physical conditions that ought to be addressed, including the following:

- The failure of clinical staff to refer potentially suicidal prisoners to programs with more intensive monitoring and care
- The provision of prompt and adequate access to higher levels of monitoring and care to prisoners identified as potentially suicidal
- The elimination of physical safety deficiencies in cells and other housing for prisoners most at risk of suicide—for example, large mesh vents or other protuberances regularly used for hanging
- The lack of adequate confidential interviewing space in most high-custody housing units, which inhibits the ability and willingness of potentially suicidal prisoners to communicate effectively with clinicians about their risk of suicide
- Clinicians' failure to review fully and carefully available documentation, such as health and classification records, for indices of prior suicidal activity or ideation
- The timely completion of all of the documentation associated with the institutional or departmental elements of the suicide review process, including the documentation of implemented remedies and adverse personnel actions

This review suggests the following recommendations and considerations for correctional administrative, clinical, and custody staff members to assist in their efforts to establish and manage an effective suicide prevention program:

- The development and timely implementation of effective policies and procedures
- Training and supervision of all staff regarding adherence to policies and procedures
- Development and implementation of a systematic quality management process with review of all completed suicides
- Use of screening criteria, clinical rounds, and timely access to care for inmates in isolated conditions of confinement, especially administrative segregation

- Access and timely transfers to higher levels of care when indicated
- Provision of a timely and complete emergency response system, including CPR, first aid, and transfer to medical units or facilities
- Consideration of the impact of overcrowding and staffing deficiencies.

Prisons and prison life create enormous stress, even for individuals who are mentally healthy. The strain for offenders with mental illness, who are often both fragile and intensely vulnerable, sometimes exceeds their ability to cope. One surpassingly critical purpose of mental health services in prisons is to help identify such individuals for intervention and provide the monitoring, treatment, and physical safety needed for their survival. This review attempts to provide some clues about recognizing prisoners most at risk of suicide and to identify some of the failed practices and inadequate conditions that often combine to prevent the provision of adequate protection and treatment. This review identifies several risk factors, as well as necessary administrative, clinical, and custody staff involvements and responsibilities for an effective suicide prevention program.

Acknowledges and Disclosures

The authors thank J. Michael Keating, Jr., JD, special master appointed through *Coleman v. Schwarzenegger*, Matthew A. Lopes, Jr., JD, deputy special master appointed through *Coleman v. Schwarzenegger*, and the other team experts and monitors also appointed through the case. The authors also thank the California Department of Corrections and Rehabilitation and plaintiffs counsel for their diligence and assistance. The authors report no competing interests.

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News From Around the Country

Offered below are brief stories regarding inmate suicide, offenders with mental illness, and other related topics that have recently occurred and/or been reported throughout the country.

New York

The SHU Exclusion Law, signed into law on January 28, 2008 as Chapter 1 of the Laws of 2008, expands and makes permanent through statute many of the provisions of a April 2007 settlement agreement entitled *Disability Advocates, Inc. v. Office of Mental Health, et al* [02- CV-4002 (S.D.N.Y.)] The settlement agreement attempted to balance the need for treatment of inmates with serious mental illness with the need to maintain safety in correctional facilities, particularly in relation to those inmates facing disciplinary proceedings and possible Special Housing Unit (SHU) placement.

According to the agreement and the new law, an inmate has a "serious mental illness" when he or she has been determined by a mental health clinician to meet at least one of the following criteria:

1) he or she has a current diagnosis of, or is diagnosed at the initial or any subsequent assessment

conducted during the inmate's segregated confinement with, one or more of the following types of Axis I diagnoses, as described in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, and such diagnoses shall be made based upon all relevant clinical factors, including but not limited to symptoms related to such diagnoses:

- schizophrenia (all sub-types),
- delusional disorder,
- schizophreniform disorder,
- schizoaffective disorder,
- brief psychotic disorder,
- substance-induced psychotic disorder (excluding intoxication and withdrawal),
- psychotic disorder not otherwise specified,
- major depressive disorders, or bipolar disorder I and II;

2) he or she is actively suicidal or has engaged in a recent, serious suicide attempt;

3) he or she has been diagnosed with a mental condition that is frequently characterized by breaks with reality, or perceptions of reality, that lead the individual to experience significant functional impairment involving acts of self-harm or other behavior that have a seriously adverse effect on life or on mental or physical health;

4) he or she has been diagnosed with an organic brain syndrome that results in a significant functional impairment involving acts of self-harm or other behavior that have a seriously adverse effect on life or on mental or physical health;

5) he or she has been diagnosed with a severe personality disorder that is manifested by frequent episodes of psychosis or depression, and results in a significant functional impairment involving acts of self-harm or other behavior that have a seriously adverse effect on life or on mental or physical health; or

6) he or she has been determined by a mental health clinician to have otherwise substantially deteriorated mentally or emotionally while confined in segregated confinement and is experiencing significant functional impairment indicating a diagnosis of serious mental illness and involving acts of self-harm or other behavior that have a serious adverse effect on life or on mental or physical health.

According to the requirements of the settlement, virtually all inmates with serious mental illness confined to a Special Housing Unit (SHU) for an aggregate disciplinary sanction of more than 30 days will receive between two and four hours per day, five days per week, of structured, out-of-cell therapeutic programming and/or mental health treatment, in addition to exercise. As detailed below, the state Department of Correctional Services (DOCS) will construct and operate a 100-bed Residential Mental Health Unit (RMHU) within an existing housing unit where inmate participants will receive at least four hours per day of out-of-cell treatment and programming. Congregate exercise will be permitted for certain inmates and will count toward out-of-cell therapeutic programming for those who qualify. The heightened level of care will become fully operational once the appropriate programs and facilities are completed (anticipated in March, 2009). At that time, inmates with serious mental illness who receive disciplinary sanctions will be offered the heightened level of care and transferred to an appropriate program within 30 days.

Further, inmates subject to Keeplock (i.e., segregation located in general population housing units) confinement of more than 60 days, and who are serving that sanction in a separate Keeplock unit, will get at least two individual, out-of-cell clinical sessions per month in a private setting with their primary therapist, and one such session with an OMH psychiatrist or nurse practitioner. A mental health and suicide prevention assessment will be conducted upon assignment to SHU and designated Keeplock units. Such inmates will receive preference for the Intensive Intermediate Care Program (IICP) at Wende Correctional Facility and will be eligible for the RMHU.

As a general rule, SHU or Keeplock confinement will not be imposed on inmates who display self-harming behavior or threats of self-harm.

OMH will strive to limit observation cell (or crisis stabilization unit) stays to four days, although clinical determinations will guide length of stay. For stays longer than a week, the Central

UPDATE
ON THE INTERNET

Recent issues of the ***Jail Suicide/Mental Health Update*** are now available on the Internet at:

www.ncianet.org/suicideprevention

Other jail/juvenile suicide prevention and jail mental health resources, including several recent articles by Lindsay M. Hayes, can be found at the following web sites:

www.hhpub.com/journals/crisis/1997
www.nicic.org
www.ncjrs.org/html/ojjdp/jjjnl_2000_4/sui.html
www.omh.state.ny.us/omhweb/forensic/suicide.htm
www.pbstandards.org/ResourceSection.aspx?id=4

New York Psychiatric Center (CNYPC) director or designee must be consulted. Clinical staff will see inmates confined in observation cells five days per week in an interview room outside the cell, unless that would pose an unacceptable security risk, and nursing staff on two shifts will see the inmates every day.

According to the settlement agreement, DOCS conducted an initial one-time, systemwide review of inmates with serious mental illness in SHU or Keeplock confinement to identify those whose confinement sanctions should be reduced and those who can be safely housed and treated elsewhere. Regular reviews of such inmates' housing status will occur at least every 90 days with an eye toward less restrictive housing if clinically appropriate and not a threat to safety or security. Correctional facility superintendents and OMH staff will review, on an on-going basis, disciplinary sanctions for inmates with serious mental illness. A Central Office Committee made up of high-level staff from DOCS and OMH will meet twice a month to conduct two-hour video conference meetings with correctional facilities' Joint Case Management Committees, on a rotating basis, to review the disciplinary sanctions of inmates with serious mental illness in SHUs and their clinical treatment, and to ensure that the settlement requirements are being implemented as envisioned.

Where mental health was an issue in a disciplinary hearing, facility superintendents will conduct an automatic review in consultation with OMH within a week of the hearing for any inmate who receives a SHU confinement order of more than 60 days — or whose accumulated SHU or Keeplock confinement sanctions reach more than 120 days.

To accommodate the alternative housing needs for inmates with serious mental illness, DOCS is converting an existing housing unit at Marcy Correctional Facility to a 100 single-cell RMHU to provide heightened level of care for inmates with serious mental illness serving disciplinary sanctions. Double-celling will be permitted if OMH determines it to be therapeutically beneficial to the inmates. DOCS will also expand its Special Treatment Program (STP) and Intermediate Care Program (ICP), adding 90 STP beds to bring the total to 133, and 91 ICP beds to supplement the previously existing 572. DOCS is also creating 215 Transitional ICP beds to assist inmates with serious mental illness transition to general population units.

DOCS is also constructing open therapeutic cubicles for group and individual therapy sessions and some small classroom work to enhance visibility and communication. The agency is replacing solid cell doors in the RMHU, STPs, SHUs and designated Keeplock cells with new security doors that allow more visibility and communication between inmates and staff. Finally, OMH is adding a 20-bed hospital ward at the Central New York Psychiatric Center for DOCS inmates.

The cost for this comprehensive initiative is expensive. This year's budget includes more than $50 million for construction, and $2 million each to the state OMH and the DOCS for staffing. Next year's budget will include an additional $12 million, with $19 million added the following year and $29 million in 2010-11 to fully implement and maintain the program.

Montana

A Montana civil rights group on Monday publicized a withering report detailing a two-year probe into the mistreatment and abuse of a mentally ill woman at the Missoula County Detention Facility. The basis for the investigation is the July 2006 pepper-balling of an inmate who — after her arrest on a misdemeanor charge of disorderly conduct — was shot a half-dozen times with a pepperball gun while detained in a maximum-security holding cell. Detention officers, failing to recognize her mental illness, then strapped the woman into a restraint chair for 44 minutes before decontaminating her.

Disability Rights Montana, formerly the Montana Advocacy Program, is a private nonprofit law firm required by the federal government to stand up for the rights of people with disabilities and investigate allegations of abuse or neglect. Believing jailers' treatment of the 24-year-old Missoula woman violated, among other statutes, Montana's Diversion Law, which is designed to prevent people with mental illness from being jailed on minor charges, the advocacy group began investigating the incident.

The 25-page report refers to the never-publicly named inmate as "Adele," and includes among her many disabilities psychotic disorder, mild retardation, fetal alcohol syndrome and post-traumatic stress. The report goes on to describe a "cascade of events which violated Adele's rights under Montana's Constitution, statutes, and multiple jail policies and procedures."

Adele was arrested late on July 1, 2006, for a misdemeanor charge of disorderly conduct, which carries a bail amount of $100. She was initially arrested at St. Patrick Hospital after falling into a dispute with emergency room personnel who refused to treat her, the report states. According to the report's findings, jail staff failed to screen Adele for mental illness when she arrived; violated its own policies, including one defining the circumstances in which non-lethal weapons such as a pepper-ball gun may be used; committed assault on an inmate; and violated the Montana Elder and Persons with Developmental Disabilities Abuse Prevention Act, which requires law enforcement and other public officials to report instances of abuse to one of several government agencies, such as the Department of Health and Human Services.

Instead, officials remained mum about the incident until veteran jailer Mike Burch, who thought the use of force was excessive, leaked a report detailing the incident to the *Missoulian*. Burch was threatened with prosecution and ultimately fired for disclosing "confidential criminal justice information," a decision made by Missoula County Sheriff Mike McMeekin after an FBI report concluded that the inmate's civil rights had not been violated. In May 2007, Burch died of a heart attack.

Although the group intended to release its findings and recommendations in March 2007, the investigation was "hindered and slowed," due in part to resistance from McMeekin and other jail officials, the report states. "The sheriff's office consistently delayed or refused to provide information for over 18 months to the extent that at the time of this report essential evidence including video tapes of Adele's arrival at the jail, audio tapes confirming when she was actually taken to the shower and other essential

documentary evidence, including the FBI investigative report, had never been provided," the report states.

While the document is predominantly remonstrative of the jail staff's response to the situation, it also highlights positive steps McMeekin has taken to improve jail policies, such as sending officers to Crisis Intervention Training to teach them how to work with people with mental lillness.

McMeekin, who also is named in a federal civil suit in the matter, declined to comment on the report's finer points, but issued a statement approved by counsel in the lawsuit. "The matter is in litigation, in federal court, and so I can't comment specifically. The matter has been reviewed, and we're working on additional training, and additional steps that can possibly be taken to better deal with this type of situation," he wrote in an e-mail. "Also, it's subject to the availability of appropriate medical, psychological, and psychiatric professionals on a 24/7 basis. The county is also working toward resolution of the litigation."

Alexandra Volkerts, an attorney for Disability Rights Montana, said the report's findings are important because jails and emergency rooms have become "default holding systems" for people with mental health issues due to a dearth of local services. "People with serious mental illness do not belong in jails, particularly those people who have been picked up on minor crimes," Volkerts said. "Those resources are inefficient, inappropriate and, sometimes, such as in this situation, inhumane. We had a detention officer who made some very bad choices, and those choices resulted in the abuse of a mentally ill woman."

Volkerts called the jail administration's response to the incident "disturbing," and criticized the decision to fire Burch. "Their investigation exonerated the officer who was abusive and punished the officer who made the correct moral choice," she said.

In the report, the group identifies five areas where the jail can improve its ability to "identify, divert and humanely treat people with mental illness and developmental disabilities who are brought to the jail as detainees." The jail's training program that teaches officers to recognize and treat detainees with mental illnesses also appears inadequate, according to the DRM report, which lists numerous recommendations on how jail staff can improve procedures for screening inmates with mental illness.

According to the leaked incident report, written by Detention Officer Jason Sorini, the woman became combative when she was booked into the jail, although Volkerts said video of the woman depicts her initial demeanor as calm. Adele also threatened to harm herself, the jailer's report states, so a team of officers strapped her in a restraint chair until she agreed to calm down and cooperate. She was then placed in a maximum-security holding cell, where she fell asleep. Several hours later, the woman began screaming for her father and climbed onto a desk inside the cell. In his report, Sorini, head of the jail's Disturbance Response Team, wrote that the woman threatened to "jump onto the floor head first and kill herself."

In a DVD recording of the incident obtained by the *Missoulian* last year, the woman, after being ordered to turn around and kneel, steps down from the desk and stands on the floor beside the bunk, screaming the entire time. Sorini twice orders her to get down on the bunk, adding "or force will be used against you" the second time.

Moments later, the guard shoots her six times with the pepper-ball gun. He then fires three additional rounds at the wall near the woman's head, "causing a copious amount of powder to contaminate the area," according to the incident report. Sorini and several other detention officers then enter the cell and again strap the woman into a restraint chair. The officers move the woman to an adjacent holding cell for 44 minutes before Sorini instructs them to shower and decontaminate the woman.

A settlement conference in the federal lawsuit, which names the Missoula County Sheriff's Department, the jail, McMeekin, Sorini and jail Capt. Susan Hintz, is scheduled for Nov. 20.

The above article, "Report Criticizes Handling of Inmate," was written by Tristan Scott, a staff writer for the ***Missoulian****, and appeared in the November 12, 2008 edition of the newspaper.*

Editor's Note: The 22-page report by Disability Rights Montana, entitled "Adele: A Detainee at the Missoula County Detention Facility," is available at: http://disabilityrightsmt.org/janda/articles/UploadFile/1226595161_FINAL%20Adele%20Report%20November%2012%202008.pdf

Arizona

In October 2008, a federal court judge ruled that the grossly inadequate conditions in the Maricopa County Jail system in Phoenix were unconstitutional and jeopardized the health and safety of inmates. In a sweeping rebuff of an attempt by Maricopa County Sheriff Joe Arpaio to terminate a long-standing federal consent decree mandating that he maintain constitutional conditions in the jail system, Judge Neil V. Wake of the United States District Court for the District of Arizona ordered that: jail officials ensure that all detainees receive necessary medical and mental health care; detainees be given uninterrupted access to all medication prescribed by medical staff; detainees be given access to toilets, sinks, toilet paper and soap; and detainees be served food that meets or exceeds the U.S. Department of Agriculture's dietary guidelines.

"Sheriff Arpaio's horrendous treatment of detainees, especially those with severe medical and mental health problems, has caused terrible suffering for years," said Margaret Winter, Associate Director of the American Civil Liberties Union (ACLU)'s National Prison Project. "Judge Wake's decision should serve as a reminder that even a man who brags about being the toughest sheriff in America has to abide by the Constitution."

The ruling comes on the heels of a decision in September by the National Commission on Correctional Health Care to terminate the accreditation of all of the Maricopa County Sheriff's Office jails for failing to maintain compliance with national standards and for providing false information to the agency.

In August 2008, the ACLU went to court to argue that deteriorating conditions within each of the jail system's five facilities necessitated federal court oversight to ensure that Sheriff Arpaio and other county officials maintained safe and humane conditions while providing basic levels of medical and mental health care. Sheriff Arpaio had been attempting for almost seven years to have an existing consent decree terminated.

According to recent allegations from the ACLU, Maricopa County Jail inmates were regularly given moldy bread, rotten fruit and other contaminated food. Detainees with serious medical, mental health and dental needs received inadequate care, and were routinely denied bunks at intake, forcing them to sleep on the floor. Additionally, severe overcrowding in three jail facilities created extremely dangerous environments by significantly increasing the potential for violence among inmates. In one recent example, jail officials chose to punish rather than treat the bizarre behavior of a young and severely psychotic African immigrant. Jail officials put him in disciplinary segregation and chose to house him with other inmates, resulting in his being so severely beaten by his cell mates that he had to be taken to the emergency room. In another case, a young man with cystic fibrosis was routinely denied breathing treatments and other medical treatment despite his repeated requests, resulting in his breathing capacity being eroded by nearly 30 percent.

Dated October 22, 2008, Judge Wake's four-page *Second Amended Judgment* in the case ordered the following:

- Defendants shall not house more than two pretrial detainees in one cell at the Towers jail if the pretrial detainees usually are confined to their cell for twenty-two hours or more per day. Defendants shall not make routine use of portable beds in cells or dayrooms. Defendants shall not place more pretrial detainees in a court holding cell at Madison or in a 4th Avenue Intake holding cell than can sit in the holding cell without making physical contact with another person.

- Defendants shall provide pretrial detainees who are taking prescribed psychotropic medications with housing in which the temperature does not exceed 85° F.

- Defendants shall provide pretrial detainees with sufficient, safe cleaning supplies to enable pretrial detainees to properly clean their cells. Defendants shall assure that cells, including but not limited to medical isolation cells, are properly cleaned and sanitized prior to occupancy by pretrial detainees.

- Defendants shall provide functional and sanitary toilets and sinks, with toilet paper and soap, to pretrial detainees in 4th Avenue Intake and the court holding cells at Madison.

- Defendants shall provide a receiving screening of each pretrial detainee, prior to placement of any pretrial detainee in the general population. The screening will be sufficient to identify and begin necessary segregation, and treatment of those with mental or physical illness and injury; to provide necessary medication without interruption; to recognize, segregate, and treat those with communicable diseases; to provide medically necessary special diets; and to recognize and provide necessary services to the physically handicapped.

- All pretrial detainees confined in the jails shall have ready access to care to meet their serious medical and mental health needs. When necessary, pretrial detainees confined in jail facilities which lack such services shall be transferred to another jail or other location where such services or health care facilities can be provided or shall otherwise be provided with appropriate alternative on-site medical services.

- Defendants shall ensure that the pretrial detainees' prescription medications are provided without interruption where medically prescribed by correctional medical staff.

NATIONAL STUDY OF JAIL SUICIDES

Through a cooperative agreement with the National Institute of Corrections (NIC), U.S. Justice Department, the National Center on Institutions and Alternatives (NCIA) is currently conducting a national study on jail suicides. The 18-month project, representing the third such national study conducted by NCIA for NIC (e.g., see *And Darkness Closes: A National Study of Jail Suicides* in 1981 and the *National Study of Jail Suicides: Seven Years Later* in 1988), will determine the extent and distribution of jail suicides (i.e., city, county, and police department facilities) during 2005 and 2006, and gather descriptive data on demographic characteristics of each victim, characteristics of the incident, and characteristics of the jail facility which sustained the suicide. NCIA will then develop a report of the findings to be utilized as a resource tool for both jail personnel in expanding their knowledge base, and correctional (as well as mental health and medical) administrators in creating and/or revising policies and training curricula on suicide prevention.

Data provided by individual agencies/facilities will be coded and held in the strictest confidence. Results of the study will be presented in summary fashion, thus preventing the linkage of any data to the particular agency/facility from which the information originated.

Phase 1 surveys were distributed in 2007. Phase 2 surveys were distributed in early 2008. Findings from the study should be available by mid-2009. For further information on the project, please contact Lindsay M. Hayes, Project Director, NCIA, 40 Lantern Lane, Mansfield., MA 02048, (508/337-8806), e-mail: lhayesta@msn.com

- Defendants shall continuously monitor conditions, including the population of pretrial detainees, in the designated intake areas.

- Defendants shall ensure that pretrial detainees always have access to toilet and wash basin facilities in the holding cells in intake areas. Defendants shall ensure that pretrial detainees incarcerated in an intake area for more than twenty-four hours are provided with a blanket and a bed or mattress on which to sleep. Defendants shall ensure that a report reflecting the length of stay of pretrial detainees in intake areas is generated by the Sheriff and made available to Plaintiffs' counsel.

- Pretrial detainees classified as general population who are housed at the Towers, Durango, Estrella, and 4th Avenue jails shall be allowed a minimum of one hour, at least four days per week, in areas that permit outdoor recreation or equivalent fresh air recreation with sufficient space for pretrial detainees to move freely.

- Pretrial detainees in administrative segregation shall be entitled to the same outdoor exercise rights as general population pretrial detainees. Pretrial detainees in disciplinary segregation who do not present security or safety risks shall be entitled to the same outdoor exercise rights as general population detainees after the seventh day of their disciplinary period. Time for outdoor exercise will be in addition to the one hour out-of-cell time that is permitted for non-recreational purposes for pretrial detainees in lockdown for twenty-two hours or more per day.

- Defendants shall provide food to pretrial detainees that meets or exceeds the United States Department of Agriculture's Dietary Guidelines for Americans.

- Defendants shall assure that each pretrial detainee in the 4th Avenue Intake areas, the Madison court holding cells, the 4th Avenue psychiatric unit, and segregation units is visually observed by detention officers in a manner and frequency that protects the pretrial detainee's health and safety.

- Defendants shall assure that written reports are recorded and statistics are compiled of all instances of inmate or officer abuse, injuries, violence, assaults, sexual assaults, suicides, deaths, and inmate riots and demonstrations, in a manner conducive to informed access by the Court.

- Defendants will maintain records of their compliance with this Second Amended Judgment and will provide quarterly summaries of those records to Plaintiffs' counsel.

Referring to Judge Wake's court-ordered requirements as simply "recommendations," Sheriff Joe Arpaio said he was pleased that the case is finally over. He stated on his website that "I became Sheriff well over a decade after this case was first filed. Still I have always maintained that we run a safe and constitutionally adequate jail system. This judgment reinforces the excellent work being performed by the detention staff and we all are always committed to improving the jail system wherever possible."

The long-running lawsuit and consent decree is currently entitled *Graves v. Arpaio* (No. CV-77-0479-PHX-NVW), and the court's 83-page *Findings of Fact and Conclusions of Law and Order* can be found at the NIC Information Center website: http://nicic.org/Library/023393

Ohio

On June 25, 2004, Christopher Probst was transported to the Central Ohio Youth Center (COYC) in Marysville to serve a 90-day commitment in the facility's Extended Detention Unit (EDU) program for violating the house arrest condition of his probation. Upon intake, an Admission Report was completed by Christopher's probation officer and noted that he threatened self-injurious behavior the previous year. (A review of prior detention records indicated that the youth self-reported that he "has threatened to kill himself, has tendency to become violent, punches things" while at county juvenile detention facility in August 2003. In addition, the 17-year-old scored in the "caution" range for suicidal ideation and "warning" range for depression/anxiety on a suicide risk screening form when confined in another juvenile facility in December 2002.) A Detention Intake Record Summary was also completed at the COYC, with a "no" response recorded to the question "Have you ever tried to harm yourself?" There were *no* inquires regarding current suicide risk.

On July 1, Christopher met with Emily Giametta, a social worker with the facility's EDU program. This initial assessment was part of the program's required case management plan. The youth denied any current suicidal ideation, but "stated he has had fleeting thoughts of suicide in the past," including drinking a bottle of bleach or shooting himself. Christopher also reported a dysfunctional family unit and a past history of sexual abuse by an uncle. He reported problem areas of substance abuse, unresolved sexual abuse, and anger. The youth was also concerned about a pending accusation that he raped a young girl.

On July 8, Christopher met with COYC medical staff and a Medical History and Physical Exam form was completed. The youth complained of "depression, worry, anxiety, 'worry all the time' – has been to a counselor (not since a year ago)….Potential self-destructive thoughts and behavior in June 2004, has cut on self before x 1, punches things." Burn scars were noted on his left forearm and upper arm, the possible result of self-mutilation. Similar to the intake screening, there were *no* inquires regarding current suicide risk. Also on July 8, Christopher met again with Ms. Giametta to further discuss his case management plan. The youth complained of impulsivity and anger problems, and requested counseling for such. He was also worried about the consequences resulting from a recent plan to escape from COYC, including a possible transfer to the state Department of Youth Services (DYS). As a result of his participation in the escape plan, Christopher had been placed on room confinement status on July 4, meaning that he was locked down in his room all day except for periods of school/program and cleaning/chores.

According to Officer Aaron Masters, sometime during the day of July 16, he escorted COYC Superintendent Victoria Jordan to Christopher's room. Ms. Jordan informed Christopher that his continuing behavior problems would probably result in failure to complete the program and transfer to the state DYS. She warned the youth that one more infraction would result in his transfer out of the facility. According to Officer Masters, Christopher became very upset during and after the conversation with Ms. Jordan. Sometime later that day, while making rounds of the housing unit, Officer Masters observed Christopher crying in his room at approximately 4:47pm. When the officer inquired as to what was wrong, the youth appeared distraught and said that he tried to commit suicide twice that day by tying a sheet around the light fixture in his room, only to have the sheet fall off. Officer Masters immediately referred Christopher to Ms. Giametta for assessment. According to Ms. Giametta's note:

> "Staff reported Chris threatened to tie a sheet around his neck and hang himself. This writer met briefly with Chris, and Chris reported to this writer he was suicidal. Chris was placed on precautions and taken back to the wing to change into a gown for safety. Staff informed this writer that CCI was called and would be coming to assess Chris. This writer met with Chris again, approximately 4:45pm. Chris reported he felt hopeless about his future and had few if any social supports. This writer questioned client regarding the change in his disposition from earlier. Client reported he was sent back to his room due to a behavior problem. Client reported he did not feel like he was capable of completing the program successfully. Client reported he was also upset due to his mother possibly going back to prison. Client reported he received a letter from her reporting that this may be the case. Client reported he felt alone and hopeless about his future. Client reported he felt violent at this time and wanted to explode. This writer questioned client if he felt like he was going to become violent with me or someone else. Client answered that this writer was safe talking with him. Client was agitated, crying hysterically, and stated he 'wanted to die.' Client stated he had nothing to live for and refused to contract for safety. This writer was informed that a crisis counselor would be assessing him soon. Client stated he would not see this writer again. This writer informed staff of client's mental state and was informed that CCI was on their way to evaluate Chris."

According to Ms. Giametta, she informed COYC staff that Christopher was a high risk for suicide and should remain on suicide precautions. She then left the COYC. A few hours later at approximately 7:00pm on July 16, Jennifer Plumley, a social worker from Consolidated Care, Inc. (the COYC's contracted provider for pre-hospital screening and crisis intervention services) arrived at the facility to assess Christopher. According to Ms. Plumley's progress notes:

> "Chris was alert/oriented x 4. Mood/affect consistent. Affect was blunted. Mood was depressed. His eyes were red from crying. Chris has been at JDC since 6/25/04 due to running away and will get out late September. Since being at JDC he has had numerous behavior difficulties and as a result, has been confined to his room most of stay. He reported being sent back to his room today from gym due to problem there. He indicated he felt hopeless and tied a sheet around his light to hang himself, but it wouldn't stay. He told an officer he did it. He reported no history of self-injury, but passive suicidal ideations. He denied any currently. He has never received mental health treatment. He regularly receives counseling here at JDC. He was future oriented and identified alternatives to addressing emotional needs while incarcerated, including utilizing support system. Reviewed crisis intervention and reasons he did not want to harm self. He committed to safety and signed contract. No precautions recommended."

As a result of this assessment, COYC staff accepted Ms. Plumley's recommendation of "no precautions recommended" and discharged Christopher from suicide precautions less than three hours after twice tying a sheet to the light fixture in his room. The youth was returned to his room on room confinement status with his clothes and bedding.

At approximately 11:35am on July 17, 2004, less than 16 hours following his discharge from suicide precautions, Christopher Probst was found hanging from the light fixture in his room by Officer Timothy Foreman. An emergency was called, other officers arrived, and life-saving measures were initiated. Christopher was transported to a local hospital and subsequently pronounced dead.

Two years later in July 2006, the family of Christopher Probst filed a lawsuit against the Central Ohio Youth Center, Superintendent Victoria Jordan and Emily Giametta, as well as Consolidated Care, Inc. and Jennifer Plumley. The lawsuit, filed in the United States District Court for the Southern District of Ohio, Eastern Division, alleged that the defendants were both negligent and deliberately indifferent to Christopher Probst, the result of which was the proximate cause of his suicide. According to the plaintiff's allegations, the issue of communication in the identification and management of suicidal youth was critical in Christopher's case, and the lack of communication between COYC and CCI personnel was the proximate cause of his suicide.

Emily Giametta of COYC assessed Christopher and found him to be at high risk for suicide. Despite this assessment, she made no effort to share her assessment, either verbally or in writing, with Jennifer Plumley of CCI. Ms. Giametta simply told facility staff that the youth was at high risk for suicide and needed to remain on suicide precautions. According to Ms. Plumley's later deposition testimony, when entering the facility during the evening of July 16, she was unaware that Ms. Giametta had placed Christopher on suicide precautions, as well as unaware of Ms. Giametta's progress notes. In addition, Ms. Plumley stated that there was very little in Christopher's file to review, and that she was unaware of his prior history of suicide attempts, sexual abuse history, and mental health treatment. She was also not aware of Christopher's pending rape accusation, or that Superintendent Jordan had talked with him several hours earlier and threatened him with transfer to the state DYS. Further exemplifying poor communication between COYC and CCI was the fact that Ms. Plumley was *not* aware that Christopher even had a medical file at the facility.

Jennifer Plumley would also later testify that it was a constant compliant among CCI clinicians "that we would go in (to COYC) without any information or not offered information." She testified that her assumption was that medical and mental health records were

not available to her, but acknowledged that she never asked for them during assessments. After being informed of all the information regarding Christopher that was contained in Ms. Giametta's assessments, his medical file, his uncertain legal future, and current behavioral problems at the facility, Ms. Plumley acknowledged that access to that information could have prevented the suicide. Specifically, she stated that "I'm upset because I think that there was a chance that it could have – indeed, that it would have provided me with better tools for assessment and that it could, indeed, have altered the outcomes of my assessment."

For her part, Emily Giametta would later testify during her deposition that she had been instructed by Superintendent Jordan that her progress notes were confidential and could not be shared with other mental health professionals from outside the agency, including CCI. This testimony was consistent with that offered by Victoria Jordan. When asked that if Jennifer Plumley had called her on the telephone on July 16 and inquired about her assessment of Christopher, what, if any, information would she have shared, Ms. Giamatta offered the following incredible testimony: "I would not give her any detailed information, clinical information, however, I would have stated, the client as has been indicated was suicidal, had made a gesture." Such a response, in and of itself, might exemplify deliberate indifference.

Ironically, at the time of Christopher's death, Emily Giametta was being provided clinical supervision by CCI. As part of this supervision, her progress notes were being reviewed by a CCI clinician. Therefore, although COYC and CCI had a contractual agreement for CCI to review COYC progress notes as part of their clinical supervision responsibilities, they also had an agreement that apparently prohibited the agencies from sharing and reviewing information contained on Christopher's progress notes, the result of which was his suicide.

All the defendants subsequently filed motions for summary judgment arguing various legal theories as to why they should not be held liable for Christopher's death. Defendants COYC, Jordan, and Giametta eventually settled their parts of the lawsuit with the Probst family. The Plaintiff argued that the remaining defendant — CCI — was liable for unconstitutional policies, failure to supervise Ms. Giametta, and for the failure to adequately train Ms. Plumley. Their policy argument rested on the theory that CCI agreed to provide suicide risk assessments knowing that they would receive less medical information about youth than was necessary to make adequate assessments. The Plaintiff's failure to supervise allegation stemmed from the fact that CCI was contracted to supervise Ms. Giametta on a weekly basis because she was unlicensed and, during the three-week period leading up to Christopher's suicide, she was practicing without any supervision from CCI. The final claim was that CCI's failure to train Ms. Plumley constituted deliberate indifference to his serious medical needs.

In response to the allegation that their policies violated Christopher's rights, CCI argued that the Plaintiff failed to cite to any specific policy in particular, and that "contracting" to make assessments with knowledge that a youth's entire medical record would not be provided was not against the law. For her part, Ms. Plumley contended that she never drew an inference that Christopher was at risk of serious harm and, therefore, she did not disregard any such risk. She attempted to establish that she conducted a thorough evaluation of Christopher and reached the conclusion that he was not suicidal.

On February 4, 2008, Judge Algenon L. Marbley ruled that the pivotal issue the Court must consider was whether Jennifer Plumley was deliberately indifferent when making a final suicide assessment knowing that, due to COYC's privacy policy, relevant information about Christopher was withheld from her. In other words, the court opined, "did Plumley infer that a serious risk of harm could befall Christopher if she made a suicide assessment based on incomplete information?" The court ruled that the Plaintiff had raised sufficient facts from which a jury could find that Ms. Plumley made such an inference, but disregarded it. Specifically, the court cited the deposition testimony of CCI social worker Mindy Koenig, who testified to the frequent concerns raised by CCI workers at staff meetings regarding the lack of communication between COYC and CCI:

> Q: And in those conversations, did it come up that there was maybe medical or mental-health information at COYC that the CCI assessor would want to know?
>
> A: I remember talking about that a little, and the only records that we had access to were up front, they were basically demographic information and our assessments of patients….
>
> Q: And did this come up at the, this communication issue between the two agencies, did that come up at CRT meetings prior to Chris's death?
>
> A: I remember talking about it in the CRT myself, and I also remember just talking with my coworkers in general outside of the meeting….

Judge Marbley found that Jennifer Plumley and other CCI social workers knew that COYC was withholding pertinent files from them at the same time that COYC was asking them to make final suicide assessments. Further, the court found that Ms. Plumley did not ask COYC for relevant background information about what prompted COYC to put Christopher on suicide precautions. According to Judge Marbley, "Given Plumley's training, and given her awareness of COYC's privacy policy and her decision to perform Christopher's suicide assessment anyway, a reasonable jury could find that Plumley actually inferred that Christopher was at risk of serious harm if assessed upon an incomplete picture of his mental state." Ms. Plumley's motion for summary judgment was denied, as was the motion by CCI, with the court ruling that the agency's agreement "to make suicide assessments in the absence of critical information may not be per se illegal, but may nevertheless rise to the level of 1983's deliberate indifference standard."

In early March 2008, defendants CCI and Plumley agreed to settle their share of the federal lawsuit. Combined with the prior settlement with COYC, the Probst family received a total of $387,500 from all defendants.

Kentucky

Ana Romero Rivera died in the Franklin County Regional Jail in Frankfort on August 22, 2008. According to the autopsy report, she hanged herself by the neck with a sheet. The 44-year-old Salvardoran immigrant had been detained while awaiting deportation following a guilty plea to immigration fraud. Ms. Rivera, who worked as a housecleaner to support her elderly mother and her two sons who were attending college in El Salvador, had not

been charged with any crimes other than those related to being an illegal immigrant. On October 13, 2005, immigration officials ordered Ms. Rivera to leave the country within 90 days. She chose not to.

Ms. Rivera's family and their attorney, Matthew Pippin, were not convinced that her death was a suicide, and requested that state police investigate the case. Mario Aguilar, the victim's brother-in-law, told the *Lexington Herald-Leader* that "We don't believe she did it herself. She was almost ready to be deported and was looking forward to it…..She was fine. And then on August 18, she said she was sick." Family members said that shortly before she died, Ms. Rivera was placed in isolation for refusing to eat. Mr. Aguilar said she had called them several times from the jail saying her stomach hurt and she was vomiting. Ms. Rivera's family believed she had lost almost 35 pounds while confined in the jail. "It seems awfully strange that she exhibited no signs of being suicidal," Attorney Pippin told the newspaper. "I think at this point the family will want to see what our expert says." The family has hired a private pathologist to conduct a second autopsy.

Congress has recently demanded that more information be made public about the dozens of deaths in jails and prisons involving individuals awaiting deportation. Many of the deaths have been suicides. *The New York Times* recently reported that at least 71 people scheduled for deportation died in custody from 2004 to May 2008. Advocates are calling for improved health care and suicide prevention measures for such detainees.

Ms. Rivera, who came to the United States from El Salvador more than three years ago, was arrested January 14, 2008 by state police after giving federal immigration officials a false identification card. Her brother-in-law said officers were looking for another suspect when they knocked on her door. As a result of the charges, Ms. Rivera spent five months in the Shelby County Jail in Shelbyville and was then transferred to the Franklin County Regional Jail in May, where she stayed for four months. On August 7, Ms. Rivera entered a guilty plea after federal prosecutors offered a sentence of time served in exchange for immediate deportation. According to her court-appointed attorney William L. Patrick, he explained to Ms. Rivera through an interpreter that although her case was resolved on August 7, the United States Marshals were going to keep her in jail until Immigration and Customs Enforcement (ICE) agents could pick her up for deportation. That process could take between three and six weeks. Attorney Patrick said that once her plea agreement was accepted and her case resolved, Ms. Romero appeared relieved, even though that meant she would be deported from the United States. "She was quite happy about it," he told the *Lexington Herald-Leader*. "She was looking forward to going home."

According to federal regulations, individuals court-ordered for deportation can only be held in local jails for 48 hours (excluding and holidays). Ms. Rivera was found hanging almost two weeks following her court hearing, and one day before ICE agents were scheduled to pick her up. ICE spokeswoman Gail Montenegro told the *Lexington Herald-Leader* that agents make every effort to take into custody a person held on a detainer within 48 hours, but offered no reason why it took much longer to pick up Ms. Rivera. The agency's position is that Ms. Rivera was not in ICE custody at the time of her death, therefore, the agency would not comment on her death. It remains unknown as to whether Ms. Rivera was aware that she was scheduled to be transferred out of the jail the day after her death. ❑

JAIL SUICIDE/MENTAL HEALTH UPDATE

This technical update, published quarterly, is part of the National Center on Institutions and Alternatives (NCIA)'s continuing efforts to keep state and local officials, individual correctional staff, mental health/medical personnel, and interested others aware of developments in the field of jail suicide prevention and jail mental health services. Please contact us if you are not on our mailing list. Readers are encouraged to offer opinions and/or submit pertinent materials for inclusion into future issues.

This publication is supported by Cooperative Agreement Award Number 07HI05GJTO from the National Institute of Corrections (NIC), U.S. Department of Justice. Points of view or opinions stated in this document do not necessarily represent the official position or policies of the U.S. Department of Justice.

Unless otherwise noted, all articles appearing in this newsletter are written by Lindsay M. Hayes, Editor/Project Director.

AVAILABLE JAIL/PRISON/JUVENILE SUICIDE PREVENTION MATERIALS

And Darkness Closes In...National Study of Jail Suicides (1981)
National Study of Jail Suicides: Seven Years Later (1988)
Training Curriculum on Suicide Detection and Prevention in Jails and Lockups—Second Edition (1995)
Curriculum Transparencies—Second Edition (1995)
Prison Suicide: An Overview and Guide to Prevention (1995)
Juvenile Suicide in Confinement: A National Survey (2004)
Jail Suicide/Mental Health Update (Volumes 1-17)

For more information regarding the availability and cost of the above publications, contact either:

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