

April 22, 2005

Dear Members of the Corrections Oversight Committee,

In late 2004, the Department of Corrections (DOC) contracted with Lindsay Hayes, a nationally recognized authority on suicide prevention at the Center on Institutions and Alternatives, to independently assess current practices and offer recommendations for improving the department's policies and practices as they pertain to suicide prevention. I have attached to this e-mail a copy of his 52-page report.

We are encouraged by this report. Mr. Hayes reinforces that we are headed in the right direction and had this to say about our state and contracted employees: "[I] consistently met numerous correctional and health care officials, as well as officers, nurses and mental health clinicians, who were genuinely concerned about inmate suicide and committed to taking whatever actions were necessary to reduce the opportunity for such tragedy in the future".

Mr. Hayes noted strengths in DOC policy and practice related to training, identification and screening of inmates and communication between correctional and health officials, reporting (. "time allotment assigned to training in the area of suicide prevention met or exceeded national correctional practices". "Overall it would be this writer's opinion that VT DOC has very good intake and screening."); nonetheless, we agree these procedures can be improved and are in need of some revision.

His recommendations relative to staff training, mental health assessment protocols, consolidation of restraint policies, clarification of special observation status and levels of supervision offer good input for the current re-writing of our administrative directives and validate the provisions already laid out in the DOC comprehensive mental health plan.

Mr. Hayes identifies lack of consistency in the application of our policies as our number one problem and warns us that to be successful, we must embark upon a comprehensive quality assurance program. We are in agreement. Interviews are already being conducted to identify a quality assurance director and create a quality council in partnership with the Department of Health. We recognize that achieving consistency will require the contributions and commitment of the hundreds of individuals involved in this important work.

Mr. Hayes' recommendations regarding housing are extensive, have potentially significant resource implications and are under review.

We are pleased by his affirmation that given ". the agency's pro-active approach, as well as both management and line staff concern about the issue, [he] is confident that implementation of the various recommendations contained within this report will result in successful efforts to reduce the likelihood of future inmate suicides within the VTDOC."

Much needs to be done. We look forward to working with the Corrections Oversight Committee, the Corrections Citizens Advisory Group and other interested parties as we implement a plan of action that is mindful of the pending Mental Health Contract RFP and balanced with the competing challenges we face from overcrowding, staff turnover, reentry initiatives, pending legislation, grievances and other issues.

A copy of his report will also be available on our web page ([www.doc.state.vt.us](http://www.doc.state.vt.us)).

Sincerely,

Robert D. Hofmann  
Commissioner

**TECHNICAL ASSISTANCE REPORT ON SUICIDE  
PREVENTION PRACTICES WITHIN THE VERMONT  
DEPARTMENT OF CORRECTIONS**

by

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April 11, 2005

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**Appendix**

## **TECHNICAL ASSISTANCE REPORT ON SUICIDE PREVENTION PRACTICES WITHIN THE VERMONT DEPARTMENT OF CORRECTIONS**

### **A. INTRODUCTION**

The following is a summary of the observations, findings, and recommendations of Lindsay M. Hayes, Project Director of the National Center on Institutions and Alternatives, following the provision of technical assistance to the Vermont Department of Corrections (VTDOC). During the past two years, the VTDOC has experienced both a high number of inmate suicides and suicide rate within its combined jail and prison correctional system. As a result, the department has reviewed those deaths and begun to revise various policy and procedural directives relating to suicide prevention, developed a comprehensive mental health services plan, as well as received critical investigative reports from both the Vermont Protection and Advocacy, Inc. and consultants of the Vermont Agency of Human Services. In order to more independently assess current practices, as well as offer any appropriate recommendations for improving the department's suicide prevention policies and practices, the Vermont Department of Corrections decided to seek the consultant services of this writer.

This assessment was based upon a review of numerous VTDOC policy directives (including *361.01.13: Suicide Prevention*) and other documents relating to suicide prevention (e.g., intake screening and assessment forms, suicide prevention lesson plans, etc.); on-site review of physical plant and suicide prevention practices within the eight correctional facilities; case file reviews of selected inmates placed on suicide precautions in each of the facilities; interviews with numerous correctional, medical, and mental health personnel at each facility; and informal interviews with several inmates at each facility.

### **Toured Facilities**

- Chittenden Regional Correctional Facility (South Burlington)
- Dale Women's Facility (Waterbury)
- Marble Valley Regional Correctional Facility (Rutland)
- Northeast Regional Correctional Facility (St. Johnsbury)
- Northern State Correctional Facility (Newport)
- Northwest State Correctional Facility (St. Albans)
- Southeast State Correctional Facility (Windsor)
- Southern State Correctional Facility (Springfield)

### **Reviewed Materials**

- *Comprehensive Mental Health Services Plan: Report by the Commissioner of Corrections to the Joint Legislative Corrections Oversight and Mental Health Oversight Committees* (dated January 15, 2005)
- VTDOC's Policy No. 361.01: *Mental Health Directive and Protocols*, including all relevant suicide prevention and mental health policies (dated October 1997)
- Revised draft of 361.01: *Mental Health Directive and Protocols*, including all relevant suicide prevention and mental health policies
- Draft of *Vermont Department of Corrections Root Cause Analysis Process* (dated October 4, 2004)
- VTDOC Policy No. 370: *The Use of Administrative and Disciplinary Segregation for Inmates with Serious Mental Illness* (dated May 2002)
- Various mental health directives from Paul G. Cotton, M.D., P.C.
- *Investigative Report into the Deaths of Seven Vermont Inmates and Related Issues* by Michael Marks, Esq., and Philip McLaughlin, Esq. (dated March 13, 2004)

- *Plan of Response*: Report by the Commissioner of Corrections to the Joint Corrections Oversight Committee (dated April 28, 2004)
- *Who's Keeping Watch?: A Review of the Department of Corrections' Oversight and Management of Selected Contracts for Inmates Services* by the Vermont State Auditor's Office (dated May 14, 2004)
- *Report of an Investigation into the Circumstances Surrounding the Death of Lawrence Bessette, Jr. on May 22, 2003 at the Northern State Correctional Facility* by Vermont Protection and Advocacy, Inc. (dated February 12, 2004)
- *Report of an Investigation into the Circumstances Surrounding the Death of James Quigley at the Northwest State Correctional Facility* by Vermont Protection and Advocacy, Inc. (dated May 21, 2004)
- *Investigation into the Suicide of R.R. while Incarcerated at the Chittenden Regional Correctional Facility* by Vermont Protection and Advocacy, Inc. (dated January 2005)
- *A Statistical Review of Incident Reports Documented as Attempted Suicides within the Vermont Department of Corrections During the Period Between January 1, 2003 and February 20, 2004* by John C. Holt, Ph.D. (dated March 8, 2004)
- Various VTDOC suicide prevention training material (including *Suicide Prevention Lesson Plans*, dated April 26, 2004, PowerPoint slides, *Suicide Prevention End of Course Test and Evaluation*, *Suicide Prevention for New Employees*, *Student Supplement*)
- Various correspondence between VTDOC Commissioner Steven M. Gold and VP & A Executive Director Ed Paquin regarding disciplinary proceedings against inmates who self-harm (dated September 12, 2004; August 31, 2004; August 12, 2004; July 23, 2004; and June 4, 2004)
- Complaint and Motion for Preliminary Injunction in *Vermont Protection and Advocacy, Inc. v. Steve Gold, Commissioner*
- Report of Plaintiff Expert Craig Van Tuinen, M.D. (dated June 3, 2004)

- Memorandum from John B. Murphy to Steven M. Gold Regarding Treatment of Inmates Who Self-Harm



## B. FINDINGS AND RECOMMENDATIONS

Detailed below is this writer's assessment of suicide prevention practices within the Vermont Department of Corrections. It is formatted according to this writer's eight (8) critical components of a suicide prevention policy: staff training, identification/screening, communication, housing, levels of supervision, intervention, reporting, and follow-up/mortality review. This protocol was developed in accordance with both Standard 4-4373 of the American Correctional Association's *Standards for Adult Correctional Institutions* (2003) and Standard P-G-05 of the National Commission on Correctional Health Care's *Standards for Health Services in Prisons* (2003).<sup>1</sup> Where indicated, recommendations are also provided.

It should be noted that the following assessment provides more focus upon corrective action than to highlighting deficiencies in current suicide prevention practices within the VTDOC. The reason for this focus is because several recent prior investigations of both mental health and suicide prevention practices within the VTDOC (e.g., see Marks and McLaughlin report and Vermont Protection and Advocacy, Inc. reports) have been completed and widely disseminated. This writer's assessment of current suicide practices within the agency mirrors many, but not all, of the findings from these recent prior reports. To repeat these deficiencies again in detail would not serve any useful purpose. Therefore, the discussion sections in the following assessment are limited to providing findings that justify a specific recommendation. Further, specific recommendations are offered in each section regarding further revision of the VTDOC's newly revised suicide prevention policy (361.01.04).

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<sup>1</sup>American Correctional Association (2003), *Standards for Adult Correctional Institutions*, 4<sup>th</sup> Edition, Lanham, MD: Author; National Commission on Correctional Health Care (2003), *Standards for Health Services in Prisons*, Chicago, IL: Author.

According to the suicide prevention deliverable that was cited in the VTDOC's *Comprehensive Mental Health Services Plan* (submitted to the Joint Legislative Corrections Oversight and Mental Health Oversight Committees in January 2005):

The Department shall ensure the existence of a program of suicide prevention at all facility sites. It is recognized that inmates are at elevated risk for self-injury and suicide and that all staff involved in the care and custody of inmates must be alert and responsive to this possibility. The Department shall ensure that mental health staff participates in prevention activities, case reviews, emergency consultation, and training of correctional staff in recognition of symptoms and interventions.

The recommendations contained within this assessment are consistent with the suicide prevention provisions of the new *Comprehensive Mental Health Services Plan*.

Finally, it is perhaps not surprisingly that this writer found inconsistent suicide prevention practices operating across the eight correctional facilities. While the recommendations to follow are offered in the context of correcting deficiencies and reducing inconsistency of suicide prevention practices throughout the system, this issue will remain a serious problem unless the VTDOC embarks upon a comprehensive quality assurance program to not only regularly monitor the services of its medical and mental health contractors, but also its own correctional personnel.<sup>2</sup>

A final word regarding consistency. Throughout the several week process of touring eight correctional facilities, this writer consistently met numerous correctional and health care

officials, as well as officers, nurses and mental health clinicians, who were genuinely concerned about inmate suicide and committed to taking whatever actions were necessary to reduce the opportunity for such tragedy in the future.

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<sup>2</sup>This should include the requirement that medical and mental health contractors develop and maintain suicide prevention policies that are consistent with the VTDOC newly revised suicide prevention policy (361.01.04).

1) **Staff Training**

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

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

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

indicate potential suicide, and how to respond appropriately. Initial and at least biennial training are provided, although annual training is highly recommended.”

**DISCUSSION:** Upon employment within the VTDOC, all correctional staff are required to complete a basic training program at the DOC Training Academy. The program includes a full-day workshop devoted to suicide prevention. In addition, correctional staff are required to complete a 2-hour condensed version of the course on an annual basis. This writer found that a comparable suicide prevention training program was not available to either medical or mental health personnel.

This writer reviewed various VTDOC suicide prevention training material (including *Suicide Prevention Lesson Plans*, dated April 26, 2004, PowerPoint slides, *Suicide Prevention End of Course Test and Evaluation*, *Suicide Prevention for New Employees*, *Student Supplement*) and was impressed by their content. In addition, the current time allotment assigned to both the pre-service and annual training in the area of suicide prevention met or exceeded national correctional practices.

Finally, it should be noted that although prior investigative reports regarding inmate suicides within the VTDOC (namely, the Marks and McLaughlin and Vermont Protection and Advocacy, Inc. reports) were critical of the adequacy of suicide prevention training within the agency, neither report cited any specific deficiencies nor offered any guidance for corrective action in this area. It would appear to this writer that such criticism was unfounded.

**RECOMMENDATIONS/POLICY REVISIONS:** A few recommendations are offered. *First*, it is strongly recommended that the following topics be added to the suicide prevention lesson plan: 1) discussion regarding recent suicides/suicide attempts within the VTDOC, 2) liability issues, 3) specific instruction (e.g., “mock drills”) regarding the proper role of both correctional and medical staff in responding to suicide attempts and providing first aid/CPR, and 4) the agency’s revised suicide prevention policy. *Second*, it is strongly recommended that both medical and mental health personnel be required to complete both the basic and annual suicide prevention training workshops. *Third*, in order for the program to become multidisciplinary, it is strongly recommended that both medical and mental health personnel take active roles in the presentation of suicide prevention training within the VTDOC.

The VTDOC’s suicide prevention policy (361.01.04) should be revised to include the following additional provisions:

1. All staff (including correctional, medical, and mental health personnel) who have regular contact with inmates shall be initially trained in the identification and management of suicidal inmates, as well as in the components of the DOC’s suicide prevention program. Initial training shall encompass eight (8) hours of instruction. New employees shall receive such instruction through the training academy. Current staff shall receive such instruction through scheduled training workshops.
2. The initial training should include inmate suicide research, why the environments of correctional facilities are conducive to suicidal behavior, potential predisposing factors to suicide, high-risk suicide periods, warning signs and symptoms, identifying suicidal inmates despite their denial of risk, components of the facility’s suicide prevention policy, and liability issues associated with inmate suicide.
3. All staff who have regular contact with inmates shall receive two (2) hours of annual suicide prevention training. The two-hour training workshop shall include a review of predisposing risk

factors, warning signs and symptoms, identifying suicidal inmates despite their denial of risk, and review of any changes to the agency's suicide prevention program. The annual training shall also include general discussion of any recent suicides and/or suicide attempts in the agency.

4. All staff who have regular contact with inmates shall receive standard first aid and cardiopulmonary resuscitation (CPR) training. All staff shall also be trained in the use of various emergency equipment located in each housing unit. In an effort to ensure an efficient emergency response to suicide attempts, "mock drills" shall be incorporated into both initial and refresher training for all staff.

## 2) Identification/Screening

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

Identification/screening is also critical to a correctional system's suicide prevention efforts. An inmate can attempt suicide at any point during incarceration -- beginning immediately following reception and continuing through a stressful aspect of confinement. Although there is disagreement within the psychiatric and medical communities as to which factors are most predictive of suicide in general, research in the area of jail and prison suicides has identified a number of characteristics that are strongly related to suicide, including: intoxication, emotional state, family history of suicide, recent significant loss, limited prior incarceration, lack of social support system, psychiatric history, and various "stressors of confinement."<sup>3</sup> Most importantly, prior research has consistently reported that at least two thirds of all suicide victims communicate their intent some time prior to death, and that any individual with a history of one or more suicide attempts is at a much greater risk for suicide than those

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<sup>3</sup>Bonner, R. (1992), "Isolation, Seclusion, and Psychological Vulnerability as Risk Factors for Suicide Behind Bars," in R. Maris et. al. (Editors) *Assessment and Prediction of Suicide*, New York, NY: Guilford Press, 398-419.



who have never made an attempt.<sup>4</sup> The key to identifying potentially suicidal behavior in inmates is through inquiry during both the intake screening/assessment phase, as well as other high-risk periods of incarceration. Finally, given the strong association between inmate suicide and special management (i.e., disciplinary and/or administrative segregation) housing unit placement, any inmate assigned to such a special housing unit should receive a written assessment for suicide risk by mental health staff upon admission to those units.

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

**DISCUSSION:** Overall, it would be this writer’s opinion that the VTDOC has very good intake screening and assessment procedures to identify potentially suicidal inmates, but that these procedures are in need of slight revision. All inmates receive basic intake screening (via the “Intake Medical Screening” and “Initial Needs Survey” forms) by booking officers upon admission into one of the facilities. The forms contain numerous pertinent questions regarding mental health and potential suicide risk. In addition, each inmate is assessed by medical staff

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<sup>4</sup>Clark, D. and S.L. Horton-Deutsch (1992), “Assessment in Absentia: The Value of the Psychological Autopsy Method for Studying Antecedents of Suicide and Predicting Future Suicides,” in R. Maris et. al. (Editors) *Assessment and Prediction of Suicide*, New York, NY: Guilford Press, 144-182.

(via the “Medical History and Screening” form. Medical staff also complete an “Intake Mental Health Screen/Suicide Prevention” form on each inmate. This form also includes numerous inquiries regarding mental health and potential suicide risk. Any inmate confined for 14 days or more is also given a “Physical Assessment.” Upon referral, mental health staff will assess an inmate utilizing a “Mental Health Evaluation.”

This writer found three areas of concern. *First*, despite the fact that the VTDOC’s current suicide prevention policy requires inquiry regarding “history of suicide risk during prior department confinement and/or at most recent sending institution,” there does not appear to be a timely process (including chart review) to determine whether the newly arrived inmate was at risk for suicide during a previous confinement within the system. Given the fact that prior history of suicidal behavior can be a key factor in determining current risk, it is critically important that the VTDOC know of any suicidal behavior of inmates based upon their prior DOC confinement. *Second*, any “incapacitated person” brought into the VTDOC for protective custody is provided a brief “Intake Health Screening by Health-Trained Staff for Incapacitated Persons Only” form that is completed by medical staff. The form, however, does not contain any inquiry regarding suicide risk.

*Third*, according to the VTDOC’s current “Disciplinary Procedures for Inmates with Serious Mental Illness”:

Shift Supervisors shall be responsible to ensure that mental health staff are consulted when a disciplinary report is issued which meets the following criteria:

1. the inmate is on the mental health roster; or

2. the inmate appears to be in need of mental health services and/or his or her behavior is such that staff suspect the presence of a mental health issue including the potential for self-harm.

To safeguard inappropriate placement of mentally ill inmates into segregation units, the VTDOC created the “Mental Health Disciplinary Report Form” several years ago. The form requires that correctional personnel determine if the inmate is on the mental health roster and/or appears “confused, presents with unusual behavior, speech, or inability to understand the DR process?” If an affirmative response is found in either question, mental health staff are required to be notified to conduct an assessment of the inmate. This writer found that mental health staff are often, but not always, notified when a disciplinary report is written on a mentally ill inmate. However, the “Mental Health Disciplinary Report Form” is rarely, if ever, used in the VTDOC. In addition, despite the requirement that mental health personnel conduct an assessment of the referred inmate, an assessment is not always conducted.<sup>5</sup>

**RECOMMENDATIONS/POLICY REVISIONS:** A few recommendations are offered. *First*, it is strongly recommended that the intake process be revised in order to allow for further inquiry of potentially suicidal behavior. The revised process should include the following inquiry on either the Initial Needs Survey form completed by booking officers or the Intake Mental Health Screen/Suicide Prevention form completed by medical staff:

*Was inmate a medical, mental health or suicide risk during any prior confinement in a DOC facility?*

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<sup>5</sup>In one very disturbing example, a mental health clinician informed this writer that they did not assess, nor review the health care chart of, any mentally ill inmate with a pending disciplinary report, and simply “signed off on a stack of the (Mental Health Disciplinary) forms” each week.

In order to determine whether the “inmate was a medical, mental health or suicide risk during any prior confinement in a DOC facility,” two options appear to be available: 1) the VTDOC’s information management system could be revised to include verification of an inmate’s prior placement on suicide precautions while in DOC custody; or 2) medical personnel could review the inmate’s old (and presumably archived) health care file to determine whether the inmate had a prior history of placement on suicide precautions while in DOC custody.

*Second*, it is strongly recommended that the “Intake Health Screening by Health-Trained Staff for Incapacitated Persons Only” form be discarded. Any “incapacitated person” brought into the VTDOC for protective custody should be provided with regular intake screening through administration of the “Intake Medical Screening” and “Initial Needs Survey” forms by booking officers, and “Medical History and Screening” and “Intake Mental Health Screen/Suicide Prevention” forms by medical staff.

*Third*, given the strong association between inmate suicide and special management housing, consistent with national correctional standards, it is strongly recommended that the Mental Health Disciplinary Report Form or a similar assessment form be developed and administered by mental health staff as soon as possible (but no later than 24 hours) following any inmate’s placement into a special management housing unit. The assessment should determine whether existing mental illness and/or suicidal behavior contraindicate the placement. Therefore, the existing requirement that an inmate be on the mental health roster and/or correctional personnel’s determination that the inmate appears to display unusual behavior

should be discarded and replaced with a procedure requiring that all inmates designated for special management housing are to be assessed by mental health staff.

The VTDOC's suicide prevention policy (361.01.04) should be revised to include the following additional provisions:

1. The Booking Officer or medical personnel shall determine (either through the information management system or manual check) whether the inmate was a medical, mental health or suicide risk during any prior contact and/or confinement within DOC custody. Such information shall be entered into the Intake Screening Form.

2. Although an inmate's verbal responses during the intake screening process are critically important to assessing the risk of suicide, staff should not exclusively rely on an inmate's denial that they are suicidal and/or have a history of mental illness and suicidal behavior, particularly when their behavior and/or actions or even previous confinement in the facility suggest otherwise.

3. Following completion of the intake screening process, the Booking Officer shall confer with the Shift Supervisor. The Shift Supervisor will review the forms for accuracy and completeness, and then confer with medical and/or mental health personnel in determining the appropriate disposition (i.e., general population, suicide precautions, hospital, mental health referral, release, etc.). The Booking Officer and Shift Supervisor shall each sign the completed forms.

4. All intake screening forms completed by both the Booking Officer and Medical Personnel (i.e., Intake Medical Screening, Initial Needs Survey, Medical History and Screening, and Intake Mental Health Screen/Suicide Prevention) shall be reviewed for accuracy and completeness.

5. Completed intake screening forms shall be performed on all inmates prior to housing assignment, except under the following circumstances:

- a) Inmate refuses to comply with process;
- b) Inmate is severely intoxicated or otherwise incapacitated;

c) Inmate is violent or otherwise belligerent;

6. For inmates listed in 5:a-c above, the Booking Officer shall still complete all non-questionnaire sections of the inmate's intake screening forms and make a notation on the forms regarding why the inmate was unable to answer the questionnaire section. The Shift Supervisor shall then make the appropriate Disposition. A continuing, but reasonable effort shall be made to complete the intake screening form.

7. If the inmate is being received from another facility (e.g., an intra-system system), the sending facility shall be required to complete a Health Services Transfer Form which documents any medical, mental health, and suicide risk needs of the inmate. The form shall be reviewed for accuracy and completeness and signed by the Medical Supervisor of both the sending and receiving facility.

8. Given the strong association between inmate suicide and special management (e.g., restrictive housing, protective custody, disciplinary confinement, administrative segregation, etc.) housing unit placement, any inmate assigned to such a special housing unit shall receive a written assessment for suicide risk by mental health staff upon admission to the special unit.

### 3) **Communication**

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

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

**DISCUSSION:** Effective communication between correctional, medical, and mental health staff is not an issue that can be easily written as a policy directive, and is often dealt with more effectively through recurring training session, treatment team meetings, and shift briefings. With two exceptions, the VTDOC appeared to have very good practices for ensuring effective communication regarding management needs of suicidal inmates. In addition, this writer sensed that correctional, medical, and mental health personnel had a good working relationship and shared pertinent information regarding inmates placed on suicide precautions as appropriate, particularly during multidisciplinary Treatment Team Meetings conducted on a weekly basis at each facility. Further, several facilities have recently begun to maintain a daily roster of inmates placed on suicides precautions.

The two areas of concern are as follows. *First*, correctional, medical, and mental health personnel do not consistently utilize both the “Notification of Suicide Watch” (previously referred to as the “Authorization for Suicide Watch” form) and “Mental Health Referral Forms” as required by VTDOC policy.

*Second*, the VTDOC has maintained a policy and practice for several years regarding the placement of inmates displaying certain concerning behavior on “special observation status.” Such status includes inmates who are: suicidal (Code 1), medical concerns (Code 2), behavior concerns (Code 3), high security/escape risk (Code 4), lock in/protective custody (Code 5), and personal reasons (Code 6). “Behavior concerns” is not defined but can include concern regarding the inmate’s mental health. “Personal reasons” might include death in the inmate’s family, divorce, or any other negative news received. Such placement and designation normally is initiated by correctional personnel and results in greater frequency of observation (e.g., 15 and 30-minute rounds). Inmates placed on Code 1 for suicidal behavior are required to be referred to mental health staff for assessment; whereas inmates on Code 3 Status (behavior concerns) and Code 6 (personal reasons) are not necessarily referred to mental health staff.

When touring housing units, this writer observed that the special observation statuses of several inmates on Code 1, Code 3, and Code 6 were unknown to mental health personnel in the facility. Because the special observation policy allows for suicidal inmates to be placed on Code 1 status, it is possible that these inmates will not be referred to mental health staff. In addition, because Code 3 and Code 6 is initiated by correctional staff, it is also possible that the concerning behavior justifying special observation status is not being communicated to mental



health personnel. Many of these Code 1-3 inmates were being observed at 15-minute intervals. The logical conclusion that can be drawn from these enhanced observation levels is that these inmates were at some level of risk. It would be this writer's opinion that any concerning and/or unusual behavior that justifies more frequent observation by correctional staff requires notification and assessment by mental health personnel.

**RECOMMENDATIONS/POLICY REVISIONS:** It is strongly recommended that VTDOC's special observation policy be revised to exclude reference to suicidal (Code 1), behavior concerns (Code 3), and personal reasons (Code 6). The revised policy should state that any concerning and/or unusual behavior that justifies more frequent observation by correctional staff requires notification and assessment by mental health personnel. Pending assessment by mental health personnel, the inmate should be placed on suicide precautions. Upon assessment, mental health staff may decide to maintain the inmate on suicide precautions or place the inmate on a 30-minute "mental health observation" level.

The VTDOC's suicide prevention policy (361.01.04) should be revised to include the following additional provisions:

1. All incidents of suicidal behavior shall be documented on the Suicide Watch Observation Sheet, which shall also be utilized to document all physical cell checks of suicidal inmates.
2. The Shift Supervisor shall keep a separate daily roster of all inmates on suicide precautions (and mental health observation). The roster shall contain the inmate's name, housing location, level of observation, and date of initiation. Copies of the roster shall be distributed to appropriate correctional, medical, and mental health personnel.

3. The Shift Supervisor shall ensure that appropriate staff are properly informed of the status of each inmate placed on suicide precautions (and mental health observation). The Shift Supervisor shall also be responsible for briefing the incoming Shift Supervisor regarding the status of all inmates on suicide precautions (and mental health observation).
4. Should an inmate be returned to the facility following temporary transfer to the hospital or other facility for assessment and/or treatment of self-injurious behavior, the Shift Supervisor shall inquire of medical and/or mental health officials what further prevention measures, if any, are recommended for the housing and supervising the returning inmate.
5. Authorization for suicide precautions, any changes in suicide precautions, and observation of detainees placed on suicide precautions shall be documented on designated forms (including the daily roster, Notification of Suicide Watch, and Suicide Watch Observation Sheet) and distributed to appropriate staff.
6. Multidisciplinary treatment team meetings (to include facility officials, medical, mental health, and case worker personnel) shall occur on a weekly basis to discuss the status of inmates on suicide precautions and mental health observation.
7. Any inmate displaying unusual and/or concerning behavior that justifies an increased level of observation shall be placed on suicide precautions until they can be assessed by mental health personnel.

#### 4) Housing

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

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

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

physical restraints (e.g., restraint chairs/boards, straitjackets, leather straps, etc.) should be avoided whenever possible, and only utilized as a last resort for periods in which the inmate is physically engaging in self-destructive behavior. Housing assignments should not be based on decisions that heighten depersonalizing aspects of incarceration, but on the ability to maximize staff interaction with inmates. Finally, an inmate engaging in self-injurious behavior should *not* receive a disciplinary sanction for such behavior.

**DISCUSSION:** This writer's tour of the eight correctional facilities found few, if any, cells that could be considered suicide-resistant. Most cells designated to house suicidal inmates had one or more of the following protrusions: clothing hooks, wall/ceiling grates without protective covering or small mesh screening, bunk holes, door hinges, and space between the Lexan glass and window bars.

In addition, until recently, VTDOC policy and practice allowed for inmates with serious mental illness who engaged in self-injurious behavior to receive a disciplinary sanction and transfer to a segregation unit. It would be this writer's opinion that any punitive sanction imposed upon any inmate (regardless of their mental status) is contrary to national correctional standards and practices. Finally, the VTDOC appears to have separate policies regarding use of restraints that are ordered by custody versus health care staff. The possible result is that health care staff may be excluded from oversight on the management of some uses of restraints.

**RECOMMENDATIONS/POLICY REVISIONS:** A few recommendations are offered. *First*, as stated in current policy, suicidal inmates should not be housed in cells that contain any

obvious protrusions that enhance a hanging attempt. As such, it is strongly recommended that suicidal inmates only be housed in suicide-resistant cells and the VTDOC embark upon a program that removes all obvious and dangerous protrusions from cells designated for housing suicidal inmates. Attached for consideration in the Appendix is a “Checklist for the ‘Suicide-Resistant’ Design of Correctional Facilities.”

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

*Third*, it is strongly recommended that the VTDOC consolidate their restraint policies and develop one policy on restraint to cover its initiation by either correctional or health care personnel. Key components of the restraint policy are offered below.

The VTDOC’s suicide prevention policy (361.01.04) should be revised to include the following additional provisions:

1. The Shift Supervisor shall immediately notify medical and/or mental health personnel when a decision has been made to remove an inmate’s clothing (and issue safety garment or other protective clothing) or to apply any physical restraints.
2. The use of any restraints shall include adherence to the following minimal guidelines:<sup>6</sup>
  - a) Restraints may not be used for punitive purposes;
  - b) Restraints require a physician’s (or licensed practitioner permitted by the state) order;

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<sup>6</sup>These guidelines are consistent with NCCHC standards, as well as the federal government’s Centers for Medicare and Medicaid Services rules on the use of restraints in hospitals.

- c) Restraint equipment must be medically appropriate;
- d) Inmates placed in restraints shall be under the constant observation of correctional staff;
- e) Vital signs of inmates placed in restraints shall be assessed every 15 minutes by medical staff;
- f) Each restrained limb shall be untied for at least 10 minutes every two hours to allow for proper circulation;
- g) Restrained inmates shall be allowed bathroom privileges as soon as practical;
- h) Restraint orders shall be reviewed by a physician (or licensed practitioner permitted by the state) every 4 hours and include a face-to-face assessment of the inmate, and must be reduced as quickly as possible to the level of least restriction necessary to protect the inmate and others as determined by the physician (or licensed practitioner permitted by the state);
- i) Restraint orders shall be automatically terminated after 4 hours unless renewed by a physician (or licensed practitioner permitted by the state) following a face-to-face assessment of the inmate. In extreme cases when the inmate's highly agitated state exceeds 12 hours and they cannot be released because of physical danger to self or others, the inmate shall be transferred to the hospital; and
- j) Inmates placed in restraints shall be assessed by mental health personnel within 24 hours.

5) **Levels of Supervision**

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

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

**DISCUSSION:** For the most part, the VTDOC’s current suicide prevention policy adequately addresses the issue of observation provided to suicidal inmates. Two levels of suicide precautions are available: *standard* and *special* observation. Mental health staff and/or a

correctional supervisor may authorize suicide precautions, but only a clinician may downgrade or remove an inmate from suicide precautions. This writer found, however, that current practices are not always consistent with VTDOC policies. For example, although “special supervision” is available in policy, it is rarely, if ever, utilized because it requires constant, uninterrupted observation by correctional staff. A “Suicide Watch Observation Sheet” is required to be completed on all inmates placed on suicide precautions. For the most part, the form is completed at all facilities (although some facilities incorrectly use either a “Special Observation Report” or “Special Confinement Report”). More importantly, this writer found several examples of late and/or incomplete entries of the form by correctional staff. In addition, the shift supervisor does not always review and sign the form as required.

Further, although current policy requires that suicidal inmates are assessed by mental health staff on a daily basis, this writer found that such inmates are not always assessed on daily basis by mental health staff. When assessed, progress notes by mental health staff do not always provide adequate justification for the decision to continue, downgrade, or discontinue suicide precautions. In addition, following discharge from suicide precautions, inmates are not always regularly followed-up by mental health staff.

Finally, current VTDOC policy requires that mental health staff conduct rounds in all segregation units on a weekly basis with documentation of the rounds noted in the “Segregation/Close Custody Rounds Log.” Despite this directive, this writer found that mental health staff did not consistently conduct weekly rounds in the segregation units within the eight



facilities.<sup>7</sup> In addition, the “Segregation/Close Custody Rounds Log” (nor any other form) was not being utilized to document mental health rounds.

**RECOMMENDATIONS/POLICY REVISIONS:** This writer would offer several recommendations. *First*, it is strongly recommended that any correctional, medical, and mental health staff be encouraged to utilize “special observation” status for an inmate who requires constant supervision because they are actively suicidal, either by threatening or engaging in self-injury, or displaying behavior that would be considered a high risk for suicide. *Second*, it is strongly recommended that the shift supervisor make periodic visits to the housing units containing inmates on suicide precautions to ensure that only “Suicide Watch Observation Sheets” are being utilized and that each form is complete, accurate, and does not contain notations recorded at exact 15-minute time intervals. In addition, each Suicide Watch Observation Sheet should be reviewed and signed by the shift supervisor at the end of each shift.

*Third*, in order to safeguard the continuity of care for suicidal inmates, all inmates discharged from suicide precautions should remain on the mental health roster and receive regularly scheduled follow-up assessments by mental health staff until their release from VTDOC custody. As such, it is recommended that the current reassessment schedule following discharge from suicide precautions be revised as follows: daily for 5 days, once a week for 2 weeks, and then once a month until release from VTDOC custody, unless their treatment plan requires more frequent assessment.

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<sup>7</sup>In fact, in one facility, mental health staff were prohibited from making cell-side rounds and selective inmates were

*Fourth*, given the strong relationship between suicidal behavior and “special management unit” (e.g., restrictive housing, protective custody, disciplinary confinement, administrative segregation, etc.) housing, it is strongly recommended that mental health increase their regular presence on those units. As such, mental health staff should conduct cell-by-cell rounds in all special management units at least three times per week. These rounds should be documented on either the Segregation/Close Custody Rounds Log or other comparable log.

*Fifth*, it is strongly recommended that the VTDOC develop a policy or directive regarding inmates requiring “mental health observation.” The directive should stipulate the concerning behaviors that necessitate this special observation status, the frequency of observation by correctional staff (i.e., staggered 30-minute intervals), and responsibilities for monitoring by mental health personnel.

The VTDOC’s suicide prevention policy (361.01.04) should be revised to include the following additional provisions:

1. Shift supervisor shall make periodic visits to the housing units containing inmates on suicide precautions to ensure that only “Suicide Watch Observation Sheets” are being utilized and that each form is complete, accurate, and does not contain notations recorded at exact 15-minute time intervals. Each Suicide Watch Observation Sheet shall be reviewed and signed by the shift supervisor at the end of each shift.
2. Closed-circuit television monitoring can be used as a supplement to, but shall never be a substitute for, the physical observation checks provided by correctional staff.

3. Given the strong association between inmate suicide and special management (e.g., restrictive housing, protective custody, disciplinary confinement, administrative segregation, etc.) housing unit placement, mental health staff shall make rounds of the special housing unit at least three times per week and, at a minimum, visually observe each inmate confined in the unit. Documentation of the rounds shall be made in the Segregation/Close Custody Rounds Log (or other comparable log), with any significant findings documented in the inmate's health care record.

4. In order to ensure the continuity of care for suicidal inmates, all inmates discharged from suicide precautions shall remain on the mental health roster and receive regularly scheduled follow-up assessment by mental health staff until their release from VTDOC custody. Unless their individual treatment plan directs otherwise, the reassessment schedule shall be as follows: daily for 5 days, once a week for 2 weeks, and then once every month until release from custody.

6) **Intervention**

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

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

**DISCUSSION:** Based upon review and observation, it would be this writer's opinion that the VTDOC has very good policies and practices regarding intervention following an inmate's suicide attempt. Most, but not all, housing units contained a first aid kit; pocket mask,

mouth shield, or Ambu bag; and rescue tool (to quickly cut through fibrous material).  
Correctional staff received regular training in this area.

**RECOMMENDATIONS/POLICY REVISION:** This writer would offer only one recommendation. The VTDOC's suicide prevention policy (361.01.04) should be revised to include the following additional provision:

1. Each housing unit should contain various emergency equipment, including a first aid kit; pocket mask, face shield, or Ambu-bag; and rescue tool (to quickly cut through fibrous material). The Shift Supervisor staff should ensure that such equipment is in working order on a daily basis.

7) **Reporting**

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

**DISCUSSION:** Following review of the investigative reports concerning the 2003 and 2004 inmate suicides, this writer found that all reporting procedures seemed to have been appropriately followed.

**RECOMMENDATIONS/POLICY REVISIONS:** None

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

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

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

**DISCUSSION:** Historically, the VTDOC has relied upon outside agencies (e.g., Vermont State Police, Attorney General's Office) to investigate inmate suicides within its correctional facilities. These investigations have not included a comprehensive and

multidisciplinary mortality review process. Most recently, the VTDOC has entered into a Memorandum of Understanding with the Vermont Department of Health (VDH) to initiate a “Root Cause Analysis Process” for reviewing both serious suicide attempts and completed suicides. In addition, the VDH has agreed to participate in the VTDOC’s new quality assurance initiative that establishes a “Quality Oversight Committee” (at central office) and “Facility-Based Oversight Committee” (at each correctional facility). Policies have been drafted for both the root cause analysis and quality assurances processes. These are all excellent initiatives.

**RECOMMENDATIONS/POLICY REVISIONS:** As offered in the introduction to this assessment, the correction of deficiencies and reduction of inconsistency throughout the correctional system in the area of suicide prevention will remain a serious problem unless the VTDOC embarks upon a comprehensive quality assurance program to not only regularly monitor the services of its medical and mental health contractors, but also its own correctional personnel. In addition to the need for immediate implementation of both the root cause analysis and quality assurances process, this writer has only one additional recommendation. The currently drafted policy for the “DOC Quality Oversight Committee” states, in part, that “the goal of the DOC Quality Oversight Committee is to serve as a vehicle to enhance communication and oversight of performance improvement activities and to assure compliance with National Commission on Correctional Health Care (NCCHC) standards.” This writer would argue that the primary purpose of the Quality Oversight Committee (as well as Facility-Based Oversight Committees) should be to ensure compliance with all VTDOC policies and directives. Compliance with these policies and directives, which are consistent with NCCHC standards, will better ensure inmate safety.



## C. SUMMARY OF RECOMMENDATIONS

### Staff Training

1) It is strongly recommended that the following topics be added to the suicide prevention lesson plan: a) discussion regarding recent suicides/suicide attempts within the VTDOC, b) liability issues, c) specific instruction (e.g., “mock drills”) regarding the proper role of both correctional and medical staff in responding to suicide attempts and providing first aid/CPR, and d) the agency’s revised suicide prevention policy.

2) It is strongly recommended that both medical and mental health personnel be required to complete both the basic and annual suicide prevention training workshops.

3) In order for the program to become multidisciplinary, it is strongly recommended that both medical and mental health personnel take active roles in the presentation of suicide prevention training within the VTDOC.

4) The VTDOC’s suicide prevention policy (361.01.04) should be revised to include the following additional provisions:

1. All staff (including correctional, medical, and mental health personnel) who have regular contact with inmates shall be initially trained in the identification and management of suicidal inmates, as well as in the components of the DOC’s suicide prevention program. Initial training shall encompass eight (8) hours of instruction. New employees shall receive such instruction through the training academy. Current staff shall receive such instruction through scheduled training workshops.

2. The initial training should include inmate suicide research, why the environments of correctional facilities are conducive to suicidal behavior, potential predisposing factors to suicide, high-risk suicide periods, warning signs and symptoms, identifying suicidal inmates despite their denial of risk, components of the facility’s suicide prevention policy, and liability issues associated with inmate suicide.

3. All staff who have regular contact with inmates shall receive two (2) hours of annual suicide prevention training. The two-hour training workshop shall include a review of predisposing risk factors, warning signs and symptoms, identifying suicidal inmates despite their denial of risk, and review of any changes to the

agency's suicide prevention program. The annual training shall also include general discussion of any recent suicides and/or suicide attempts in the agency.

4. All staff who have regular contact with inmates shall receive standard first aid and cardiopulmonary resuscitation (CPR) training. All staff shall also be trained in the use of various emergency equipment located in each housing unit. In an effort to ensure an efficient emergency response to suicide attempts, "mock drills" shall be incorporated into both initial and refresher training for all staff.

### **Identification/Screening**

5) It is strongly recommended that the intake process be revised in order to allow for further inquiry of potentially suicidal behavior. The revised process should include the following inquiry on either the Initial Needs Survey form completed by booking officers or the Intake Mental Health Screen/Suicide Prevention form completed by medical staff:

*Was inmate a medical, mental health or suicide risk during any prior confinement in a DOC facility?*

In order to determine whether the "inmate was a medical, mental health or suicide risk during any prior confinement in a DOC facility," two options appear to be available: a) the VTDOC's information management system could be revised to include verification of an inmate's prior placement on suicide precautions while in DOC custody; or b) medical personnel could review the inmate's old (and presumably archived) health care file to determine whether the inmate had a prior history of placement on suicide precautions while in DOC custody.

6) It is strongly recommended that the "Intake Health Screening by Health-Trained Staff for Incapacitated Persons Only" form be discarded. Any "incapacitated person" brought into the VTDOC for protective custody should be provided with regular intake screening through administration of the "Intake Medical Screening" and "Initial Needs Survey" forms by booking officers, and "Medical History and Screening" and "Intake Mental Health Screen/Suicide Prevention" forms by medical staff.

7) Given the strong association between inmate suicide and special management housing, consistent with national correctional standards, it is strongly recommended that the Mental Health Disciplinary Report Form or a similar assessment form be developed and administered by mental health staff as soon as possible (but no later than 24 hours) following any inmate's placement into a special management housing unit. The assessment should determine whether

existing mental illness and/or suicidal behavior contraindicate the placement. Therefore, the existing requirement that an inmate be on the mental health roster and/or correctional personnel's determination that the inmate appears to display unusual behavior should be discarded and replaced with a procedure requiring that all inmates designated for special management housing are to be assessed by mental health staff.

8) The VTDOC's suicide prevention policy (361.01.04) should be revised to include the following additional provisions:

1. The Booking Officer or medical personnel shall determine (either through the information management system or manual check) whether the inmate was a medical, mental health or suicide risk during any prior contact and/or confinement within DOC custody. Such information shall be entered into the Intake Screening Form.

2. Although an inmate's verbal responses during the intake screening process are critically important to assessing the risk of suicide, staff should not exclusively rely on an inmate's denial that they are suicidal and/or have a history of mental illness and suicidal behavior, particularly when their behavior and/or actions or even previous confinement in the facility suggest otherwise.

3. Following completion of the intake screening process, the Booking Officer shall confer with the Shift Supervisor. The Shift Supervisor will review the forms for accuracy and completeness, and then confer with medical and/or mental health personnel in determining the appropriate disposition (i.e., general population, suicide precautions, hospital, mental health referral, release, etc.). The Booking Officer and Shift Supervisor shall each sign the completed forms.

4. All intake screening forms completed by both the Booking Officer and Medical Personnel (i.e., Intake Medical Screening, Initial Needs Survey, Medical History and Screening, and Intake Mental Health Screen/Suicide Prevention) shall be reviewed for accuracy and completeness.

5. Completed intake screening forms shall be performed on all inmates prior to housing assignment, except under the following circumstances:

- a) Inmate refuses to comply with process;
- b) Inmate is severely intoxicated or otherwise incapacitated;

c) Inmate is violent or otherwise belligerent;

6. For inmates listed in 5:a-c above, the Booking Officer shall still complete all non-questionnaire sections of the inmate's intake screening forms and make a notation on the forms regarding why the inmate was unable to answer the questionnaire section. The Shift Supervisor shall then make the appropriate Disposition. A continuing, but reasonable effort shall be made to complete the intake screening form.

7. If the inmate is being received from another facility (e.g., an intra-system system), the sending facility shall be required to complete a Health Services Transfer Form which documents any medical, mental health, and suicide risk needs of the inmate. The form shall be reviewed for accuracy and completeness and signed by the Medical Supervisor of both the sending and receiving facility.

8. Given the strong association between inmate suicide and special management (e.g., restrictive housing, protective custody, disciplinary confinement, administrative segregation, etc.) housing unit placement, any inmate assigned to such a special housing unit shall receive a written assessment for suicide risk by mental health staff upon admission to the special unit.

### **Communication**

9) It is strongly recommended that VTDOC's special observation policy be revised to exclude reference to suicidal (Code 1), behavior concerns (Code 3), and personal reasons (Code 6). The revised policy should state that any concerning and/or unusual behavior that justifies more frequent observation by correctional staff requires notification and assessment by mental health personnel. Pending assessment by mental health personnel, the inmate should be placed on suicide precautions. Upon assessment, mental health staff may decide to maintain the inmate on suicide precautions or place the inmate on a 30-minute "mental health observation" level.

10) The VTDOC's suicide prevention policy (361.01.04) should be revised to include the following additional provisions:

1. All incidents of suicidal behavior shall be documented on the Suicide Watch Observation Sheet, which shall also be utilized to document all physical cell checks of suicidal inmates.

2. The Shift Supervisor shall keep a separate daily roster of all inmates on suicide precautions (and mental health observation).

The roster shall contain the inmate's name, housing location, level of observation, and date of initiation. Copies of the roster shall be distributed to appropriate correctional, medical, and mental health personnel.

3. The Shift Supervisor shall ensure that appropriate staff are properly informed of the status of each inmate placed on suicide precautions (and mental health observation). The Shift Supervisor shall also be responsible for briefing the incoming Shift Supervisor regarding the status of all inmates on suicide precautions (and mental health observation).

4. Should an inmate be returned to the facility following temporary transfer to the hospital or other facility for assessment and/or treatment of self-injurious behavior, the Shift Supervisor shall inquire of medical and/or mental health officials what further prevention measures, if any, are recommended for the housing and supervising the returning inmate.

5. Authorization for suicide precautions, any changes in suicide precautions, and observation of detainees placed on suicide precautions shall be documented on designated forms (including the daily roster, Notification of Suicide Watch, and Suicide Watch Observation Sheet) and distributed to appropriate staff.

6. Multidisciplinary treatment team meetings (to include facility officials, medical, mental health, and case worker personnel) shall occur on a weekly basis to discuss the status of inmates on suicide precautions and mental health observation.

7. Any inmate displaying unusual and/or concerning behavior that justifies an increased level of observation shall be placed on suicide precautions until they can be assessed by mental health personnel.

### **Housing**

11) It is strongly recommended that suicidal inmates only be housed in suicide-resistant cells and the VTDOC embark upon a program that removes all obvious and dangerous protrusions from cells designated for housing suicidal inmates. Attached for consideration in the Appendix is a "Checklist for the 'Suicide-Resistant' Design of Correctional Facilities."

12) It is strongly recommended that no inmate (regardless of their mental status) received a punitive sanction (i.e., disciplinary report) based solely upon self-injurious behavior.

13) It is strongly recommended that the VTDOC consolidate their restraint policies and develop one policy on restraint to cover its initiation by either correctional or health care personnel. Key components of the restraint policy are offered below.

14) The VTDOC's suicide prevention policy (361.01.04) should be revised to include the following additional provisions:

1. The Shift Supervisor shall immediately notify medical and/or mental health personnel when a decision has been made to remove an inmate's clothing (and issue safety garment or other protective clothing) or to apply any physical restraints.

2. The use of any restraints shall include adherence to the following minimal guidelines:<sup>8</sup>

a) Restraints may not be used for punitive purposes;

b) Restraints require a physician's (or licensed practitioner permitted by the state) order;

c) Restraint equipment must be medically appropriate;

d) Inmates placed in restraints shall be under the constant observation of correctional staff;

e) Vital signs of inmates placed in restraints shall be assessed every 15 minutes by medical staff;

f) Each restrained limb shall be untied for at least 10 minutes every two hours to allow for proper circulation;

g) Restrained inmates shall be allowed bathroom privileges as soon as practical;

h) Restraint orders shall be reviewed by a physician (or licensed practitioner permitted by the state) every 4 hours and include a face-to-face assessment of the inmate, and must be reduced as quickly as

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<sup>8</sup>These guidelines are consistent with NCCHC standards, as well as the federal government's Centers for Medicare and Medicaid Services rules on the use of restraints in hospitals.

possible to the level of least restriction necessary to protect the inmate and others as determined by the physician (or licensed practitioner permitted by the state);

i) Restraint orders shall be automatically terminated after 4 hours unless renewed by a physician (or licensed practitioner permitted by the state) following a face-to-face assessment of the inmate. In extreme cases when the inmate's highly agitated state exceeds 12 hours and they cannot be released because of physical danger to self or others, the inmate shall be transferred to the hospital; and

j) Inmates placed in restraints shall be assessed by mental health personnel within 24 hours.

### **Levels of Supervision**

15) It is strongly recommended that any correctional, medical, and mental health staff be encouraged to utilize "special observation" status for an inmate who requires constant supervision because they are actively suicidal, either by threatening or engaging in self-injury, or displaying behavior that would be considered a high risk for suicide.

16) It is strongly recommended that the shift supervisor make periodic visits to the housing units containing inmates on suicide precautions to ensure that only "Suicide Watch Observation Sheets" are being utilized and that each form is complete, accurate, and does not contain notations recorded at exact 15-minute time intervals. In addition, each Suicide Watch Observation Sheet should be reviewed and signed by the shift supervisor at the end of each shift.

17) In order to safeguard the continuity of care for suicidal inmates, all inmates discharged from suicide precautions should remain on the mental health roster and receive regularly scheduled follow-up assessments by mental health staff until their release from VTDOC custody. As such, it is recommended that the current reassessment schedule following discharge from suicide precautions be revised as follows: daily for 5 days, once a week for 2 weeks, and then once a month until release from VTDOC custody, unless their treatment plan requires more frequent assessment.

18) Given the strong relationship between suicidal behavior and "special management unit" (e.g., restrictive housing, protective custody, disciplinary confinement, administrative segregation, etc.) housing, it is strongly recommended that mental health increase their regular presence on those units.

As such, mental health staff should conduct cell-by-cell rounds in all special management units at least three times per week. These rounds should be documented on either the Segregation/Close Custody Rounds Log or other comparable log.

19) It is strongly recommended that the VTDOC develop a policy or directive regarding inmates requiring “mental health observation.” The directive should stipulate the concerning behaviors that necessitate this special observation status, the frequency of observation by correctional staff (i.e., staggered 30-minute intervals), and responsibilities for monitoring by mental health personnel.

20) The VTDOC’s suicide prevention policy (361.01.04) should be revised to include the following additional provisions:

1. Shift supervisor shall make periodic visits to the housing units containing inmates on suicide precautions to ensure that only “Suicide Watch Observation Sheets” are being utilized and that each form is complete, accurate, and does not contain notations recorded at exact 15-minute time intervals. Each Suicide Watch Observation Sheet shall be reviewed and signed by the shift supervisor at the end of each shift.
2. Closed-circuit television monitoring can be used as a supplement to, but shall never be a substitute for, the physical observation checks provided by correctional staff.
3. Given the strong association between inmate suicide and special management (e.g., restrictive housing, protective custody, disciplinary confinement, administrative segregation, etc.) housing unit placement, mental health staff shall make rounds of the special housing unit at least three times per week and, at a minimum, visually observe each inmate confined in the unit. Documentation of the rounds shall be made in the Segregation/Close Custody Rounds Log (or other comparable log), with any significant findings documented in the inmate’s health care record.
4. In order to ensure the continuity of care for suicidal inmates, all inmates discharged from suicide precautions shall remain on the mental health roster and receive regularly scheduled follow-up assessment by mental health staff until their release from VTDOC custody. Unless their individual treatment plan directs otherwise, the reassessment schedule shall be as follows: daily for 5 days, once a week for 2 weeks, and then once every month until release from custody.

### **Intervention**



21) The VTDOC's suicide prevention policy (361.01.04) should be revised to include the following additional provision:

1. Each housing unit should contain various emergency equipment, including a first aid kit; pocket mask, face shield, or Ambu-bag; and rescue tool (to quickly cut through fibrous material). The Shift Supervisor staff should ensure that such equipment is in working order on a daily basis.

### **Reporting**

None

### **Follow-up/Mortality Review**

22) The currently drafted policy for the "DOC Quality Oversight Committee" states, in part, that "the goal of the DOC Quality Oversight Committee is to serve as a vehicle to enhance communication and oversight of performance improvement activities and to assure compliance with National Commission on Correctional Health Care (NCCHC) standards." This writer would argue that the primary purpose of the Quality Oversight Committee (as well as Facility-Based Oversight Committees) should be to ensure compliance with all VTDOC policies and directives. Compliance with these policies and directives, which are consistent with NCCHC standards, will better ensure inmate safety.

**D. CONCLUSION**

It is hoped that the short-term technical assistance provided by this writer, as well as the recommendations contained within this report, will be of assistance to the Vermont Department of Corrections. As stated in the introduction of this report, throughout the several week process of touring eight correctional facilities, this writer consistently met numerous correctional and health care officials, as well as officers, nurses and mental health clinicians, who were genuinely concerned about inmate suicide and committed to taking whatever actions were necessary to reduce the opportunity for such tragedy in the future. Based upon the agency's pro-active approach, as well as both management and line staff concern about the issue, this writer is confident that implementation of the various recommendations contained within this report will result in successful efforts to reduce the likelihood of future inmate suicides within the VTDOC.

Respectfully Submitted By:

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April 11, 2005

## **APPENDIX**

## CHECKLIST FOR THE “SUICIDE-RESISTANT” DESIGN OF CORRECTIONAL FACILITIES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9) CCTV monitoring does *not* prevent a suicide, it only identifies a suicide attempt in progress. If utilized, CCTV monitoring should *only* supplement the physical observation by staff. The camera should obviously be enclosed in a box that is tamper-proof and

does not contain anchoring points. It should be placed in a high corner location of the cell and all edges around the housing should be caulked or grouted.

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

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

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

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

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

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

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

14) Some inmates hang themselves under desks, benches, tables or stools/pull-out seats. Potential suicide-resistant remedies are: (a)

Extending the bed slab for use as a seat; (b) Cylinder-shaped concrete seat anchored to floor, with rounded edges; (c) Triangular corner desk top anchored to the two walls; and (d) Rectangular desk top, with triangular end plates, anchored to the wall. Towel racks should also be removed from any desk area;

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

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

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

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

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

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

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

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

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

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