Department of Corrections and Rehabilitation

NOTICE OF CHANGE TO REGULATIONS

Sections:	NCR Number:	Publication Date:
3000, 3335.6, 3343.1, 3349	24-06	August 9, 2024

INSTITUTION POSTING AND CERTIFICATION REQUIRED

This Notice announces the proposed amendment of Sections 3000 and 3349, and the adoption of sections 3335.6 and 3343.1 of the California Code of Regulations (CCR), Title 15, Crime Prevention and Corrections, Division 3, Chapter 1, regarding Intake Cells and Security/Welfare Checks.

PUBLIC COMMENT PERIOD

The public comment period will close on **September 24, 2024.** Any person may submit written comments about the proposed regulations by mail to the California Department of Corrections and Rehabilitation (CDCR), Regulation and Policy Management Branch (RPMB), P.O. Box 942883, Sacramento, CA 94283-0001, or by e-mail to RPMB@cdcr.ca.gov. All written comments must be received or postmarked no later than September 24, 2024.

PUBLIC HEARING INFORMATION

A public hearing regarding these proposed regulations will be held **September 24, 2024, from 10:00 a.m. to 11:00 a.m. in Room 113, located at 9172 Laguna Springs Dr. Elk Grove CA, Building G-1**. The purpose of the hearing is to receive comments about the proposed regulations. It is not a forum to debate the proposed regulations. No decision regarding the permanent adoption of these regulations will be rendered at this hearing. Written comments submitted during the prescribed comment period are given the same significance and weight as oral comments presented at the hearing. This hearing site is accessible to the mobility impaired.

POSTING

This Notice shall be posted immediately upon receipt at locations accessible to incarcerated or supervised persons, and employees in each Department facility and field office not later than five calendar days after receipt. Also, institutions and facilities shall make this Notice available for review by incarcerated persons in segregated housing who do not have access to the posted copies, and shall distribute it to incarcerated person law libraries and advisory councils. CDCR Form 621-A (Rev. 05/19), Certification of Posting, shall be returned to RPMB by mail or email. See Department Operations Manual Section 12010.6.7 for posting and certification of posting procedures.

CONTACT PERSON

Inquiries regarding this Notice should be directed to Josh Jugum, by mail to California Department of Corrections and Rehabilitation, RPMB, P.O. Box 942883, Sacramento, CA 94283-0001, by telephone at (279) 223-2317, or e-mail to RPMB@cdcr.ca.gov. Inquiries regarding the subject matter of these regulations should be directed to Deepak Sampley, Division of Adult Institutions, at (279) 223-3505.

Original Signed By:

TAMMY FOSS
Undersecretary, Operations
California Department of Corrections and Rehabilitation

Attachment

NOTICE OF PROPOSED REGULATIONS
California Code of Regulations
Title 15, Crime Prevention and Corrections
Department of Corrections and Rehabilitation

NOTICE IS HEREBY GIVEN that the Secretary of the California Department of Corrections and Rehabilitation (CDCR or the Department), proposes to amend sections 3000 and 3349, and adopt new sections 3335.6 and 3343.1, of Title 15, Division 3, Chapter 1, regarding Intake Cells and Security/Welfare Checks.

PUBLIC HEARING

Date and Time:	**September 24, 2024 – 10:00am to 11:00am**
Place:	Department of Corrections and Rehabilitation Room 113 9172 Laguna Springs Dr. – Building G-1 Elk Grove, CA 95758
Purpose:	To receive comments about this action.

PUBLIC COMMENT PERIOD

The public comment period begins **August 9, 2024,** and closes on **September 24, 2024.** Any person may submit written comments by mail addressed to the primary contact person listed below, or by email to rpmb@cdcr.ca.gov, before the close of the comment period. For questions regarding the subject matter of the regulations, call the program contact person listed below.

CONTACT PERSONS

Primary Contact	Back-Up	Program Contact
Josh Jugum Telephone: (279) 223-2317 Regulation and Policy Management Branch P.O. Box 942883 Sacramento, CA 94283-0001	Y. Sun Telephone: (279) 223-2316 Regulation and Policy Management Branch P.O. Box 942883 Sacramento, CA 94283-0001	Deepak Sampley Telephone: (279) 223-3505 Division of Adult Institutions

AUTHORITY AND REFERENCE

Government Code Section 12838.5 provides that commencing July 1, 2005, CDCR succeeds to, and is vested with, all the powers, functions, duties, responsibilities, obligations, liabilities, and jurisdiction of abolished predecessor entities, such as Department of Corrections, Department of the Youth Authority, and Board of Corrections.

Penal Code (PC) Section 5000 provides that commencing July 1, 2005, any reference to Department of Corrections in this or any code, refers to the CDCR, Division of Adult Operations. **PC Section 5050** provides that commencing July 1, 2005, any reference to the Director of Corrections in this or any other code, refers to the Secretary of the CDCR. As of that date, the office of the Director of Corrections is abolished.

PC Section 5054 provides that commencing July 1, 2005, the supervision, management, and control of the State prisons, and the responsibility for the care, custody, treatment, training, discipline, and employment of persons confined therein are vested in the Secretary of the CDCR. **PC Section 5055** provides that commencing July 1, 2005, all powers and duties previously granted to and imposed upon the Department of Corrections shall be exercised by the Secretary of the CDCR. **PC Section 5058** authorizes the Director to prescribe and amend rules and regulations for the administration of prisons and for the administration of the parole of persons.

INFORMATIVE DIGEST / POLICY STATEMENT OVERVIEW

Pursuant to court orders, the department is taking steps to reduce suicides committed by incarcerated persons in CDCR custody.

This action will:

- Retrofit some prison cells to reduce the likelihood of suicide attempts by reducing attachment points for hanging and by increasing visibility into the cell.
- Reduce single-celling in restricted housing, as incarcerated persons with a cell partner are less likely to attempt to harm themselves.
- Establish regular security/welfare checks of restricted housing units by custody staff.

SPECIFIC BENEFITS ANTICIPATED BY THE PROPOSED REGULATIONS

The department anticipates the proposed regulations may reduce suicides and suicide attempts by incarcerated persons housed in restricted housing.

DOCUMENTS INCORPORATED BY REFERENCE

CDCR Form 3070 (Rev. 07/24) Security/Welfare Check Manual Tracking Sheet
CDCR Form 114 (Rev. 07/24) Housing Unit Isolation Logbook

EVALUATION OF INCONSISTENCY/INCOMPATIBILITY WITH EXISTING LAWS AND REGULATIONS

Pursuant to Government Code 11346.5(a)(3)(D), the department has determined the proposed regulations are not inconsistent or incompatible with existing regulations. After conducting a review for any regulations that would relate to or affect this area, the department has concluded that these are the only regulations that concern intake cells and security/welfare checks.

LOCAL MANDATES

This action imposes no mandates on local agencies or school districts, or a mandate which requires reimbursement of costs or savings pursuant to Government Code Sections 17500 - 17630.

FISCAL IMPACT STATEMENT

- Cost or savings to any state agency: *None*
- Cost to any local agency or school district that is required to be reimbursed: *None*
- Other nondiscretionary cost or savings imposed on local agencies: *None*
- Cost or savings in federal funding to the state: *None*

EFFECT ON HOUSING COSTS

The department has made an initial determination that the proposed action will have no significant effect on housing costs.

COST IMPACTS ON REPRESENTATIVE PRIVATE PERSONS OR BUSINESSES

The department is not aware of any cost impacts that a representative private person or business would necessarily incur in reasonable compliance with the proposed action.

SIGNIFICANT STATEWIDE ADVERSE ECONOMIC IMPACT ON BUSINESS

The department has made an initial determination that the proposed regulations will not have a significant statewide adverse economic impact directly affecting business, including the ability of California businesses to compete with businesses in other states, because the proposed regulations place no obligations or requirements on any business.

EFFECT ON SMALL BUSINESSES

The department has determined that the proposed regulations will not affect small businesses. This action has no significant adverse economic impact on small business because they place no obligations or requirements on any business.

RESULTS OF THE ECONOMIC IMPACT ASSESSMENT

The department has determined that the proposed regulations will have no effect on the creation of new, or the elimination of existing, jobs or businesses within California, or effect the expansion of businesses currently doing business in California. The department has determined that the proposed regulation will have no effect on the state's environment or worker safety, or the welfare of California residents. The proposed regulations may benefit the health and welfare of incarcerated persons by reducing suicides and suicide attempts.

CONSIDERATION OF ALTERNATIVES

The department must determine that no reasonable alternative considered by the department or that has otherwise been identified and brought to the attention of the department would be more effective in carrying out the purpose for which the action is proposed, would be as effective and less burdensome to affected private persons than the proposed regulatory action, or would be more cost-effective to affected private persons and equally effective in implementing the statutory policy or other provisions of law. Interested persons are invited to present statements or arguments with respect to any alternatives to the changes proposed at the scheduled hearing or during the written comment period.

AVAILABILITY OF PROPOSED TEXT AND INITIAL STATEMENT OF REASONS

The department has prepared and will make available the text and the Initial Statement of Reasons (ISOR) of the proposed regulations. The rulemaking file for this regulatory action, which contains those items and all information on which the proposal is based (i.e., rulemaking file) is available to the public upon request directed to the department's contact person. The proposed text, ISOR, and Notice of Proposed Regulations will also be made available on the department's website: www.cdcr.ca.gov.

AVAILABILITY OF THE FINAL STATEMENT OF REASONS

Following its preparation, a copy of the Final Statement of Reasons may be obtained from the department's contact person.

AVAILABILITY OF CHANGES TO PROPOSED TEXT

After considering all timely and relevant comments received, the department may adopt the proposed regulations substantially as described in this Notice. If the department makes modifications which are sufficiently related to the originally proposed text, it will make the modified text, with the changes clearly indicated, available to the public for at least 15 days before the department adopts, amends or repeals the regulations as revised. Requests for copies of any modified regulation text should be directed to the contact person indicated in this Notice. The department will accept written comments on the modified regulations for at least 15 days after the date on which they are made available.

TEXT OF PROPOSED REGULATIONS

In the following text, underline indicates newly added text.

California Code of Regulations, Title 15, Division 3, Adult Institutions, Programs and Parole

Article 1. Behavior

3000. Definitions.

Section 3000 is amended to alphabetically merge the definitions below with currently existing definitions in Title 15, Division 3 regulations.

*

*

Intake Cells means a suicide-resistant cell that has been retrofitted to reduce access to attachment sites for hanging and to increase visibility into the cell.

*

*

Security/Welfare Check means a personal observation by a correctional officer of the welfare of the incarcerated person and the security of the cell in which an incarcerated person is housed. It shall include a visual and physical observation of a living, breathing incarcerated person, free from obvious injury, ensuring a clear and unobstructed view into the cell, and looking for damage to the cell or signs of any misconduct or self-injurious behavior.

*

*

NOTE: Authority cited: Sections 243(f)(4), 2717.3, 3000.03, 5058, 5058.3 and 1170.05, Penal Code; Section 10115.3(b), Public Contract Code; and Sections 4525(a), 4526 and 14837, Government Code. Reference: Sections 186.22, 243, 314, 530, 532, 600, 646.9, 653, 832.5, 1170.05, 1203.8, 1389, 2080, 2081.5, 2084, 2600, 2601, 2700, 2717.1, 2717.6, 2932.5, 3003.5(a), 3007.05, 3020, 3450, 3550, 4570, 4576, 5009, 5050, 5054, 5068, 7000 et seq., 7286.5, 11180 and 11191, Penal Code; Sections 1132.4, 1132.8 and 1203(b)(1), Labor Code; Sections 10106, 10108, 10108.5, 10115, 10115.1, 10115.2, 10115.3 and 10127, Public Contract Code; Section 999, Military and Veterans Code; Section 391, Code of Civil Procedure; Section 297.5, Family Code; Sections 8550, 8567, 12838 and 12838.7, Government Code; Sections 11007, 11351, 11352, 11378 and 11379, Health and Safety Code; Governor's Prison Overcrowding State of Emergency Proclamation dated October 4, 2006; *In re Bittaker*, 55 Cal.App. 4th 1004, 64 Cal. Rptr. 2d 679; *Madrid v. Cate* (USDC ND Cal. C90-3094 TEH); *Sassman v. Brown* (E.D. Cal. 2015) 99 F.Supp.3d 1223; *Mitchell v. Cate*, USDC ED 2:08-CV-01196-TLN-EFB; *In re Garcia* (2012) 202 Cal.App.4th 892; and *Quine v. Beard*, No. C 14-02726 JST.

Subchapter 4. General Institution Regulations

Article 7 Restricted Housing

New Section 3335.6 is adopted.

Section 3335.6. Restricted Housing Unit Intake Cells

(a) Upon initial placement of an incarcerated person into restricted housing, the following considerations shall be followed:

(1) Incarcerated persons approved for double-cell housing and for whom an appropriate cell partner is available shall be housed in a double-cell with an appropriate cell partner where a vacancy exists and will not require an intake cell.

(2) Any incarcerated person who cannot be double-celled upon initial placement in restricted housing must be housed in an intake cell for the first 72 hours after placement in restricted housing. This includes single-cell restricted, and double-cell approved incarcerated persons for whom an appropriate cell partner is unavailable upon initial placement.

(3) When intake cells are not available and double-celling is not appropriate, newly assigned incarcerated persons must be placed in cells in close proximity to each other and near high-traffic areas to allow for better observation by staff. In such cases, these non-intake cells shall be clearly labeled utilizing a door tag to indicate “Intake Cell” for staff awareness.

(4) If the cell partner is re-housed before the conclusion of the 72 hours with an initial intake incarcerated person, another compatible cell partner shall immediately be identified if one is available. If a compatible cell partner is not available, custody staff shall house the incarcerated person in an available intake cell as soon as possible but no later than eight hours after the cell partner has been moved from the cell.

(5) After the initial 72 hours, incarcerated persons shall be re-housed in restricted housing consistent with their case factors as described in section 3269.

(6) All approved intake cells will be clearly identified as intake cells to ensure all staff assigned to restricted housing unit know their location. All intake cells shall have “Intake Cell” stenciled on or near the cell door using either black or white paint, whichever provides the strongest contrast.

(7) Incarcerated persons in Restricted Housing Unit intake cells are authorized to possess one entertainment appliance in accordance with section 3190(m)(3).

NOTE: Authority cited: Section 5058, Penal Code. Reference: Section 5054, Penal Code; Coleman et al. v. Newsom et al., United States District Court for the Eastern District of California.

New Section 3343.1 is adopted.

Section 3343.1. Restricted Housing Unit Security/Welfare Check

(a) Security/welfare checks must be completed on all incarcerated persons housed in Restricted Housing Units.

(b) Staff shall utilize the statewide security/welfare tracking system to ensure security/welfare checks are being completed at staggered (non-regular) intervals, not exceeding 35 minutes between each security/welfare check. Staggered means the checks are to be conducted at unannounced and irregular intervals so that they are unpredictable to the incarcerated person population.

(c) When incarcerated persons are out of their assigned cell (e.g., yard, classification committee, appointments, visiting), custody staff are required to conduct a security/welfare check to inspect for damage and potential security concerns.

(d) Disruptions of a security/welfare check (e.g., instances where staff have to address an emergency) shall be documented in the CDCR Form 114, Housing Unit Isolation Logbook (Rev. 07/24), which is incorporated by reference.

(e) If the statewide security/welfare tracking system is inoperable, custody staff shall utilize the CDCR Form 3070, Security/Welfare Check Manual Tracking Sheet (Rev. 07/24), which is incorporated by reference, to document the required checks until the tracking system is operational.

(f) CDCR shall issue earplugs to all incarcerated persons housed in Restricted Housing Units.

NOTE: Authority cited: Section 5058, Penal Code. Reference: Section 5054, Penal Code; Coleman et al. v. Newsom et al., United States District Court for the Eastern District of California.

Section 3349. Restricted Housing Records.

Subsection 3349(a) is amended.

(a) A CDCR Form 114, Isolation Log (rev: 07/24 ~~3/03~~), shall be maintained in each Restricted Housing Unit. One Isolation Log may serve two or more special purpose units which are administered and supervised by the same staff members.

Subsection 3349(b) is unchanged.

NOTE: Authority cited: Section 5058, Penal Code. Reference: Section 5054, Penal Code.

ADOPT

Month______________ **Day**__________ **Year**___________

MOVEMENTS OF INCARCERATED PERSONS

NUMBER	NAME	CELL	TIME IN	TIME OUT	COMMENT

ISOLATION LOG

12:01 a.m. To 12:00 p.m.

OFFICIAL VISITATIONS

NAME	TITLE	IN	OUT	REASONS FOR YOUR VISIT AND COMMENT

DOCTOR'S CALLS

NAME	IN	OUT

DOCTOR'S COMMENT & SUGGESTIONS

OFFICERS' ROSTER

NAME	IN	OUT

REPORT OF ANY UNUSUAL INCIDENTS

Month______________ Day__________ Year__________

REPEAL

MOVEMENTS OF INMATES

NUMBER	NAME	CELL	TIME IN	TIME OUT	COMMENT

ISOLATION LOG

12:01 a.m. To 12:00 p.m.

OFFICIAL VISITATIONS

NAME	TITLE	IN	OUT	REASONS FOR YOUR VISIT AND COMMENT

DOCTOR'S CALLS

NAME	IN	OUT

DOCTOR'S COMMENT & SUGGESTIONS

OFFICERS' ROSTER

NAME	IN	OUT

REPORT OF ANY UNUSUAL INCIDENTS

SECURITY/WELFARE CHECK MANUAL TRACKING SHEET

INSTITUTION:_____ FACILITY:_____

HOUSING UNIT:_____ CELL NUMBER:_____

DATE:_____ WATCH: ☐ 1ST ☐ 2ND ☐ 3RD

INSTRUCTIONS: COMPLETE 2 SECURITY/WELFARE CHECKS PER HOUR AT STAGGERED INTERVALS NOT TO EXCEED 35 MINUTES. The Security/Welfare Check shall include a visual/physical observation of a living, breathing incarcerated person, free from obvious injury, ensuring a clear and unobstructed view into the cell, looking for damage to the cell and/or signs of any misconduct or self-injurious behavior. This form shall be used when the Security/Welfare system is down and not operable. Staff shall still perform Security/Welfare checks, documenting legibly the time the check was conducted, name of staff member, and any unusual observations in the "comments" section. In addition, staff must author a memorandum explaining the reason for the use of the manual tracking sheet. These documents should be summited to the Custody Supervisor for review at the end of each shift. The manual tracking sheet along with the attached memorandum shall be stored and filed per the designated institutions Local Operating Procedure.

TIME	ASSIGNED STAFF (print)	ASSIGNED STAFF (signature)	COMMENTS

SUPERVISOR NAME (print) **SUPERVISOR SIGNATURE** **DATE**

INITIAL STATEMENT OF REASONS

The California Department of Corrections and Rehabilitation (CDCR or the department) proposes to amend sections 3000 and 3349, and adopt new sections 3335.6 and 3343.1 in the California Code of Regulations, Title 15, Division 3, regarding Intake Cells and Security/Welfare Checks.

Background

On May 9, 2006, the court-appointed special master in the *Coleman* class-action suit filed a report on suicides completed in the California Department of Corrections and Rehabilitation in 2004. The special master recommended that CDCR develop a plan for dealing with the escalating number of suicides occurring in Restricted Housing Units (RHUs), formerly referred to as Administrative Segregation Units (ASUs). The plan was based on an analysis of the causes of the increasing rate of suicide in these housing units.

On May 19, 2006, CDCR filed a response to the report and its recommendations. Plaintiffs requested that CDCR be required to collaborate with plaintiffs and their suicide prevention expert in developing the plan, and that CDCR be directed to include a schedule for implementing the plan.

This rulemaking action implements, in part, a remedial plan adopted by CDCR as directed by a court order issued in Coleman et al. v. Newsom et al., United States District Court for the Eastern District of California, on June 7, 2006 (Order). This order required CDCR to develop a plan for dealing with the escalating number of suicides occurring in restricted housing. The plan was based on an analysis of the causes for the increasing rate and, dependent on the outcome of the analysis, provides adequate resources for mental health and custody staff, creates sufficient confidential interview space, and enhances the quality of mental health services provided in restricted housing. The court determined these actions to be necessary in response to several concerns expressed by the plaintiffs. Lastly, CDCR was required to collaborate with the special master's experts, plaintiffs' counsel, and plaintiffs' expert, to develop the plan required by the order dated June 7, 2006.

In response to this order, CDCR developed recommendations and an implementation plan for the RHU intake cells on October 2, 2006. A percentage of cells in each RHU statewide were retrofitted to reduce the opportunity for incarcerated persons to die by suicide. The institutions were surveyed to determine an average intake by each restricted housing building and the most appropriate location for the Intake Cells based upon proximity to staff traffic and ease of observation from control booths. Incarcerated persons newly housed into Restricted Housing Units (RHU) would be housed in retrofitted intake cells when they could not be double celled with a cellmate. The department recommended incarcerated persons be housed in intake cells for at least 72 hours. To the degree possible, the proposed intake cells were retrofitted to reduce availability of hanging attachment points. Given the diversity (physical plant design, age, construction materials, etc.) of the restricted housing cells at each state prison, the department was to be mindful, discerning, and deliberate in their planning and

implementation of the proposed retrofits for the best location possible for these intake cells.

The term “restricted” encompasses all housing units that have a higher level of security than General Population housing. These proposed regulations refer to “restricted housing” throughout.

In addition to the implementation of intake cells, CDCR was urged to adopt the American Correctional Association's (ACA) standard for welfare checks in restricted housing, which required incarcerated persons in such units "be personally observed by a correctional officer at least every thirty minutes at an irregular schedule." On December 1, 2006, CDCR agreed to provide 30-minute welfare checks by July 1, 2007, for all newly arriving incarcerated persons in restricted housing for the first three weeks of their stay in the unit. While not fully responsive to the experts' recommendation or the ACA Standard, the procedure partially addressed the expert’s recommendation for more intensive observation of arriving incarcerated persons during the first two to three weeks of their presence in restricted housing units. This directive was established to preserve life and improve emergency response to suicide attempts by incarcerated persons during the difficult time of transition to a more restrictive housing environment.

On May 9, 2014, CDCR expanded the security/welfare checks to all incarcerated persons housed in restricted housing for the entirety of their stay. Staff were required to conduct security/welfare checks twice an hour, at staggered intervals, not to exceed 35 minutes.

This rulemaking action aims to improve the safety and wellbeing of incarcerated persons within RHUs. One of the fundamental changes involves double-celling within the first 72 hours of housing in these units, which can help to reduce the risk of suicide. Additionally, there will be a standard established for intake cells to ensure consistency across the department, and guidance for what to do if a cell partner is rehoused during the 72-hour intake status. Staff will be required to use the security/welfare tracking system to ensure timely welfare checks, and any disruptions to these checks will be documented in the housing unit isolation logbook. Finally, custody staff will be required to perform a security/welfare check on an incarcerated person’s cell when the incarcerated person is out of the cell for various reasons, such as yard time, classification committee, appointments, visiting, etc. All these changes are designed to create a safer and more consistent environment for incarcerated persons in RHUs and ensure the safety and security of all incarcerated persons.

CONSIDERATION OF ALTERNATIVES:

The department must determine that no reasonable alternative considered, or that has otherwise been identified and brought to the attention of the department, would be more effective in carrying out the purpose for which this action is proposed, would be as effective and less burdensome to affected private persons than the action proposed, or would be more cost-effective to affected private persons and equally effective in implementing the statutory policy or other provision of law.

Currently, no reasonable alternatives have been brought to the attention of the department that would alter the department's initial determination.

ECONOMIC IMPACT ASSESSMENT:

In accordance with Government Code Section 11346.3(b), the department has made the following assessments regarding the proposed regulations:

Significant Adverse Economic Impact on Business

The department has made an initial determination that the proposed regulatory action will not have a significant adverse economic impact on business. Additionally, there have been no facts, evidence, documents, testimony, or other evidence provided that would alter the department's initial determination. The proposed regulations do not have a direct impact on California businesses as the proposed regulations affect the internal management of CDCR only.

Creation of New or the Elimination of Existing Jobs within the State of California

The department has determined that the proposed regulations will have no impact on the creation of new or the elimination of existing jobs within California as the proposed regulations affect the internal management of CDCR only.

Benefits to the Health and Welfare of California Residents, Worker Safety, and the State's Environment

The department has determined that the proposed regulations will have no impact on the health and welfare of California residents. The proposed regulations will have no impact on worker safety or the State's environment, as the proposed regulations affect the internal management of CDCR only.

Creation of New, Expansion or the Elimination of Existing Businesses Currently Doing Business within the State of California

The department has determined that the proposed regulations will have no impact on the creation of new or elimination of existing businesses within the State of California or affect the expansion of businesses currently doing business in California as the proposed regulations affect the internal management of CDCR only.

BENEFITS OF THE REGULATIONS:

These processes are already in effect pursuant to the *Coleman* court order and agreements. Enacting these regulations will assist in improving the department's consistent direction in the prevention of incarcerated person deaths by suicide in RHUs. This will enhance departmental safety, security, and staff accountability. These regulations will also bring CDCR into compliance with expanded *Coleman* court orders CDCR is responsible for complying with. To that end, CDCR is required to continue

working under the guidance of the Special Master to meet this responsibility. CDCR continues to work closely and in full cooperation with the Special Master in a focused effort to resolve all outstanding obstacles.

DOCUMENTS RELIED UPON

The department, in proposing amendments to these regulations, relied in part, upon the following documents:
5/9/2006 (Docket No. 1806) – Special Master's Suicide Report re 2004 Suicides
6/8/2006 (1830) – Order Adopting the Special Master's Recommendation
10/2/2006 (1990) – CDCR's Plan to Prevent Suicides in AdSeg
12/1/2006 (2061) – CDCR's Amended Plan in Response to Plaintiffs' Objections
12/18/2006 (2084) – OSM Report & Rec Re Plan to Prevent Suicide in AdSeg

These documents are available upon request from the Contact Persons listed in the Noticed of Proposed Regulations and are posted on the department website at the following address: https://www.cdcr.ca.gov/regulations/cdcr-regulations/pending-changes-to-department-rules-2/

SPECIFIC PURPOSE AND RATIONALE FOR EACH SECTION, PER GOVERNMENT CODE SECTION 11346.2(b) (1):

Section 3000 is amended to adopt and alphabetically merge the following definitions into existing definitions:

Intake Cells is defined to establish that these are cells which have been retrofitted to reduce and prevent suicide while incarcerated persons are housed in restricted settings. These cells are crucial to help prevent suicide attempts when double-celling is not available upon initial placement in restricted housing.

Security/Welfare Check is defined to establish the parameters of these frequent checks of incarcerated person welfare, which will help to reduce suicide attempts when incarcerated persons are housed in restricted settings.

New Section 3335.6 is adopted to establish processes and procedures for housing incarcerated persons newly placed in restricted housing. This section is necessary to establish rules to help ensure the safety of incarcerated persons who have recently been placed in restricted housing, and to reduce and prevent suicide attempts by these incarcerated persons.

Subsection 3335.6 (a) is adopted to introduce several subsequent regulatory provisions that shall be adhered to by the department. Upon initial placement into restricted housing, the following considerations shall be followed when housing an incarcerated person:

Subsection 3335.6(a)(1) is adopted to establish the process that incarcerated persons approved for double-cell housing and for whom an appropriate cell partner is available

shall be housed in a double-cell with an appropriate cell partner where a vacancy exists and will not require an intake cell. This will ensure staff does not utilize retrofitted intake cells when the ability to double-cell is appropriate. Statistical information suggests that suicide risk is substantially reduced when incarcerated persons have a cellmate. Therefore, double celling is encouraged to place incarcerated persons into double-celled housing whenever case factors allow, especially when the incarcerated person is initially placed into restricted housing.

Subsection 3335.6(a)(2) is adopted to establish that any incarcerated person who cannot be double-celled upon initial placement in restricted housing must be housed in an intake cell for the first 72 hours after placement in restricted housing. The 72-hour timeframe is based on the department's recommendations following the 2006 *Coleman* court order. This includes single-cell restricted, and double-cell approved incarcerated persons for whom an appropriate cell partner is unavailable upon initial placement. Not all incarcerated persons are eligible for double celling due to specific case factors, including but not limited to the incarcerated person's age, term status, county of commitment, sex-related arrest or convictions, enemy concerns, Security Threat Group (STG) concerns, history of in-cell violence against another incarcerated person, or medical/psychiatric/disability concerns. Also, some incarcerated persons who are approved for double-celling may not be appropriate to house with other incarcerated persons due to enemy/STG or other concerns. These incarcerated persons will be housed in intake cells upon placement to help reduce the risk of suicide attempts.

Subsection 3335.6(a)(3) is adopted to establish the process for when intake cells are not available, and double-celling is not appropriate, newly assigned incarcerated persons must be placed in cells in close proximity to each other and near high-traffic areas to allow for better observation by staff. In such cases, these non-intake cells shall be clearly labeled utilizing a door tag to indicate "intake cell" for staff awareness. This will ensure staff is able to observe and interact with these incarcerated persons frequently. Regular and frequent observation and interaction are intended to help to reduce suicide attempts by these incarcerated persons.

Subsection 3335.6(a)(4) is adopted to establish that if the cell partner is re-housed before the conclusion of the 72 hours with an initial intake incarcerated person, another compatible cell partner shall immediately be identified if one is available. If a compatible cell partner is not available, custody staff shall house the incarcerated person in an available intake cell as soon as possible, but no later than eight hours after the cell partner has been moved from the cell. This 8-hour requirement allows the department reasonable time to locate a suitable cell-partner while ensuring the incarcerated person isn't without a cell partner for an extended period of time. These provisions establish rules and provide staff with direction to rehouse an incarcerated person in a retrofitted intake cell if a cellmate has been moved for reasons including but not limited to incompatibility, transfer to another institution, transfer to an outside hospital for longer than 24 hours, parole, or discharge from ASU within the first 72 hours, and another compatible cellmate is not available. This is to ensure that incarcerated persons who are newly assigned to restricted housing have less opportunity to attempt to harm themselves. As stated above,

statistics demonstrate that placing an incarcerated person with a cellmate helps to reduce suicide attempts. When this is not an option the retrofitted intake cells are the next best viable option.

Subsection 3335.6(a)(5) is adopted to establish the process that after the initial 72 hours, incarcerated persons shall be re-housed in restricted housing unit consistent with their case factors as described in section 3269. This rule ensures the department does not utilize the limited retrofitted intake cells beyond the required 72-hour timeframe, and cites section 3269, Incarcerated Housing Assignments, regarding incarcerated person case factors that may affect their housing situation.

Subsection 3335.6(a)(6) is adopted to establish that all approved intake cells will be clearly identified as intake cells to ensure all staff assigned to the restricted housing unit know their location. All intake cells shall have “Intake Cell” stenciled on or near the cell door using either black or white paint, whichever provides the strongest contrast. This provision is adopted to complete a statewide quality improvement plan for all approved retrofitted intake cells to be clearly identified. This will ensure all staff assigned to RHUs are aware of their locations when a newly assigned incarcerated person is placed into restricted housing.

Subsection 3335.6(a)(7) is adopted to establish that all incarcerated persons in restricted housing unit intake cells are authorized to possess one entertainment appliance in accordance with Title 15 subsection 3190(m)(3).

New Section 3343.1 is adopted to establish the process and procedures for conducting security/welfare checks in restricted housing. This process was developed to reduce suicide risk in restricted housing. The security/welfare check process has been in practice pursuant to the *Coleman* court orders and will now be adopted into regulations.

Subsection 3343.1(a) is adopted to establish the requirement that security/welfare checks shall be completed on all incarcerated persons housed in RHUs. This is to ensure staff respond promptly to emergencies while incarcerated persons are housed in a more restrictive environment.

Subsection 3343.1(b) is adopted to establish that staff shall utilize the security/welfare tracking system to ensure security/welfare checks are completed at staggered (non-regular) intervals not exceeding 35 minutes. Security/welfare checks conducted at irregular intervals can ensure observation times are not predictable by the incarcerated person population. This measure is intended to reduce and interrupt suicide attempts, thereby saving lives. The staggered 35-minute intervals were determined to be a best practice to avoid discernible patterns not exceeding the 35-minute ACA recommendation.

Subsection 3343.1(c) is adopted to establish that when incarcerated persons are out of their assigned cell, custody staff shall conduct a cell inspection to inspect for damage and potential security concerns. Incarcerated persons are often out of their cells for a variety of reasons (e.g., yard, classification committee, appointments, visiting, etc.). This will

ensure staff address any potential safety issues that may arise. Utilizing this practice while an incarcerated person is out of the cell allows the officer to have uninterrupted time to ensure the integrity of the cell.

Subsection 3343.1(d) is adopted to establish that disruptions of a security/welfare check (e.g., instances where staff have to address an emergency) shall be documented in the CDCR Form 114, Housing Unit Isolation Logbook. Staff shall document any instance in which a security/welfare check could not be completed within the required time frame. This is necessary to ensure documentation is available to address any concerns or discrepancies with the security/welfare check process when unforeseeable emergencies may occur.

Subsection 3343.1(e) is adopted to establish that if the security/welfare tracking system is inoperable, custody staff shall utilize the CDCR Form 3070, Security/Welfare Check Manual Tracking Sheet to document the required checks until the tracking system is operational. The security/welfare tracking system is an automated system that may sometimes experience outages. Due to these occurrences, and to ensure that security/welfare checks continue and are documented during outages, the CDCR Form 3070 shall be utilized.

Subsection 3343.1(f) is adopted to establish that the department shall issue earplugs to all incarcerated persons housed in Restricted Housing Units. Earplugs may allow incarcerated persons in RHUs to relax and/or sleep, which may be beneficial to their mental health.

Section 3349(a) is amended solely to update the revision date of the amended CDCR Form 114. This change does not alter the meaning or effect of the provisions contained in this subsection.

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REPORT ON SUICIDES COMPLETED IN THE CALIFORNIA DEPARTMENT OF CORRECTIONS IN CALENDAR YEAR 2004

I. Overview and Introduction

This is the sixth annual report on completed suicides in the California Department of Corrections (CDC)[1] submitted as part of the Special Master's continuing review of the defendants' overall compliance with court mandated remedies and requirements in Coleman v. Schwarzenegger. To set the suicide rate in CDC in some national perspective, past reports have provided statistics on the incidence of suicide in the general U.S. population and correctional institutions. The most recent data from the U.S. Department of Justice's Bureau of Justice Statistics indicates that state prison suicide rates dropped from 54 per 100,000 inmates in 1980 to 14 per 100,000 in 2002. This represents a slight increase from the incidence rate of 12 per 100,000 cited in the preceding report on suicides in CDC in 2003.

The data analysis and recommendations provided in this report follow the same format used in these reports of the special master on suicides in CDC since 1999. The report includes two tables: Table 1 summarizes collected demographic data, while Table 2 provides a summary of mental health information on CDC inmates who completed suicides while incarcerated in 2004. The tables represent an extreme distillation of the 26 case reviews, which constitute the heart of this report, and provide in graphic form the data on which the summary analysis is based.

The vast bulk of the data captured in this report has been generated pursuant to the defendants' still evolving suicide review process. The process requires the preparation of a Suicide Report for each death that includes an executive summary and a more detailed narrative, typically with sections covering the suicide incident itself, the medical autopsy, background information, mental health history, medical history, the deceased inmate's institutional functioning and personality dynamics, precipitating events, pre-suicidal functioning and motive for suicide. Sources of information for the various sections may include custody incident reports, death reports, central classification records, uniform

[1] In 2005, the California Department of Corrections was reorganized and incorporated into the larger California Department of Corrections and Rehabilitation. Throughout this report, the department will be referred to as the California Department of Corrections, the applicable appellation in 2004.

health records (UHRs), coroners' autopsy reports, interviews with custody, mental health and medical staff, inmates and kin of the deceased, reports from institutional Investigative Services Units, a variety of possibly relevant unit logs and the deceased inmate's trust account and personal property. Each report ends with conclusions drawn from an analysis of the assembled data and specific recommendations for local and/or departmental actions to address the problems identified in the report. The final component in the review process is a subsequent report from the institution on implementation of the corrective action plan (CAP) included in the Suicide Report.

The reporting process together with its framework of supportive documentation has evolved gradually over the past six years, as chronicled in previous annual reports on suicides in CDC. The department's overall policies and procedures for the review and reporting of suicides, which were finalized in January 2002, established specific time frames for the completion of reviews by clinical and administrative components of CDC. They also mandated the development and implementation of CAPs, which became an integral part of the department's suicide prevention strategy. In response to the special master's report on CDC suicides in 2003, the court directed the defendants in June 2005, after the completion of review of the suicides covered in this report, to develop procedures to ensure implementation of the CAPs included in suicide reports and required them to submit regularly to the special master a summary description of the methods and outcomes of investigations of staff for incompetence, malfeasance or negligence referred to investigatory or disciplinary channels.

Meanwhile, CDC continued to generate its own annual statistical reports on suicides. The department's summary on suicides completed in 2004 was issued in September 2005. The CDC reports, valuable in many ways, do not provide information on the potential foreseeability or preventability of reported inmates' deaths. They do, however, collate much useful information on likely precipitating events for inmate suicides. Equally useful was the defendants' statistical compilation on suicides in the department during the five-year period from 1999 to 2003, which was issued in January of 2005. During that period, the incidence rate of suicides in the department averaged 14.5 per 100,000 inmates.

Those reports, no less than this report and its predecessors, confirm that the placement of inmates in administrative segregation is a consistently high-risk factor for suicide. The need for timely screening and assessment of individuals placed in administrative segregation, whether or not they have been participants in the Mental Health Services Delivery System (MHSDS) and receiving mental health care, is absolutely critical. Data on suicides in 2004, moreover, indicated that half of the suicides committed in administrative segregation occurred within the first two weeks of the inmates' placement.

Another aspect of the department's evolving suicide review process is the generally improving timeliness of submission of most of the required reports in most cases. Nonetheless, some cases did not meet mandated timelines. To a considerable extent, delays in the handful of errant cases were attributable to more effective and intrusive corrective actions demanded by the department. Institutions increasingly are being

required to develop and implement corrective actions that go beyond enhanced training and the review of policies and procedures. The CAPs described in this report often required institutions to establish quality improvement teams (QITs), conduct extensive audits of performance, ensure effective peer review of clinical judgments, create new policies and procedures and more effectively enforce existing standards with improved monitoring and supervisory practices.

While most of the review documents for the 26 suicides completed in calendar year 2004 were provided timely, a quartet of reports required supplemental reports on a range of elements in the recommended CAPs that pushed completion way beyond mandated timelines. The untimeliness of reports resulting from the department's insistence that responding institutions improve or demonstrate more complete compliance with recommended remedies reflects well on the overall suicide review process.

The overall quality of the defendants' Suicide Reports continued to improve, and the data provided in most reports permitted a reasonably objective assessment of the application of relevant policies and procedures. Helpful data was sometimes unavailable because institutional clinicians had neither requested nor collected it during the course of the inmate's incarceration. In other cases, following the suicide, the institution failed to gather complete data and provide it to the department.

While sometimes uneven, the quality of the defendants' review, analysis and recommendations for remedial actions in individual reports continued gradually to improve. Many of the plans for corrective action described in the case reviews in Appendix B to this report were thoughtful and clinically appropriate, raising questions about the quality of evaluation and treatment services, communication and coordination among mental health, medical, and custody staffs and individual cultural or disability barriers to the delivery of effective mental health services in specific cases. More rarely, reviews reflected some clinicians' preoccupation with the character logical problems of deceased inmates that somehow were seen as excusing the clinicians' downplaying or ignoring legitimate mental illness and/or indicators of risk for suicide. See, for example, Case Reviews Nos. 9, 21, 23 and 26. Some few recommendations for corrective actions simply invoked repetitively the need for better orientation, education and/or training of permanent and contracted staff on established policies and procedures or cited, again repetitively, recurring documentation problems including undated, unsigned, illegible or uninformative clinical notes and forms.

On the other hand, institutional responses particularly to critical reviews were often inadequate. In problematic cases, institutions failed either to comprehend or respond to recommended remedies, especially when they included directions to establish adequate and timely supervisory practices, including individual counseling, progressive discipline where indicated, increased peer review and audits with more thoughtful and targeted methodologies to demonstrate the achievement of intended outcomes. The quality of departmental review of institutional remedial responses also varied significantly. In some instances, issues related to delayed access to more intensive levels of mental health care, untimely responses to referrals, the lack of confidentiality during screenings and intake

assessments, particularly in administrative segregation, or other deviations from policy that were identified in the review process for correction were allowed to go unaddressed. Finally, in some cases where recommendations were made for the investigation of clinical or custody staff involved in one or another aspect of the suicide, the results have either not been provided or provided in so cursory a form as to be useless.

As in past years, Coleman experts and monitors reviewed information on completed suicides during their regularly scheduled institutional visits, and the resulting information has been included in this report. Comments from plaintiffs' counsel on pending or completed suicide reviews have also been considered and, where appropriate, cited.

The terms "foreseeable" and "preventable" are used in this report, as in the preceding reports on suicide, to analyze the adequacy of suicide prevention responses in each of the reviewed suicides. These concepts have already been discussed in considerable detail, reviewed and critiqued by the parties and confirmed by the court as appropriate.

Suicides are "foreseeable" where information already available about an inmate indicates the presence of a substantial or high risk for suicide, which requires reasonable clinical, custody and/or administrative intervention(s) to prevent self harm. Determination of foreseeability includes, but is not limited to, an assessment of the level of risk for suicide, whether high, moderate, or low to none. Demonstrated adequate completion of the defendants' standard Suicide Risk Assessment Checklist (SRAC) varied in the suicides reviewed in this report, with some institutions employing their own local forms and criteria. The department has tried to standardize implementation of the SRAC and employed video conferences to train clinical staff in the use of the SRAC and criteria for determining levels of suicide risk. Despite these efforts, the case reviews of suicides in 2004 indicate that some clinicians, and at times some institutions, have not used the SRAC when indicated. As previously defined, a high risk of suicide requires the immediate monitoring by clinical and custody staff to ensure that the inmate remains in a safe environment until evaluated further and/or transferred to a more appropriate clinical setting. Inmates assessed with a "moderate" risk of suicide typically present a more ambiguous set of circumstances requiring significant clinical judgment, a judgment that needs to be based on adequate training and timely assessments in an appropriate and confidential setting to determine the most appropriate and relevant interventions to prevent suicide or other self-injury. Even individuals evaluated with "low risk," "no risk," or "negligible risk" for suicide may require some degree of monitoring and subsequent evaluation with appropriate notification to clinical and custody staff of the potential for self-injury and/or suicidal ideation or activity.

A significant number of the Suicide Risk Assessments (SRAs) described in the cases reviewed for this report failed to estimate the level of suicide risk found in the assessed inmates. The department developed and implemented its new checklist or form for SRAs during 2004, but the revised form eliminated the checked boxes formerly used to estimate different levels of risk and, instead, required the clinician conducting the assessment to provide a narrative assessment of the level of the inmate's risk for suicide. Review of the narrative assessments involved in suicides completed in 2004 indicated that clinicians

sometimes failed to estimate specifically the level of risk for suicide posed by the inmate at the time of the evaluation, leaving subsequent clinical reviewers in doubt about the level of risk found earlier and the extent of safety planning intended to be applied. Further, a number of reviewed SRAs were based solely on an interview with the inmate and failed to incorporate information from the UHR, central classification file or referral sources, including custody staff who often observed significant behavior and could provide useful input into clinical management planning for individual inmates.

"Preventable" applies to those situations in which, if some additional information had been gathered and/or some additional intervention(s) undertaken, usually as required in existing policy, the likelihood of a completed suicide might have been reduced substantially. The concept includes situations where inmates report self-injurious behaviors and threats but do not receive appropriate evaluation or treatment, are not transferred to a more clinically appropriate and safe environment or fail to receive appropriate life-saving procedures, such as timely CPR.

The placement of inmates at risk for self-injury or suicide in a safe environment, such as inpatient DMH programs, Mental Health Crisis Bed (MHCB) units or Outpatient Housing Units (OHUs) with enhanced or constant observation, has been an ongoing practice in CDC. In 2004, only one suicide was completed in one of these enhanced settings, namely, the Transitional Living Unit of CMC. The provision of five days of clinical follow-up, as well as more limited custody follow-up, for suicidal inmates released from these higher levels of care and/or observation has expanded steadily but still did not occur universally in 2004. The purpose of the clinical follow-up is to monitor and evaluate the inmate's adjustment in his/her "regular" housing after release from a more intensely monitored and protected environment. One suicide in 2004 was completed by an inmate during the five days of clinical follow-up.

The 26 suicides completed in CDC in 2004 represented a substantial decrease from the 36 suicides that occurred in 2003. With an inmate population of approximately 163,346 CDC's suicide rate per 100,000 inmates was 15.9. Another four deaths were initially identified as possible suicides during the year, but all were subsequently determined by the defendants not to be suicides. The four included one inmate who was determined to have bled to death accidentally from an uncapped shunt utilized for dialysis, one who was subsequently determined to have been a victim of homicide, one who died as the result of the use of force and one whose death was ruled to be a restraint-related accidental death.

The first completed suicide for calendar year 2004 occurred on January 13, 2004, and the last occurred on December 2, 2004. The documents provided by CDC for each suicide included, as in previous years, the deceased inmate's UHR, official incident reports, the autopsy report, if one was conducted, the Suicide Report, the Executive Suicide Report, and, where relevant, the facility's implementation report of corrective actions recommended in the Suicide Report. Corrective actions were recommended in 23 of the 26 suicides that occurred in 2004. Institutional responses to the recommended corrective actions were due within 90 days of receipt of the Suicide Report, although the process of

review of the submitted responses at headquarters often delayed distribution of the reports for weeks or months.

Among the suicides documented in Appendix B to this report, it is notable that 18 of the 26 suicides completed in 2004 (69.2 percent) involved hangings in administrative segregation cells. All 18 were single-celled. Two suicides involved inmates, who needed medication, were known to be non-compliant with their medications, met requirements for involuntary medication via the Keyhea process and whose Keyhea orders had expired just weeks before their suicides. At least three cases involved inmates who needed placement in a Mental Health Crisis Bed or a Department of Mental Health inpatient program, but instead were placed in a holding cell on "strip cell" status where they committed suicide. During the year, a significant number of inmates who were referred or should have been referred to higher levels of care, including DMH, were not considered for referral, were not referred, had their referral cancelled or were awaiting transfer pursuant to a referral when they died. Ten of the case reviews for the year indicated that apparent or real delays in the immediate initiation of CPR may have contributed to the completion of the suicide.

Appendix A provides the timelines for the completion of the various elements of the then existing suicide review process according to policy. These timelines were usually, but not always, met for 2004 suicides. Delays occurred in the completion of some CDC Suicide Reports and some institutional responses to recommended corrective actions. As noted earlier, more rigorous reviews of institutional responses at headquarters resulted in additional directives to revise, modify or otherwise improve deficient responses to CAPs and provide additional information on audits, Quality Improvement Team (QIT) results, training events or management and supervisory practices. When the Suicide Report included a recommendation for an investigation, the results were typically shared with the special master much later.

Appendix B provides the narrative case summaries of the 26 CDC inmates who committed suicide in 2004.

II. Discussion

Twenty-six suicides were completed in CDC in calendar year 2004, down ten from 2003. No completed suicides of CDC inmates occurred in DMH inpatient facilities in 2004. The three suicides of female inmates in 2004 tripled the total of female suicides in CDC since 1990. The sole preceding suicide of a female inmate during that 16-year span occurred in 2001 at CIW. The following data summarizes much of the information presented graphically in Tables 1 and 2 on the 26 completed suicides.

- Frequency of suicides by facility

CCWF	3
CMF	3

SAC	2
PBSP	2
CMC	2
FSP	2
DVI	2
MCSP	2
SVSP	1
CEN	1
COR	1
ASP	1
RJD	1
CIM	1
NKSP	1
ERCC (Eel River Conservation Camp)	1

- Single-cell housing — 22 of 26 (84.6%)
- Single-cell housing in administrative segregation or a SHU (1) — 19 of 26 (73.1%)
- On MHSDS caseload at time of death — 13 of 26 (50%)
- History of past mental health treatment — 20 of 26 (76.9%)
- History of past suicidal behavior — 15 of 26 (57.6%)
- Housing in EOP (1) or TLU in CMC (1) — 2 of 26 (7.7%)
- On a Keyhea order (Keyhea orders on 2 other inmates expired weeks before inmates' deaths) — 2 of 26 (7.7%)
- Severe or life-threatening illness — 3 of 26 (11.5%)
- Inmates incarcerated for sex offenses (R Suffix) — 4 of 26 (15.4%)
- Method

Hanging	24 of 26 (92.3%)
Overdose	2 of 26 (7.7%)

- Age range

Under 18	0	(0%)
18-30	10	(38.5%)
31-40	13	(50%)
41-50	1	(3.8%)
50+	2	(7.7%)

- Race

Hispanic	12 of 26 (46.2%)
Caucasian	8 of 26 (30.8%)
African-American	3 of 26 (11.5%)
Pacific Islander	2 of 26 (7.7%)
Other (Armenian)	1 of 26 (3.8%)

- Gender

Male	23 of 26 (88.5%)
Female	3 of 26 (11.5%)

- Indications of inadequate treatment (including, e.g., canceled appointments not rescheduled, no response to referrals, past medical records not reviewed, unsupported diagnoses, noncompliance with treatment without reassessment, assignment to inappropriate level of care, failure to provide five-day clinical follow-up, failure to provide immediate CPR) 20 of 26 (76.9%).

As indicated, 20 of 26 (76.9%) of completed suicides in 2004 involved some measure of inadequate treatment or intervention. That represents an increase in the number of suicides so identified in 2003. This category includes, in addition to the indices of inadequate care listed above, insufficient communication among clinical, medical and custody staffs, the failure to review documented histories in medical records, central files and/or referral forms and a failure to provide timely screening and assessment of inmates on intake in administrative segregation. A number of inmates, moreover, were not considered for referral to a higher level of care or placed on the mental health caseload, when they should have been.

The annual suicide rate per 100,000 inmates in CDC since 1998 has been as follows:

1998 – 22 suicides in a population of approximately 158,159
resulted in a suicide rate of 13.9/100,000

1999 – 25 suicides in a population of approximately 160,970
resulted in a suicide rate of 19.9/100,000

2000 – 15 suicides in a population of approximately 160,855 resulted in a suicide rate of 9.3/100,000

2001 – 30 suicides in a population of approximately 155,365 resulted in a suicide rate of 19.3/100,000

2002 – 22 suicides in a population of approximately 158,099 resulted in a suicide rate of 13.9/100,000

2003 – 36 suicides in a population of approximately 155,722 resulted in a suicide rate of 23.1/100,000

2004 – 26 suicides in a population of approximately 163,346 resulted in a suicide rate of 15.9/100,000

III. Summary of Observations and Recommendations

From 1999 to 2004 the suicide rate for inmates in CDC ranged from a low of 9.3/100,000 in 2000 to a high of 23.1/100,000 in 2003, compared to the national average for correctional institutions of 12 to 14/100,000 during most of that same time period. The difference between the national and CDC rates provides a standard against which to measure the department's record in dealing with suicides. From an incredibly low rate of suicides in 2000 to significantly higher rates in 1999, 2001 and 2003, with intermediate rates in 1998 and 2002, the department has had over this six-year period an average annual rate of suicides per 100,000 inmates of 16.47[2].

This report indicates that 76.9% (20 of 26) of suicides completed in 2004 were foreseeable, preventable or both based on the definitions used in this review and the information that was, or should have been, available to clinical staff. The findings also confirm that the department's process for developing both local and system-wide corrective responses to deficiencies identified in individual completed suicides continued to improve, but still reflected some significant substantive inconsistencies.

An analysis of the case reviews provided in Appendix B allows some generalizations, many of which are consistent with conclusions reached in earlier annual reports on suicides in CDC.

- The three suicides among women in 2004 were a shock. The number surpassed the total number of suicides for women in CDC in the previous 16 years combined. All three of these suicides were foreseeable or preventable; two of them were both foreseeable and preventable.

[2] These figures on the annual suicide rate differ somewhat from the rates reported in the department's five-year report on suicides. The department's calculations were based on the average daily CDC population during the given year, while these reports have used the department's population count on the last day of the covered year.

- In ten of the 26 case reviews of suicides in 2004 (38.5 percent), delays in the immediate initiation of CPR were cited as potentially contributing to successful completion of the suicide. The report on suicides in 2003 led to a mid-2005 court order directing the defendants to develop and implement a policy requiring custody staff trained to do so to provide immediate life support measures, including CPR, in responding to medical emergencies, including suicides. The completeness of the defendants' response has been the subject of court pleadings and negotiation throughout the past six months and will be a focus of monitoring during the 17th compliance review that begins in March 2006.

- The failure of clinicians to make use of available information to ensure that inmates are fully and appropriately screened, assessed and treated remained a dominant problem. In too many cases, completed suicides occurred when information in a UHR or central file, had it been reviewed by mental health clinicians during interviews with inmates, might have alerted mental health staff to inmates' potential for suicide. The lack of appropriate screening in confidential settings for new intakes into administrative segregation, including the administration of Suicide Risk Assessments, was also an important recurring problem. Both of these problems represent essentially inadequate clinical practices on the part of the department's clinicians, although the second problem often seemed to involve inadequate custody escort resources and private interview space in administrative segregation units.

- Inadequate treatment interventions included the failure to place inmates in need of more intensive treatment in appropriate mental health programs or units. This failure, which contributed to a number of 2004 suicides, was confirmed by the Unmet Needs Assessment conducted by the Special Master's experts and CDC clinicians. That assessment, conducted in early 2005, led to a requirement that the defendants substantially expand the availability of DMH inpatient programs.

- Two completed suicides in 2004 involved inmates whose Keyhea orders expired within weeks of their completed suicides. In both cases, the inmates were non-compliant with medications, resulting in each case in predictable decompensation. The expiration of the inmates' Keyhea orders was attributable to the failure to anticipate and pursue renewal of the orders, rather than to improvement in the inmates' mental health symptoms or condition. Other medication-related issues contributing to suicides in 2004 included the hording of medications (two suicides resulted from overdoses) and the slow response, or failure to respond at all, to non-compliance with medications.

- Large-mesh screens covering air ventilation ducts particularly in administrative segregation cells to which a noose can be attached to accomplish suicide by hanging emerged as an issue in 2003 and resulted in a June 9, 2005 court order requiring the defendants to develop a plan for dealing with the large-mesh ventilation screens in administrative segregation cells in which mental health

caseload inmates are housed. In 2004, 18 of the 26 completed suicides occurred in administrative segregation units, all but one of which were accomplished by hanging. Five of the 17 hangings involved the large-mesh screens. In the remaining 12, the noose was attached to a variety of anchors, including bunks (in seven instances), light fixtures (two), windows (two) and a shelf (one). While physical plant structure is an important element of prevention efforts to reduce the incidence of suicide in administrative segregation units, the careful, thorough screening of inmates entering administrative segregation, daily rounding by psych techs as required by departmental directives and the prompt identification of inmates whose conditions may be deteriorating, followed by appropriate assessments in a confidential setting and referrals to appropriate levels of mental health treatment, are even more important.

- While the suicide review process continued to improve, identification of facility versus departmental issues and the documentation of efforts to achieve the objectives, goals, and outcomes for corrective actions specified in some suicide reports varied widely. In some instances, implementation problems were local and involved individual clinician/correctional officer/treatment team issues, as well as human resource and other resource allocation concerns. In some other instances, the suicide review too readily accepted institutional failures as inevitable.

Based on a review of the suicides completed in CDC in 2004, there appears to be less need of new recommendations than a greater need to focus on the full implementation of the recommendations included in the predecessors to this report, namely:

1. Implement fully all of the elements of the suicide review process already in place, including both institutional and departmental follow-up to corrective action plans and submission to the special master of documentation on the outcome of investigations of staff misconduct, negligence and errors.

2. Conclude the pilot project at Pelican Bay State Prison and finalize and submit to the special master forthwith a system-wide plan for dealing with the large-mesh ventilation screen issue.

3. Fix the now broken mechanisms for tracking and maintaining Keyhea orders for the involuntary medication of inmates in need of psychotropic medications.

4. Continue to work on improving timely access to DMH inpatient placements, particularly for Level III and Level IV inmates, and focus greater training, supervisory and peer review efforts on the placement of decompensating inmates in appropriate levels of mental health care.

5. Determine whether clinicians' failure to review and utilize existing UHRs and central files, including probation reports, was attributable to difficulties in access to pertinent records or faulty clinical practices. The department needs to address

the accessibility issue, a problem shared by all of the components of health care services. In the meantime, increased training, supervisory and peer review efforts need to be focused on clinicians' review and use of available records and documentation.

6. Undertake increased efforts to understand more clearly and respond adequately to the potential for suicide among the department's female inmates. Fortunately, no female offenders in CDC committed suicide in 2005.

7. Implement fully the finally approved policy on the application of CPR by custody staff.

In 2004, 69.2 percent of all CDC suicides (18 of 26) occurred in administrative segregation, up from an already high 48.5 percent in 2003 (17 of 35). In both years, a majority of the suicides completed in administrative segregation involved inmates who were not on the mental health caseload at the time of their deaths (11 in 2003; ten in 2004). The defendants need to analyze this rising trend more closely and focus more energy and resources on reversing it. Policies and practices appeared to be in place to deal with the problem, including mental health screenings and, where indicated, suicide risk assessments of inmates newly placed inmates in administrative segregation, regular psych tech rounding of caseload and non-caseload inmates, more frequent clinical contacts with caseload inmates, regular interdisciplinary team meetings and classification hearings, but the number of suicides in administrative segregation went unabated. These policies and practices were fully implemented in 2001 and 2002. In the latter year, just 27.2 percent of suicides in CDC occurred in administrative segregation (six of 22).

The individual case reviews of suicides in 2004 in Appendix B suggest that some initial screenings, SRAs and many psych tech rounds were performed perfunctorily and most often at cell-front or in holding cells, where the lack of privacy often precluded meaningful inmate participation, especially for those inmates placed in administrative segregation for protective reasons. Based on the information in the suicide reports, it is uncertain whether these inadequacies reflected poor clinical practices, a lack of adequate mental health staff, insufficient correctional officers to escort inmates to interview space, inadequate confidential space for clinical contacts or some combination of all of these factors.

From all of this comes the single specific recommendation of this report:

- The defendants need to develop by May 31, 2006 a plan for dealing with the escalating percentage of suicides occurring in administrative segregation units. The plan must be based on an analysis of the causes for the increasing rate and, depending on the outcome of the analysis, provide adequate resources of mental health and/or custody staff, create sufficient confidential interview space and/or enhance the quality of mental health services provided in administrative segregation units.

As is so often the case, neither party contests the specific findings in the draft version of this report of the special master's expert on suicides in 2004, but both object to the proffered recommendation. The defendants insist the recommendation is unnecessary and redundant, while the plaintiffs find the stated recommendation unsatisfactorily vague and also want additional recommendations.

The defendants' objection is posited on the fact that the reportedly "escalating" percentage of suicides occurring in administrative segregation units noted in 2004 ceased to escalate further, based on a preliminary review of suicides in 2005. Of course, data on 2005 suicides were neither complete nor fully available when the draft version of this report was being composed. The judgment in the draft report on the escalation in the percentage of suicides occurring in administrative segregation, moreover, was based on performance during the two preceding years, as well as 2004 itself. In 2002, six suicides occurred in administrative segregation cells (27 percent of total suicides in that year); in 2003, 17 suicides occurred in administrative segregation (47 percent of the suicide total); and in 2004, 18 of a total of 26 suicides (69 percent) occurred in administrative segregation. That history certainly reflects an escalating trajectory in the percentage of CDC suicides occurring in administrative segregation.

The defendants report that a significantly reduced 37 percent of the department's suicides occurred in administrative segregation in 2005, a year in which the overall number of suicide soared to its highest total ever. The defendants attribute the decline in the number of suicides in administrative segregation in 2005, moreover, to their own aggressively proactive measures, which essentially make the special master's recommendation redundant. The plaintiffs respond with a somewhat different analysis of suicides in 2005, which points to the overall increase in suicides, lumps together all suicides occurring in any "locked unit" and discounts from the total of 2005 suicides those that occurred in unusual units where previously suicides rarely, if ever, occurred. Whatever the arguments over the significance of the 2005 data on suicides, the ratio of suicides among the administrative segregation population was relatively and extraordinarily high in 2004 and 2005 and continues, apparently, to be high in the current year.

In their objections, the defendants list eight explicit measures already adopted to respond to suicides in administrative segregation. In addition, other pending or planned improvements are cited, two of which are dependent on requests included in the FY2006-07 budget for additional resources to meet certain Program Guide enhancements. The plaintiffs argue that the defendants' citation of memoranda and directives to institutional administrators is an ineffective substitute for a genuine plan. The plaintiffs, for example, point to a February 2005 decision of a Division of Adult Institutions Executive meeting cited by the defendants that reiterated the expectation, formally announced in an earlier memorandum, that inmates admitted to administrative segregation units will be double-celled unless otherwise "precluded." In 2004, all 18 inmates in administrative segregation who committed suicide were single-celled; preliminary data from 2005 suggests that all but one or two of all inmates who committed suicide in administrative segregation were single-celled. More needs to be done to make custody managers of

administrative segregation units address the single-celling issue; it is a matter of life or death.

Another suggestion from the plaintiffs encourages a system-wide operating protocol for the performance of psych tech rounds in administrative segregation that includes specific guidance on the nature of rounding for both caseload and non-caseload inmates and the documentation required to record performance of psych tech rounding tasks. These points affirm the requirement in the draft version of this report that the defendants develop a plan by May 31 to address suicides in administrative segregation. In addition to citing memoranda, the plan should include a more detailed prescription for their operational implementation. In particular, the issues of single-celling and measures for the operational improvement of psych tech rounding need to be incorporated in the plan.

Plaintiffs also seek a recommendation that would require the defendants to replace "the large-mesh ventilation screens in all administrative segregation units within 90 days" of an order. This issue needs some background. In the report on suicides in 2003, the special master noted that nine inmates in administrative segregation used the large-mesh ventilation screens in their cells to hang themselves. This led to a June 2005 order requiring the defendants to submit a plan for dealing with the hazard of large-mesh ventilation screens in administrative segregation units. On July 8, 2005, the defendants filed a report which indicated that in late 2004 they had initiated a process for ascertaining the feasibility of replacing existing ventilation screens in administrative segregation cells with a so-called "S-Vent," which purported to be a suicide-proof screen. The defendants contracted with a manufacturer of the S-Vent screen to test its compatibility with the department's HVAC systems in 20 locked unit cells in California State Prison, Corcoran. The testing process found that the S-Vent screen so inhibited the ventilation of cells, it was unusable.

In the defendants' July 8, 2005 response, Facilities Management personnel also reported that "the size variations of the whole design offer little or no significant deterrence to an inmate intent on suicide." The response also stated that "staff readily demonstrated the ability to quickly thread materials through even the smallest openings (3/16") in a manner that would be robust enough to create a hanging mechanism. This appears to be validated by published vendor caveats that their respective products are not suicide proof." Facilities Management letter, dated July 8, 2005, to the special master, pp.1-2.

Meanwhile, the special master in Madrid, troubled by the suicide of Pelican Bay State Prison inmates in the newly opened administrative segregation by means of the large-mesh screens, obtained an agreement from the defendants in mid-July 2005 to replace existing vents in the newly opened, so-called "stand alone" administrative segregation facility with 3/16th inch vents within six months.

In 2004, five of the 18 suicides that occurred in administrative segregation involved a hanging that used the present large-mesh air vent screen, i.e., with openings that are 5/16th of an inch. Among other anchors for the remaining 12 suicides by hanging that occurred during 2004 in administrative segregation units (one administrative segregation

suicide involved a drug overdose) were light fixtures, window fixtures and latches, double bunk tops, a bunk ladder and a book shelf. Administrative segregation cells are not "safety cells," where inmates suspected of being at high risk for suicide are housed. Safety cells, located typically in Correctional Treatment Centers, Mental Health Crisis Bed units or Outpatient Housing Units, have been purged of all architectural features and furnishings that might contribute to a possible suicide, including sinks and toilets. If an administrative segregation inmate is deemed to be at risk for suicide, CDCR policy dictates his or her removal forthwith to a Mental Health Crisis Bed unit or an Outpatient Housing Unit. This explains why the defendants' current lack of an adequate supply of Mental Health Crisis Beds is so serious and dangerous. Installing 3/16th-inch vent screens will not make administrative segregation cells safety cells, and experience suggests that inmates intent on suicide will use light fixtures, window fixtures or latches, double bunks, bunk ladders or book shelves to anchor a noose. Moreover, given that the best alternative to the current large mesh screens is a screen with 3/16th -inch openings, which apparently is an ineffective deterrent to an inmate intent on hanging him or herself, a requirement that the defendants replace "the large-mesh ventilation screens in all administrative segregation units within 90 days" is inappropriate.

The defendants' July 8, 2005 response contained an outline of a proposed feasibility study to assess the conversion of large mesh screens in administrative segregation cells to the smaller mesh size of no more than 3/16th of an inch. Several of the milestones laid out in the proposal have passed, and it is time to revisit the feasibility assessment and map out further appropriate steps. This does not require an order of the court to accomplish.

Lastly, the plaintiffs complain that the defendants have failed to implement the court's June 9, 2005 order to develop a plan within 60 days for a process to track the suicidal history of inmates in CDC's mental health caseload in the Mental Health Tracking System and/or any successor information system used by the department. The original plan, they assert, was too vague and unspecific especially in regard to timelines for its full implementation. The criticism is accurate and deserved. Neither the plaintiffs nor the special master presently know whether modifications to the defendants' Mental Health Tracking System to retrieve and highlight suicidal history in the records of inmates on the Mental Health Services Delivery System have been fully installed and are now operating on a routine basis. The special master will ensure that monitoring teams determine the status of the modifications during institutional site visits remaining to be conducted during the present 17th round of monitoring and in the next round as well.

The plaintiffs also raise a substantive issue about the tracking of non-caseload and former caseload inmates with a suicide history. In the pending litigation over various aspects of the Program Guide, the plaintiffs are seeking a code identifier for all CDC inmates with any past involvement in the Mental Health Services Delivery System. The original impetus for the recommendation in the report on suicides in 2003 on tracking caseload inmates with a suicidal history came from the case of an inmate, who was in and out of the caseload during a lengthy incarceration and whose status at the time of his suicide was uncertain. The Suicide Report for this case noted clinicians' failure to track the

inmate's suicidal history and suggested the potential utility of the Mental Health Tracking System for reminding clinicians of the presence of a suicide history. That utility prompted a fairly simple and straightforward response: the defendants have pledged to create a field in the Mental Health Tracking System to alert clinicians to a caseload inmate's suicide history. The defendants claim they have instituted the required change, and it is time to determine whether they have done so operationally at the institutional level.

Appendix A

Tracking Timelines for Preparation of Documents on Completed Suicides

	Event/Document	Timeline
1	Date of Death	0 hour
2	Chief Medical Officer to Death Review Coordinator (DRC)	8 hours
3	Initial Inmate Suicide Report (Form 7229B) by Suicide Prevention Coordinator to DRC	2 business days
4	DRC to Mental Health Suicide Prevention Coordinator (MHSPC)	3 business days
5	MHSPC appoints Mental Health Suicide Reviewer (MHSR)	5 business days
6	MHSR writes Preliminary Report; Notifications of suspected misconduct to Suicide Review Committee (SRC)	15 days
7	SRC completes Review and Adds Corrective Action Plan (CAP); Review to MHSR to Complete Executive Report	30 days
8	MHSR submits Executive Report and all documents to SRC to complete Final Suicide Report	60 days
9	Facility, Warden, and CMO or HCM implement CAP	120 days
10	Report on implementation of CAP by facility Warden and CMO or HCP to SRC	150 days

EXHIT B

Case Reviews of Suicides Completed
in the California Department of Corrections
in Calendar Year 2004

REPORT ON SUICIDES COMPLETED IN THE CALIFORNIA DEPARTMENTOF CORRECTIONS IN CALENDAR YEAR 2004

Case Reviews

1. Inmate X01378

Brief History: This inmate was a 35-year-old Hispanic female who committed suicide by hanging on 1/13/04 in the Enhanced Outpatient (EOP) housing unit at the Central California Women's Facility (CCWF). The inmate was a part of the Mental Health Services Delivery System (MHSDS) at the EOP level of care, and was the sole occupant of a double cell. The inmate entered the California Department of Corrections (CDC) through the reception center at Valley State Prison for Women (VSPW), having pled guilty to possession of a controlled substance, which resulted in a 16-month term in CDC. The Suicide Report noted a lack of clarity in the record as to whether she had been admitted to Patton State Hospital (PSH) from a county jail prior to being admitted to CDC. The inmate was transferred to CCWF on 12/24/03.

The inmate was discovered on 1/13/04 at approximately 10:39am by a painter and an inmate worker who were painting the second tier housing in the 504 EOP program. Those two individuals notified a correctional officer that an inmate was "hanging herself in cell 210." Officers responded and discovered the inmate on the floor, slumped over in a kneeling position with a sheet tied around her neck and suspended from the upper bunk in her cell. The Incident Report indicated that a licensed practical nurse (LPN), who was part of the EOP medical staff, arrived while the sheet was being removed from the inmate's neck and began performing CPR assisted by a correctional officer. The inmate was transported to the CCWF emergency room via Stokes litter and medical gurney at approximately 11:23am. A physician pronounced the inmate dead at that time. An autopsy was performed on 1/13/04 by a pathologist for the Madera County Coroner's office. The cause of death was listed as hanging. Samples were taken for toxicology analysis. The toxicology report of 1/21/04 revealed no illegal drugs or alcohol detected in the samples. The presence of Zyprexa and Benadryl was detected.

The Suicide Report contained the inmate's criminal history and described the commitment offense as having occurred on 4/7/03, when the inmate was stopped in her vehicle because of malfunctioning equipment. She failed a sobriety test and was subsequently charged with possession of a controlled substance and being under the influence of a controlled substance (methamphetamine). She pled guilty to possession of a controlled substance and was sentenced to 16 months beginning on 9/23/03. She did not enter VSPW until 10/1/03. It was not clear whether she had a psychiatric or other type of hospitalization during the intervening time period.

The inmate had a history of multiple arrests (more than five) involving controlled substances, driving under the influence of alcohol and other charges, including disorderly

conduct and cruelty to a child. Records indicated that she had served two previous prison terms in CDC, the last of which occurred between 6/11/97 and 12/30/97. Particulars on the first term were not provided. The inmate apparently had a different CDC number during the earlier incarceration.

The inmate was admitted to CDC via the VSPW reception center on 10/1/03. Her bus screening was positive, indicating the inmate had been treated for mental illness, was taking psychotropic medication, had experienced hallucinations and had been diagnosed as Schizophrenic and Manic Depressive. The bus screening indicated the inmate denied thoughts of hurting herself or having ever attempted suicide.

On 10/2/03 the inmate was seen by two different psychology interns, one of whom administered a Developmental Disability Program (DDP) screening instrument, while the other documented the inmate's history of having been treated at PSH in July 2003 and current reports of active hallucinations, racing thoughts, paranoid thoughts and depression; the inmate again denied suicidal thoughts. The intern referred the inmate for psychiatric evaluation. The Suicide Report stated that the inmate was seen by a psychiatrist on 10/13/03 and diagnosed with a Psychotic Disorder NOS rule out Schizophrenia with prescriptions of Risperdal, Topamax, and Trazodone. The psychiatrist's note of 10/13/03 was not provided for review.

According to the Suicide Report, the inmate was seen for follow-up by a psychiatrist on 10/27/03. All of her medication was increased at that time. Evaluations by a psychiatrist on 11/4 and 11/10/03 indicated the inmate continued to have psychotic symptoms; her medications were either continued or increased. A psychiatrist's note of 12/4/03 indicated that the inmate was seen in response to a "crisis referral." The note described her as having attempted suicide on four past occasions and having been hospitalized at PSH for two months. The note also reported that the inmate was first prescribed psychotropic medications approximately four to five years prior to the interview. The psychiatrist indicated a number of positive and negative symptoms of psychosis and noted a negative suicide evaluation. The psychiatrist decreased her medications. From 10/1 through 12/18/03, different psychiatrists continued, decreased, increased and finally decreased her psychotropic medications. The inmate was evaluated on 12/22/03 by a psychologist who indicated the inmate was continuing to decompensate and was increasingly anxious about a possible recommendation for an EOP level of care. The interdisciplinary treatment team (IDTT) reviewed the recommendation, and the inmate was placed in EOP. On 12/24/03, she was transferred to CCWF.

A MH-4 dated 12/17/03 indicated the Uniform Health Record (UHR) was not available but described the inmate's report of her arrest and past treatment. The account included family history and history of treatment at PSH in July 2003, as well as at other mental health facilities, and her suicide attempt by hanging in early 2003. New diagnoses offered on the MH-4 included PTSD, Panic Disorder without Agoraphobia, Psychotic Disorder NOS, and Alcohol Abuse in institutional remission, with a GAF of 52. A subsequent MH-4 dated 1/5/04 was reviewed. It, too, contained information on the inmate's history, including the fact that she was placed on a suicide watch on 12/18/03.

The MH-4 stated the inmate "does not endorse psychotic symptoms or suicidal ideation, and does not appear to be responding to internal stimuli, has good self-care, is medication compliant and may be seeking medication for anxiety" and recommended discharge to the Correctional Clinical Case Management System (3CMS) level of care. New diagnoses offered on this MH-4 were rule out Bipolar Disorder, diagnosis deferred with borderline traits and anti-social traits, with a GAF of 60. An IDTT was held on 1/7/04 for an initial review of EOP placement and it was determined that she "does not meet criteria for EOP level of care." It was unclear from the signatures on the treatment plan whether a psychiatrist attended the IDTT meeting. A clinical case manager (CCM) and a recreation therapist signed in the appropriate places to document their presence. A chrono of 1/7/04 indicated the inmate's new level of care was 3CMS with a global assessment of function (GAF) score of 60 and contained a behavioral alert about the inmate's medication seeking.

A psychologist's assessment note on 1/7/04 indicated that the inmate reported a history of sexual molestation, physical abuse and a family history of mental illness. The inmate reported that she had been receiving SSI benefits for four or five years because of her severe mental illness. The assessment also included statements by the inmate that she had thoughts of suicide but no plan in December 2003. She also reported an attempted hanging two years prior to this incarceration when she hospitalized herself at a psychiatric hospital. The psychologist's note included the inmate's statement that claustrophobia "triggers" her hopelessness and that she currently did not want to leave her cell because she did not want to become involved with inmates who might be using drugs. The psychologist's note also indicated that the inmate reported occasional thoughts about suicide but stated she would not hurt herself.

The following day, 1/8/04, the inmate was seen by a psychologist after being referred by a correctional officer. The officer described her as appearing to be talking to herself and wandering aimlessly. The psychologist evaluated the inmate and reported that she was cooperative and calm but guarded with flat affect, appeared anxious and was reporting auditory hallucinations and persecutory beliefs. Based on this, the psychologist assessed the inmate's GAF score as 50 and referred her back to the EOP program. She was transferred back to EOP housing that day. On 1/9/04, the inmate was re-evaluated by the psychologist who had evaluated her earlier and recommended the 3CMS level of care placement. The inmate stated that she thought she belonged in a mental institution rather than a prison, even if it meant her time might be extended. The psychologist further noted that the inmate was cooperative, her appearance was within normal limits and her behavior was manipulative with agitated activity. This psychologist indicated the inmate reported suicidal ideation, which she attributed to anxiety, and denied any current intent to harm herself. The psychologist indicated the inmate reported auditory hallucinations and compliance with medication. The psychologist opined that the inmate's claims of auditory hallucinations and thoughts of suicide were inconsistent with her presentation. The plan was to continue to assess the inmate and obtain the UHR and central file under her previous CDC number to verify her reported psychiatric history. It did not appear that this information was received prior to the inmate's death.

The Suicide Report noted that the inmate's last contact with a health care professional occurred on 1/13/04, when she came for her morning medication. She was described at that time as being "in good spirits" and reportedly stated, "I feel good – I get to see the doctor tomorrow for anxiety meds." The next note in the record, dated 1/13/04, was medical staff's description of the inmate's emergency room visit and attempted treatment after she was discovered hanging in her cell. A physician's earlier note on 1/5/04 indicated the inmate's blood pressure was elevated and would continue to be monitored for two weeks. That note also suggested that mental health should evaluate the inmate for anxiety.

The Suicide Report identified a number of documentation errors or problems with the inmate's UHR. A review of the record by an RN consultant to CDC indicated that the nursing notes did not meet acceptable standards for assessment of the inmate's chest pain and anxiety. A review by a physician consultant to CDC indicated that given the inmate's history the workup for her chest pain and complaints was inadequate and none of the treatment suggested by medical staff addressed the inmate's extreme anxiety.

The Suicide Report referred to two letters found in the inmate's property in which she "states she is sad." There were no references to any specific note indicating her intent to commit suicide.

The Suicide Report identified five problem areas and recommended corrective actions:

Problem 1: Mental health staff had difficulty clarifying this inmate's diagnosis.
Recommendation: Training should be provided to staff on anxiety disorders, the risk of suicide, the importance of completing a Suicide Risk Assessment (SRA), consideration of double-cell housing for at-risk inmates, and drug addiction and the short and long-term effects of drugs on human functioning.

Problem 2: Some inmates were apparently aware that the deceased inmate was making comments about committing suicide, but none believed she would actually kill herself.
Recommendation: The institution should consider providing educational information to inmates in the EOP housing unit on when to notify staff about other inmates' difficulty with coping and/or verbalizing suicidal intent.

Problem 3: Several psychiatrists attempted to manage this inmate's anxiety and other symptoms without success. She was seen by several contract psychiatrists who changed her medication with little regard for continuity of care.
Recommendation: Provide training to CDC and contract psychiatrists to emphasize the importance of not changing treatment levels until the inmate is stabilized. The recommendation also referred to statewide video conferences planned to address the issue of polypharmacy.

Problem 4: The inmate had a history of drug abuse. Although she received some medical testing, neither a cardio workup nor an EKG were performed.

Recommendation: Medical and mental health staff needed to work together to address symptoms in a coordinated manner and provide training to medical and nursing staff on the need to exchange information on both medical and mental health symptoms. A statewide video conference being planned to address issues of medical problems in mental health patients was noted.

Problem 5: Documentation problems were noted in the UHR.
Recommendation: Provide training to staff on legal and ethical standards for documentation.

CCWF submitted a memorandum dated 8/30/04 to Health Care Services Division (HCSD) in response to the Suicide Report of this inmate. The cover memorandum indicated that mental health supervisors and staff received training in the relevant issues recommended in the Suicide Report. The institution provided an agenda and a list of attendees at psychiatry staff meetings where covered topics included peer review notes, medication management, psychiatry chart audit results and an update on anxiety disorders. A sign-in sheet for a psychiatry staff meeting on 6/24/04 indicated that in-service training on anxiety disorders was provided to psychiatrists. These institutional responses appeared to be consistent with the Suicide Report's recommendations mandating "supporting documents" for the delivery of recommended training.

Findings: This suicide did not appear to have been foreseeable; the decedent did not make known to staff imminent threats to harm herself. The death might arguably have been preventable with better coordination among her mental health treatment team and medical staff and more thorough SRAs. The inmate had numerous changes of medication regimens by different psychiatrists without apparent collaboration among the mental health treatment team members or the psychiatrists who made the changes. In addition, behaviors observed by custody staff, some mental staff and medical staff were not integrated into an organized and comprehensive treatment plan. Contradictory assessments by psychology staff about whether she should have been at the EOP level of care appeared to have been made in the absence of documented review and consideration of the inmate's past and current behavior.

The inmate reported symptoms consistent with a psychotic disorder as well as an anxiety disorder (PTSD). The approach to her reported symptoms and the historical factors indicating that she was at an increased risk for self-harm did not appear to have included a comprehensive evaluation of all relevant factors. The Suicide Report recommendations did not require any outcome measurements or studies to ascertain or encourage appropriate collaboration among mental health staff in complex cases, and between mental health staff and medical staff when both departments have had contact and involvement with a specific inmate. While the training provided can certainly be helpful, no measures were identified to determine whether improvement in managing inmates with complex histories and symptomatology, such as that demonstrated by this inmate prior to her death, occurred in the future.

2. Inmate E81250

Brief History: This 62-year-old Caucasian male incarcerated at Salinas Valley State Prison (SVSP) completed suicide on 1/18/04 by an overdose of medications. The inmate was in the 3CMS level of care in the MHSDS and was housed on a Sensitive Needs Yard (SNY). The inmate was admitted to CDC on 1/15/91 via the San Quentin (SQ) reception center, having been convicted of two counts of first-degree murder. He was serving a life sentence without possibility of parole.

On 1/18/04 at approximately 7:08am the floor officer in facility A Building/5 was notified by this inmate's cellmate that the inmate was experiencing some medical problem. The officer responded to the inmate's cell and found that the inmate was "breathing but unresponsive." After the officer sounded his alarm, custody and medical staff responded. They discovered that the inmate was breathing with extreme difficulty and had a pulse but was unresponsive. An emergency response vehicle was summoned, but at 7:18am the inmate stopped breathing and did not have a pulse. CPR and other medical efforts were begun. These efforts were continued when an ambulance and paramedic arrived at 7:39am. The resuscitative efforts stopped at the direction of EMS staff at 7:42am. The inmate apparently was not transported to the ER by the emergency response vehicle; his body was left in the cell.

The Incident Report indicated the inmate's condition showed no signs of victimization, and the possibility of suicide was being investigated because the inmate "had been placed on 24-hour observation in a housing unit due to several letters he had written to his wife." The Incident Report also stated that the inmate had a cut on the first finger of his right hand which was actively bleeding when staff first responded to his cell. The Coroner's Report of 2/11/04 indicated "this was a death of suicidal cause and origin, and no further investigation is warranted by the coroner's office." The toxicology report indicated that the inmate had Gabapentin (Neurontin) and Pseudoephedrine at toxic levels, reported respectively as 85.5 mg/L (blood range 2-6mg/L) for Gabapentin, and 2.32mg/L (blood range .5-.8mg/L) for Pseudoephedrine. The blood levels for Gabapentin and Pseudoephedrine were extremely high. According to the toxicology report dated 1/23/04, there is no potentially toxic level known for Pseudoephedrine, although the lethal level is greater than 19mg/L. The Suicide Report noted that the inmate had a plastic baggie tied around his neck by a blue string which included "end of life instructions and 2 mortuary business cards."

This inmate was serving a life sentence without parole that began on 1/15/91 following his conviction in October 1990 on two counts of first-degree murder. He had been housed at SQ, Folsom, and SVSP, where he was placed on 7/31/03 on a SNY. This transfer was in concert with his work-up for possible hip surgery and a MRI. He had experienced chronic pain and medical problems since at least 2/18/03. He filed several 602s (CDC inmate grievance forms) because he felt that his medical treatment was inadequate. His complaints included not being provided with results of his MRI studies and inadequate pain management.

This inmate's medical conditions were reported as Adhesive **Osteomyelitis** in the left hip, Hypertriglyceridemia, and borderline Diabetes Mellitis. At the time of his death, his left hip arthritis was estimated to have been present for approximately 11 years. He had received treatment for his chronic hip pain with various analgesics, including Motrin, Naprosin, Baklofin, Omethasin and Vicodin. Left hip osteoarthritis and mild degenerative arthritic changes were noted secondary to x-ray examinations on 2/20/03 and 6/20/03. A permanently mobility-impaired (lower extremities) DPM was completed by a physician on 7/10/03. A health care services physician's Request for Services form indicated a principal diagnosis of possible avascular necrosis on 9/19/03 and the need for an MRI. An MRI screening scheduled for 9/29/03 was performed on 10/7/03, with a report received on 12/1/03.

Although incarcerated in CDC since 1991, this inmate did not receive mental health services until December 12, 2001. At that time, based on a clinical case manager's evaluation, a diagnosis of Major Depressive Disorder single episode was made and a referral to psychiatry was initiated. His GAF score was estimated at 60. He was placed in the MHSDS at the 3CMS level of care. SRAs were administered on 12/12/01 and 1/3/02. They indicated that the inmate consistently denied any suicidal attempts or plans and agreed to report any suicidal thoughts to staff. The risk assessments all concluded there was no need for any referral. Treatment plans were dated 12/12/01, 1/3/02, 2/19/02, 2/4/03, 4/11/03 and 8/20/03. All of the treatment plans indicated the inmate continued to be treated for depression and, once started on psychotropic medications, he was compliant with his medications. The majority of these treatment plans, including the most recent treatment plan of 8/20/03, did not specify conditions or concerns on Axis III (physical disorders or conditions). The most recent treatment plan, dated 8/20/03, noted on Axis III, "see UHR," while the treatment plan on 4/11/03 had "none reported" on Axis III.

The inmate was transferred from a dormitory to administrative segregation in January 2003 for safety reasons. Mental health progress notes indicated the inmate did not receive his Celexa for several days in February 2003 and reported having significant trouble sleeping, a lack of energy and depression. Remeron was added to his regimen of Celexa at that time. The inmate was subsequently released from administrative segregation pending transfer to a custody Level III institution. It was noted in a progress note of 4/11/03 that the inmate was programming well, was compliant with mental health treatment and his wife, children, and grandchildren visited him weekly. There was an indication that the family had recently moved to Sacramento. A subsequent progress note indicated the inmate continued to suffer from Depressive Disorder NOS and had some periods of being down and withdrawn, but his main problem was the painful left hip, which by that time had immobilized him. These notes indicated the inmate did not leave his cell much of the time because of the pain in his hip and stated that his medication was "like drinking a glass of water." The inmate was subsequently transferred to SVSP SNY, and a progress note of 8/15/03 described him as stable with plans to continue his medications. He was recommended for group treatment at that time. The psychiatrist at SVSP discontinued his Celexa and continued only the Remeron on 8/20/03. The inmate's medication order, however, appeared to have run only through 11/12/03, and no

follow-up occurred by psychiatric staff after 8/20/03. His antidepressant medication appeared to have expired without psychiatric follow-up, although his MAR noted in November 2003, "psychiatrist aware of med expiring." Progress notes indicated the inmate had reported his psychotropic medications were tolerated well and were helpful, but he continued to have complaints of pain and problems getting pain medication prescriptions refilled. The last progress note provided was dated 1/12/04. It indicated the inmate had contracted to keep himself safe and reported no suicidal ideation or plan. The note also indicated that he was "feeling much less angry and depressed, and had spoken to his wife after writing 'desperate' letters." The inmate reported that he was not receiving his medications, and his sleep remained poor.

According to the Suicide Report, a correctional officer generated a crisis referral by means of a 128B chrono on 1/12/04, because he was concerned that the inmate was possibly suicidal. The correctional officer provided copies of three letters the inmate had written that were described as "reflecting his death and funeral." The officer also informed the psychologist that the inmate's central file indicated he had considered suicide before he was arrested for his commitment offenses. The chrono reportedly indicated that the contract psychologist/case manager intended to place the inmate in the Mental Health Crisis Bed (MHCB) unit for observation. This crisis appointment of 1/12/04 appeared to be the first time that a CCM had seen the inmate since 8/22/03, a gap of almost five months between appointments.

Although no SRA dated 1/12/04 was included in the records provided, the Suicide Report indicated that an SRA on that date identified several risk factors, including a history of suicidal ideation, the inmate's Caucasian race, a history of mental illness, chronic illness, recent suicidal ideation, current insomnia, lack of a perceived support system and recent rejection or loss. The level of suicide risk was estimated as "low." Despite the Suicide Report's reference to a 1/12/04 SRA, the only SRAs provided for review were dated 12/12/01 and 1/3/02.

A MH-3 note written by the psychologist on 1/12/04 reported that the inmate contracted to keep himself safe. The plan was to "See PRN and ongoing right now during" (sic). There was no comment about an actual assessment of the inmate, and in the area on the form for indications of suicidality, suicidal ideation was circled as "absent." The CCM decided not to admit the patient to the MHCB. That conclusion appeared to have been reached without a review of the UHR or central file, or reference to the correctional officer's statements in the referral for a crisis appointment on 1/12/04.

The UHR contained a quarterly case management contact note dated 11/25/03 by a different psychologist, apparently conducted without the inmate's UHR. The lack of psychiatric follow-up on the expiration of the inmate's medications in November 2003 did not appear to have been noticed or noted by mental health staff.

The Suicide Report also included information about pertinent anniversary issues that were available in the UHR and/or central file. Anniversary dates of note included the end of the inmate's second marriage in December/early January of 1987, his entry into CDC

in January 1991, and the celebration of his 15th wedding anniversary with his third wife on 12/28. On 12/31/03, the inmate learned of his third wife's intention to end their relationship. Based on available documentation, these factors did not appear to have been known to mental health staff. The inmate, as indicated, was also in chronic pain and had written 602s to complain that he was not being treated appropriately. He had been off his antidepressant medications for two months at the time of the evaluation on 1/12/04.

The Suicide Report identified seven problems and associated recommendations:

Problem 1: Psychiatric medication changes for this newly arrived inmate were not followed up to assess their efficacy or identify any medication-related problems.
Recommendation: Establish a Quality Improvement Team (QIT) to develop a clinically appropriate procedure for psychiatric follow up after medication changes.

Problem 2: Orders for medications expired without psychiatric follow-up.
Recommendation: A QIT should review existing procedures and make corrections to ensure adherence to medication management policy.

Problem 3: Psychiatric follow-up did not occur in accordance with applicable 3CMS MHSDS guidelines to ensure that medication was effective and appropriate
Recommendation: A QIT was needed to determine whether this was a systems problem or a personnel problem and take steps to correct it.

Problem 4: Lack of available information about the history of the deceased inmate impeded patient care.
Recommendation: A QIT should be conducted to ensure that UHR and central files are available for initial assessments and UHRs are available for each clinical contact.

Problem 5: Extreme delay in reporting this death as a suicide. Initially reported as a "natural" death on a 7229A, dated 1/18/04, the event was reported as a possible suicide to HCSD by phone on 3/3/04. It was not reported as a suicide on a 7229B until 4/20/04.
Recommendation: A QIT should establish local policy and procedures for immediate referral for suicide review when evidence or circumstances suggested suicide as the possible mode of death.

Problem 6: The deceased's body was placed back in his cell rather than being removed to an appropriate location in the Correctional Treatment Center (CTC).
Recommendation: The institution should review the rationale for this decision, determine whether local policy was followed, review and revise the local policy as needed to conform with departmental policy and train medical and custody staff in the appropriate handling of the bodies of deceased inmates prior to their removal from the institution.

Problem 7: Inmate was able to hoard the medication used to overdose.
Recommendation: Staff needed to review and ensure compliance with nurse administered and direct observation therapy (DOT) procedures for administering medications by conducting at least one audit of medication passes on each yard.

The Suicide Report was dated 9/22/04. SVSP responded to the Suicide Report's corrective action plan recommendations on 1/13/05. The cover letter from SVSP indicated that several QITs were formed to address the following problems:

- Orders for medication expiring without psychiatric follow-up;
- Psychiatrists' failure to meet MHSDS guidelines ensuring that ordered medication was effective and appropriate;
- Lack of available information on inmates' histories;
- Extreme delay in reporting this death as a suicide;
- Treatment of the deceased inmate's body; and,
- The deceased inmate's hoarding of medications.

Although a number of issues were identified by the institution for correction, essentially all of the recommendations were reported as of 2/28/05 as ongoing or requiring no further action. HCSD responded to the SVSP's submission on 1/31/05, indicating that several key recommendations were not addressed or were missing from the facility's follow-up report, including:

- Audits for six months of psychiatric follow-up of medications;
- Audits for two months of the availability of central files during IDTT meetings;
- Documentation on the timely reporting of suicides;
- Because results of the DOT/nurse-administered audit were unacceptably low, audits needed to be continuously conducted and submitted until 85-per cent compliance was reached.

SVSP subsequently responded on 2/16/05, indicating it would address these issues and provide appropriate follow-up documentation over the next six months. Additional documentation was submitted by SVSP on 6/14/05 on three ongoing audits. The audits were examining follow-up to expiring medications audit, DOT administration of medications and the availability of central files for IDTT meetings.

Findings: This inmate's death may have been foreseeable and was certainly preventable. The inmate's early care and treatment for Depressive Disorder appeared to have been generally appropriate until his transfer to SVSP, where coordination was lacking between medical and mental health staff relative to the inmate's reports of chronic pain and between custody and mental health staff about possible changes in the inmate's relationship with his wife. In response to the correctional officer's appropriate referral for a crisis evaluation on 1/12/04, the contract psychologist who performed the evaluation apparently failed to consider information available in the inmate's central file and UHR or provided by the referring correctional officer.

The reference in the Suicide Report to an SRA completed on 1/12/04 was not verifiable in the documents reviewed. The progress note written by the psychologist who saw the inmate on 1/12/04 did not clearly document suicidal risk factors or situational factors that had recently changed, including the inmate's letters to his wife, discussion with the inmate about those letters, or the rationale for determining that the inmate's risk for suicide was "low" and that he should not be admitted to the MHCB unit. Nor did the note document any consideration of an admission to the MHCB for an evaluation and further assessment.

Although the inmate's medications expired two months prior to the evaluation and had not been renewed, he was not referred for further review or evaluation by the treatment team, a psychologist or a psychiatrist. The method of his suicide pointed to serious problems with the implementation of nurse-administered and/or DOT medications. His ability to hoard enough medication to put together the fatal overdose or obtain medications from others indicated problems with medication administration.

The decision to perform CPR and move the inmate back into the cell rather than transport him to the CTC emergency room was unexplained. It was identified as a problem for further review in the Suicide Report by HCSD.

The response by SVSP was untimely and inadequate. It did not provide outcome measures to show that problem areas identified in the Suicide Report were reviewed and improvements made. Neither the particulars surrounding this individual's death nor the systems issues that were identified, such as medication management, evaluation of inmates in crises, crisis management and collaboration between medical and mental health staff, were demonstrated as having been reviewed and rectified.

3. Inmate V11066

Brief History: This 35-year-old Hispanic male committed suicide by hanging on 1/21/04 at Centinela State Prison (CEN) while housed in administrative segregation. He was the only occupant of the cell at the time of his death. He did not receive mental health treatment during his incarceration.

On 1/21/04 at approximately 9:00pm a correctional officer making routine security checks discovered the inmate in his administrative segregation cell apparently sitting at the end of the lower bunk with a sheet around his neck. The inmate was unresponsive. The officer activated his alarm to which a sergeant, an officer and an MTA responded. A medical emergency cell extraction was ordered by the sergeant who removed the noose from the inmate's neck and began CPR. The MTA arrived with additional officers and continued CPR as the inmate was transported on a Stokes litter to a medical emergency cart and subsequently to the emergency room. CPR continued. An effort to intubate the inmate was unsuccessful. He was pronounced dead at approximately 9:15pm. An autopsy conducted on 1/23/04 indicated the cause of death as hanging. A toxicology report indicated a blood alcohol level of .10% with no further explanation.

This inmate had a juvenile history of arrest in 1984 involving an assault on another person allegedly because the victim had threatened his son. At age 18 he was convicted as an adult of assault with a firearm resulting in a three-year sentence to the California Youth Authority (CYA). He violated probation and finished his term in CDC. At the time of his death he was serving his second term in CDC.

The commitment offense for his second incarceration occurred in July 1993 and involved the possession and sale of cocaine, for which he was sentenced to one year in jail. He violated probation by leaving the state and obtaining employment in Nevada. He also had a dirty urine while on probation. A warrant was issued for his arrest on October 6, 1995. He was returned to CDC on 10/22/03 despite a probation officer's recommendation that probation be reinstated because he had been supporting his family through regular employment in Nevada. Because of the probation violation he was eventually sentenced to serve the full six-year term and was returned to CDC via the North Kern State Prison (NKSP) reception center on 10/22/03.

A bus screening on 10/22/03 at NKSP indicated he had dental complaints but was negative for mental health problems. The Sheriff's department transfer summary from LA County also indicated no mental health problems or treatment for this inmate while in the county. A DDP screening on 10/24/03 indicated the inmate had normal cognitive functioning. A mental health screening conducted on 10/24/03 indicated that the inmate was not suffering from a mental illness, and no referral to a mental health professional was indicated. He was transferred to CEN on 12/23/03.

At CEN on 12/23/03, a bus screening indicated that the inmate was on preventive treatment for tuberculosis and had a complaint of a broken tooth, but was again negative for any mental health problems. The inmate was subsequently placed in the CEN administrative segregation unit on 1/14/04. The record indicated that he reported to a sergeant that he had been threatened by the Mexican mafia and had provided information on inmates selling illegal drugs in the yard.

A psychiatric contact was made on 1/17/04 in response to an emergency verbal referral (not documented in the record) made by a licensed psych tech (LPT) on 1/16/04. The LPT who made the referral believed the inmate was delusional, paranoid and overtly psychotic. A progress note written on 1/17/04 by a psychiatrist indicated the inmate refused to come for an interview, stating, "I don't want anyone here to see me talking to a psychiatrist." This note also indicated that the chart was not available to the psychiatrist. Despite the emergency request, the inmate was not seen until the following day.

The record indicated the inmate was concerned that his family would be killed and requested an emergency phone call, which was refused. The inmate was seen during the weekend by another LPT, who initiated a routine referral on 1/18/04. He was scheduled to see a mental health clinician on 1/22/04, the day after he committed suicide. The inmate reportedly was seen each day during his stay in administrative segregation,

including, 1/21/04, the morning of his death, by an LPT. No psychotic symptoms were noted.

The Suicide Report indicated a correctional lieutenant at CEN informed the inmate's wife of his death on 1/21/04. The decedent's wife told the lieutenant that she had received a letter indicating the inmate's concerns that the Mexican mafia would kill his family and advising her that she should contact the FBI. The inmate's wife also requested protection. The warden generated a memorandum requesting that the Southern Region Law Enforcement Investigations Unit contact the FBI and local law enforcement agencies about her concerns. The Suicide Report noted further that an inmate who lived in the cell adjacent to the deceased inmate's reported that on the day of his suicide the inmate had been trying to get the attention of custody staff by "yelling, screaming, and banging on his door continuously for well over five minutes," but gave up when there was no response. The inmate neighbor also reported that the decedent had been pressured by other inmates to commit suicide.

According to the Suicide Report, a 1/26/04 progress note from a supervising registered nurse (SRN) indicated "she had heard from another registered nurse and two LPT's that after the suicide the C.O.'s, while passing out routine supplies on the tier where the inmate had been housed were saying to the inmates, 'Do you want a noose with that.'" The report indicated the SRN recommended an investigation be initiated. An investigation was initiated.

The Suicide Report identified four problems and associated corrective recommendations:

Problem 1: The inmate should have been seen by a psychiatrist on 1/16/04.
Recommendation: Develop an operating procedure for the immediate evaluation of emergency referrals in administrative segregation and train contract clinicians on its provisions.

Problem 3: Clinicians working outside normal business hours did not have access to the inmate's UHR.
Recommendation: An operating procedure making UHRs available on weekends, holidays and outside normal business hours needed to be established and disseminated.

Problem 3: Mental health and custody staff in administrative segregation communicated inadequately about the inmate.
Recommendation: Mental health and custody staff needed additional training on the importance of exchanging information about inmates under their care.

Problem 4: Staff should never taunt or make jokes with inmates about suicidal behavior, especially after a recent suicide.
Recommendation: Investigation of custody staff conduct in Building 5 following the suicide.

CEN staff submitted a follow-up report on 1/28/05. It reported that the institution had developed a Suicide Prevention Operation Procedure that explained the procedure for emergency evaluations; hired two full-time clinical staff to conduct monthly quality assurance chart audits; and adopted a requirement that all new contract staff participate in orientation and training prior to starting work in the CEN CTC. The report also included an attachment from the CEN CTC Policy and Procedure Manual on authorized access to health records services area; materials relevant to Suicide Prevention Training for mental health and custody staff in administrative segregation; memoranda from the warden on monitoring inmates discharged from the MHCB unit; and training attendance sheets for Suicide Prevention.

The investigation of custody staff misconduct reportedly was unable to identify inmates, who had been subjected to any of the alleged misbehavior, or custody staff, who had witnessed any such behavior, willing to substantiate what the SRN had heard about inmates being asked if they wanted a noose with their supplies.

A supplemental report on corrective actions was submitted by the CEN warden on 2/02/05, which indicated that the investigation, which included interviews with two registered nurses (RNs), two LPTs and the SRN, who reported the allegations of misconduct, concluded that no evidence existed to support the allegations. The report recommended that no further action be pursued relative to this issue.

Plaintiffs' counsel complained that the fact-finding investigation was so inadequate it raised serious questions about the competency of the individual(s) who conducted it, the warden and whoever reviewed and approved it, as well as the commitment of those individuals to eradicate the "code of silence." Plaintiffs' counsel felt strongly that those allegations that custody staff had committed serious misconduct, including efforts to encourage the inmate to kill himself, were inadequately investigated. Additionally, those who reviewed and approved the fact-finding did so despite serious and obvious questions about the adequacy of the investigation. CDC, they argued, should conduct a formal investigation of the original allegations and the failure of the investigative process in this case.

Findings: This inmate's death did not appear to have been foreseeable, but might have been preventable. The inmate indicated to custody staff serious concerns with regard to his own and his family's safety, and during at least one interview with clinical staff was viewed as psychotic and decompensating. Psychiatric staff did not respond in a timely manner to an emergency referral and, when a psychiatrist did respond, indicated the inmate refused to be interviewed. When he was seen the following day, the documentation suggested strongly that the assessment was inadequate, and no SRA was conducted. Although the inmate had not been in the MHSDS and had not previously reported suicidal ideation, his change in mental status and reported fears for his own safety that led to his move to administrative segregation and an emergency referral were not adequately evaluated by mental health staff.

The scope and quality of the investigation of custody misbehavior appeared to be inadequate based on the documentation provided. For example, the incriminating progress note of the SRN was not provided, while the exculpatory statements of clinical staff during the investigatory process were all included.

4. Inmate E09742

Brief History: This inmate was a 33-year-old African American male who committed suicide by hanging at California State Prison, Corcoran (CSP/Corcoran) on 1/23/04. He was housed in the Security Housing Unit (SHU) and was the only occupant of his cell. He was treated at the 3CMS level of care at the time of his death. He had been under a Keyhea order for involuntary medication, which expired approximately one week prior to his death.

A correctional officer discovered the inmate at approximately 9:33pm hanging by a sheet from the air vent in the cell he occupied alone. The officer activated his alarm, and an emergency cell entry team of three officers was assembled and entered the cell. They cut the inmate down and removed him from the cell. The officers began CPR and called for an emergency transport vehicle. The vehicle transported the inmate to the General Acute Care Hospital (GACH), where he was pronounced dead by a physician at 10:03pm.

This was the deceased inmate's first adult incarceration in CDC. He entered CDC on 10/10/90 via the reception center at Deuel Vocational Institution (DVI) as a parole violator with a new term secondary to having pled guilty to two counts of residential burglary. He received a sentence of 12 years and 4 months for the two new offenses. The inmate was paroled in January 1989 from CYA. He had been committed to CYA after a conviction for burglary in the first degree. He had difficulties with his placement with his grandparents and was ultimately rearrested after testing positive for cocaine.

During the course of his incarceration, this inmate incurred a remarkably high number of rule violation reports (RVRs), including threats against staff, setting his cell on fire, aggravated assaults on staff and assaults on inmates. Because of his batteries on staff, the inmate received two convictions with added prison time. This additional time included a two-year sentence imposed in May 2002 and another sentence in December 2003 based on a guilty plea to battery, attempted battery and associated charges.

He also had a number of MHCB admissions with suicidal ideation and/or behavior. The suicidal behaviors included cutting himself on the wrists with objects and thoughts of hanging or otherwise injuring himself. He had filed 602s alleging unfair treatment by clinical staff and asserting dissatisfaction with their reports. On 2/14/02, an administrative law judge ordered that the inmate be placed on involuntary psychotropic medication because he was a danger to himself by reason of his mental disorder. Keyhea orders were subsequently continued until the last one lapsed just a week before the inmate's death. In their Keyhea petitions, clinicians at Pelican Bay State Prison (PBSP) represented that the inmate had become a danger to himself, in part, because of his history of poor medication compliance. The petitions also referred to the inmate's history

of multiple assaults on custody staff, recurrent depression with suicidal ideation and multiple episodes of self-mutilation. These acts of self-harm and mutilation were described as including a laceration to his left wrist in June 2000, threats to swallow razors that were in his mouth in July 2000 and cutting both arms with a staple in August 2000. Other staff interventions were required because the inmate had possession of various pieces of metal or glass in September, November and December 2000. He had also set fire to his cell in the past.

In December 2003, this inmate was admitted to CSP/Corcoran's MHCB because of suicidality. He remained in the MHCB until 1/15/04, when he was returned to the SHU. The Suicide Report referred to a suicide pact the inmate had formed with another inmate who was housed nearby in the MHCB. The report implied that the suicide pact was intended to make a political statement regarding abusive behavior by correctional staff and poor mental health care, as well as possibly motivating his family to file a lawsuit and receive money for his completed suicide. The Suicide Report also suggested that the inmate's motivation for writing to the plaintiffs' counsel in Coleman might possibly have been to support a future lawsuit by his family.

The inmate was being treated at the 3CMS level of care while housed in the CSP/Corcoran SHU. He was admitted to the MHCB from 12/31/03 through 1/15/04 because of suicidal ideation. His diagnoses were Depressive Disorder, Polysubstance Abuse and Antisocial Personality Disorder. Although the GACH admission data sheet indicated the inmate was admitted with "severe depression," the SRA of 1/02/04 by a social worker indicated the inmate was at "low risk." A second SRA conducted on 1/16/04 (not on the official CDC SRA form) also indicated the inmate was at "low risk." He remained in the MHCB through 1/15/04 after he was clinically discharged.

A note by the on-call CCM on 1/16/04 indicated the inmate had been seen because of a "referral from Coleman Case." This note said the inmate was released from the "(G)ACH-5 day has been conducted however, in addition I/M was seen by CM." The note stated the inmate had met Keyhea criteria, but the order had expired. It also reported that the inmate had taken all of his medications and reportedly planned to continue taking his medications. Despite compliance with his medication, the note indicated the inmate requested to continue on his Keyhea order. The on-call CCM indicated a plan to refer this request to the regular CCM. The inmate was encouraged to inform staff of any suicidal ideations or mental health concerns that he might be experiencing. The inmate was noted to have been somewhat depressed. The CCM's information on five-day follow-up and the inmate's compliance with medications after the Keyhea order expired was inconsistent with other information in the record.

The Suicide Report indicated that the ER psychiatrist who evaluated the inmate one day prior to his suicide determined the inmate was not in need of admission to the MHCB unit and discontinued his medications. No SRA conducted at the time of this admission to the ER was included in the provided documentation.

The Suicide Report identified five problems and corrective recommendations:

Problem 1: On 10/31/03 this inmate went out to court in Del Norte County related to a battery on staff, allegedly committed while he was housed at PBSP. During the court proceedings, he was housed at PBSP. Staff there had initiated the renewal of his Keyhea order, which was due to expire on 1/11/04. However, the order was allowed to expire shortly after he returned to CSP/Corcoran on 12/31/03.

Recommendation: CSP/Corcoran needed to establish a procedure to ensure that the Keyhea list in the Mental Health Tracking System (MHTS) is reviewed daily and expiring orders are addressed promptly. Institutions that have scheduled Keyhea hearings should not send inmates to the other institutions until the hearings are completed.

Problem 2: The CCM believed the inmate was at risk for suicide and referred him to the ER for admission to the MHCB unit. The ER psychiatrist did not review the inmate's UHR or the referring clinician's note and decided not to admit the inmate and discontinue his medications.

Recommendation: Clinicians need to review the record and, if possible, talk to the referral source. The institution should establish a QIT to study and develop ways to improve communication among clinicians and decision makers about admissions to MHCB, particularly for inmate-patients referred for suicide concerns.

Problem 3: The contract psych social worker did not complete the SRA Checklist properly when she evaluated the inmate in the ER.

Recommendation: The institution should establish a system for training contract clinicians on documentation requirements and monitoring their clinical work.

Problem 4: The UHR did not document five-day follow-up after the inmate's final discharge from the MHCB unit.

Recommendation: The institution needed to develop a system to ensure that five-day follow-up is completed, provide training to staff on the requirement and conduct audits to confirm compliance.

Problem 5: Documentation problems were noted in the UHR, the most common of which was the failure to note the time of actual documentation.

Recommendation: Clinical staff needed to be trained on the standards for documentation.

The Suicide Report was dated 5/19/04. The follow-up on the corrective action plan for this inmate's suicide was dated 3/14/05, based on a 2/09/05 submission from CSP/Corcoran. The institution provided supporting documents such as local operating procedures, appendices for staff training and audit tools. The response cited corrective actions directed at its procedures for monitoring Keyhea orders; training on the administration of SRAs and team-building, together with attendance sheets; a final report from a QIT chartered in March; scheduled training for new and contract clinicians; an order to monitor requirements for five-day follow-up after MHCB discharges; and training on UHR documentation. Development of a statewide policy addressing inter-institutional communications about pending Keyhea hearings was deferred to HCSD.

Plaintiff's counsel submitted letters on 10/4/04 and 4/4/05 critical of the Suicide Report's focus on the "suicide pact" rather than more obvious clinical failures and CSP/Corcoran's attachment of a "blank audit form" without including actual monthly audits of five-day follow-up of inmates discharged from the MHCB unit.

Findings: This inmate's suicide appeared to have been both foreseeable and preventable. The inmate had numerous admissions to MHCB units because of suicidal ideation and/or self-harming behaviors. He was under a Keyhea order because of the deterioration in his functioning when not receiving psychotropic medications. The breakdown in communication between PBSP and CSP/Corcoran on the inmate's pending Keyhea renewal led to the subsequent lapse of his Keyhea order.

The evaluations by MHCB clinicians, including particularly that by the ER psychiatrist, without the completion of a SRA were unexplained. The clinical determination to return the inmate to housing and discontinue his medications, when he was so recently on a Keyhea order, was inexplicable. Moreover, given the inmate's history, the lack of documented five-day follow-up after his final MHCB hospitalization was inexcusable. This inmate's death appeared foreseeable because he reported suicidal ideation and had a clear history of suicidal ideation and self-harming behaviors. In addition, he had a history of Keyhea orders for involuntary medication tied precisely to the likelihood that he would harm himself in the absence of medication. The death was preventable because, had an SRA been completed and had he been housed in an MHCB, the inmate would have been under more consistent suicide-related monitoring.

5. Inmate V06645

Brief History: This inmate was a 21-year-old Hispanic male who committed suicide by hanging on 2/11/04 in the reception center at Deuel Vocational Institution (DVI). He was serving his first term in CDC. He was admitted on 9/12/03, having pled guilty to unlawful sexual intercourse with a minor and corporal injury on his spouse. He received a sentence of 32 months and was housed in a single-cell in administrative segregation secondary to safety reasons at the time of his suicide.

He was discovered on 2/11/04 at approximately 9:20pm by a correctional officer conducting "securities" prior to the 9:30pm count in administrative segregation. He was found hanging in his cell from a noose made from a sheet that was connected to the cell's ventilation grill. The officer activated his alarm and radioed for assistance. Custody and medical staff responded, and an ambulance was called. The inmate was removed from the cell, and life-saving measures were initiated. He was transported to the emergency room. The ambulance arrived and the inmate was subsequently pronounced dead at 9:32pm by an emergency medical technician from the ambulance crew. Review of the incident report indicated that the inmate was handcuffed after having been cut down and the handcuffs were not removed until the inmate was in the emergency room. The incident report indicated that "life-saving measures were begun promptly and continued as inmate was transported to the emergency room." However, the life-saving measures

were unspecified and it was uncertain whether CPR was administered in the cell. The initial Inmate Death Report indicated that the inmate was transported to the emergency room and "IV with NaCl started. CPR started. O2 started." The ER notes reported that the inmate was discovered at 9:30pm, an IV was started at 9:40pm, and CPR was started at 9:41pm.

A coroner's 2/12/04 report indicated the cause of death to be asphyxia by hanging, and the death was classified as a suicide. The records also included a suicide note without date or signature that was extremely difficult to read. The note consisted of five pages of hand written script and appeared to be addressed to the inmate's girlfriend. The note cited the deceased inmate's stress and concern because his girlfriend had not written him, might be pregnant, might not want to be with him and did not come to visit him. It also noted his belief that his girlfriend might leave him, expressed his love for his girlfriend and reported that his head hurt. The letter ended with the cryptic phrase, "see you in ill," without further explanation.

Various documents indicated that the inmate was not in the MHSDS program. The Suicide Report confirmed that he was not in the MHSDS, but also cited a psychologist's decision to place the inmate at the 3CMS level of care on the day prior to his death on the basis of a custody referral.

The inmate may have had a criminal justice history as a juvenile; the record referred to an evaluation for fighting in juvenile hall. The inmate reportedly was arrested at age 19 for robbery and had arrests for threatening crime with intent to terrorize, assault with a deadly weapon not a firearm, exhibiting a dangerous weapon, trespass, fight/challenge to a fight in a public place, and battery of a non-cohabitant former spouse. Whether these arrests resulted in convictions was not clear. His arrest for the instant offense seemed to have been related to his 16-year-old girlfriend of at least two years. He was living with the girlfriend and her family. The inmate was arrested after the family called the police about an argument between him and the girlfriend.

When the inmate entered CDC on 9/12/03, his bus screening was negative. He did not have a mental health evaluation in the reception center until 11/18/03, more than two months after his admission. The evaluation appeared to be in response to a self-referral.

The mental health evaluation of 11/18/03 indicated that the inmate had a history of special education, SSI for a "mental" reason and a mental health history since childhood. He had also been treated with Wellbutrin. The inmate reported no prior psychiatric hospitalizations and denied any history of suicide attempts. The evaluation noted that the inmate "hears voices" but "appears to be doing ok." The diagnostic impression given on this mental health evaluation was Adjustment Disorder with anxious mood and a GAF of 70. The inmate received a second reception center mental health evaluation on 2/10/04 which indicated an abnormal development problem as "ADHD, hyperactive." Other diagnoses included Polysubstance Dependence and Adjustment Disorder with mixed anxiety, along with Depression (provisional), rule out Major Depressive Disorder. The

initial plan was for the inmate to be referred for a psychiatric evaluation, which the CCM was scheduled to follow-up in one week.

According to the MHTS the inmate was seen for a follow-up appointment on 12/17/03. There was no documentation in UHR on this contact. A DDP evaluation on 9/12/03 found that the inmate had normal cognitive functioning. A psychiatrist's 1/13/04 medical evaluation progress note did not indicate the reason for the appointment but reported that the inmate was hearing voices and having problems sleeping, as well as experiencing other vegetative depressive symptoms. No medication was prescribed at that time. It was not clear whether the psychiatrist knew that the inmate had been prescribed Wellbutrin in the past. A follow-up appointment was scheduled, but the psychiatrist was not available and the appointment was not rescheduled.

The reception center mental health assessment of 2/10/04, the day before the inmate's death, appeared to have occurred in response to a referral by correctional officers. The evaluator indicated the inmate believed his father was sexually involved with his girlfriend. He was sad and tearful and reported having problems with sleep and appetite. At this time the inmate was placed at the 3CMS level of care, although no chrono was found in the records reviewed. The inmate's cellmate apparently moved out that same day, claiming that the inmate yelled all night. The cellmate also stated that the deceased inmate called him names, challenged him to a fight and alleged that people were putting things in his food. After being in the cell with the inmate for less than two days, the cellmate reportedly asked to be moved and told custody that the inmate was hearing voices.

The decedent was initially placed in administrative segregation in Annex A for safety reasons after reporting that he was a gang drop out and had enemies at DVI. He was endorsed to a SNY at MCSP. On 2/05/04, his endorsement to MCSP was rescinded, and he was endorsed for transfer to a SNY at CSP/LAC.

The Suicide Report noted that the inmate was seen by different clinicians, some of whom did not document their contacts. These failures to document contacts impeded the effective overview of the inmate's obviously difficult adjustment.

The Suicide Report identified three problems and corresponding corrective recommendations:

Problem 1: The inmate was handcuffed after being cut down when he was discovered.
Recommendation: There was a need for institutional and HCSD review of the guidelines for the use of handcuffs in emergency responses.

Problem 2: Documentation was incomplete. Reasons for evaluation were not provided on MH-7s, and the clinical contact on 12/17/03 was not documented at all. More complete notes might have facilitated better understanding and diagnosis in subsequent contacts.

Recommendation: This case should be presented in a mental health staff meeting to emphasize documentation issues, and a memorandum should be sent to all mental health staff reminding them of the critical importance of thorough documentation. Repeated and documented mental health contacts might require clinicians to take a closer look at underlying issues.

Problem 3: The inmate was in reception administrative segregation for five months.

Recommendation: The Suicide Prevention Committee needed to evaluate why this inmate remained in administrative segregation in reception for so long a period.

The Suicide Report was dated 7/09/04. DVI provided a follow-up report on its corrective action plan on 11/12/04. In response to the first problem, DVI reported that a 10/18/04 meeting of the Emergency Response Review Committee (ERRC) endorsed as standard practice in administrative segregation the handcuffing of inmates in such situations for safety and security reasons. The second problem was addressed in a mental health staff meeting on 8/11/04 that discussed and emphasized the importance of accurate and timely documentation. A copy of the agenda and an attendance sheet for that meeting were provided. The length of the deceased inmate's stay in reception administrative segregation was attributed to his referral to the Mule Creek State Prison (MCSP) SNY, where beds were not readily available. Eventually he was endorsed to a SNY at California State Prison, Los Angeles County (CSP/LAC) on 2/05/04, along with a recommendation to increase the number of SNY beds.

In a letter on this suicide, plaintiffs' counsel raised concerns **about** placing the inmate in handcuffs after he was cut down as a barrier to the immediate initiation of CPR. The minutes of the 10/18/04 ERRC meeting reflected no discussion of the delays or impediments to the delivery of CPR occasioned by the need to handcuff dead or dying inmates. The letter also requested information on any follow-up that occurred at DVI on this issue and the current policy and practice at the institution when an inmate is found hanging in administrative segregation. More generally, plaintiffs' counsel questioned the defendants' overall process for reviewing the implementation of corrective action plans contained in Suicide Reports.

Findings: This inmate's suicide did not appear to have been foreseeable. In light of his history and his clearly decompensating mental health after his arrival at DVI, it might have been preventable, if there had been better coordination of his care. While the Suicide Report referred to the handcuffing issue, it did not examine the time delay from his discovery at approximately 9:30pm until the initiation of CPR at 9:41pm in the triage area of the emergency room. DVI's follow-up response to the Suicide Report failed to address adequately the poor documentation of clinical contacts. Lastly, although this inmate denied a mental health history at his bus screening, clinical staff learned during subsequent evaluations that he did have a troubled mental health history. That knowledge, however, did not result in his inclusion in the MHSDS caseload until the day before his suicide.

6. Inmate P43083

Brief History: This inmate was a 22-year-old Hispanic male who committed suicide by hanging in his single cell in the administrative segregation unit of Avenal State Prison (ASP) on 3/3/04. He was convicted of a second strike on 11/22/02 based on two burglary charges resulting in a 21-year sentence. At that time, he returned to CDC via the reception center at Wasco State Prison (WSP) as a parole violator with a new term. The inmate was not receiving services in the MHSDS.

He was discovered by a correctional officer who was taking a count in the administrative segregation unit. He was housed alone in a double-cell. At approximately 2:40am he was found hanging from a sheet attached to a light fixture. The officer notified his partner to request medical assistance and informed a sergeant. The officer also attempted to get some response from the inmate by banging on his cell door, an attempt that was unsuccessful. The sergeant responded, an ambulance was requested, and a cell door shank bar was utilized to open the cell door. Custody staff entered the cell, and an MTA arrived and began CPR. The inmate was subsequently placed on a Stokes litter, carried to a gurney and transported to the emergency room. CPR was continued during transport. The outside ambulance and crew arrived at approximately 3:05am. At 3:06am a paramedic ordered that CPR stop and pronounced the inmate dead.

When the inmate was discovered hanging from a sheet his hands were tied behind his back with a strip of sheet and his legs were bent such that his feet were resting on the bottom bunk and they were also tied. A cloth was stuffed in his mouth. There were two notes on his desk as well as various letters from family members. There was also a letter in the outgoing mail addressed to the inmate's mother. The letter was retrieved. It was dated 3/2/04 and written in Spanish. He wrote to his mother thanking her for a package she had sent to him, asked her forgiveness and stated that he loved her even though he had made her cry and suffer because of his behavior.

An autopsy report conducted by the office of the coroner in King's County on 3/4/04 indicated the cause of death was asphyxia due to hanging. The death was classified as a suicide. Toxicology screening indicated there was no evidence of illicit drugs or alcohol in the inmate's system.

The inmate's first incarceration in CDC occurred in 1999 when he was 17-years-old. He was convicted on three burglaries and incarcerated for approximately one year. The inmate was paroled in May 2000 with a release to the United States Immigration and Naturalization Service (INS) and deported to Mexico. He subsequently returned to the United States, where he incurred a number of charges, including absconding, failure to report to the Parole and Conditions Supervision Division, failure to notify his parole officer of a change of address and possession of drug paraphernalia. He was convicted in March 2001 for possession of a controlled substance, which resulted in revocation of his parole and a return to custody for ten months. During his incarceration he went back to court in October 2001 to face two burglary charges, which resulted in his second strike

and the 21-year sentence. The inmate's suicide occurred one day prior to the anniversary of his arrest on 3/04/99, which led to his first incarceration.

In the ten months following his return from court with a new sentence in December 2002, the inmate received three RVRs. In January 2003 he was charged with delaying a peace officer in the performance of his duties related to gang activities. On 9/8/03 he incurred an RVR for disobeying orders related to gang activities. On 10/29/03 he was charged with battery on staff requiring the use of force. The third RVR could have resulted in a third strike for the inmate. Records indicated that the inmate became more isolated and reclusive after receiving RVR in October.

Although this inmate was not involved in the MHSDS, he had a history of drug dependency and attempted suicide by hanging. The inmate was in administrative segregation from 12/3/02, after his return from court with a second strike and a close custody status. During this extended stay in administrative segregation, the inmate had several ICC reviews. Due to the RVRs, his custody score increased and his custody level was raised to Level IV. He was briefly transferred from ASP to Pleasant Valley State Prison (PVSP) for just over one week in October 2003 but was returned to ASP because of the change in his custody level.

A developmental disability screening in October 2003 indicated that the inmate had normal cognitive functioning. The inmate's last bus screening occurred when he was transferred to PVSP in October 2003. That bus screening indicated no history of mental illness or prior suicide attempts. The inmate had medical evaluations and physical examinations. With the exception of a history of having been treated for positive PPD, he did not have medical problems and was not receiving any medical treatment at the time of his death.

The Suicide Report identified three problems with associated recommendations:

Problem 1: On 6/18/99, when the inmate entered prison for the first time, he reported a hanging attempt "over his criminal charges." Those charges were minor in comparison to the legal predicament in which he found himself prior to his suicide. Although he denied any history of suicidal behavior in subsequent screenings there was no indication that any mental health clinician adequately assessed the suicide risk given this known history.

Recommendation: Clinical staff needed training on the necessity of reviewing historical information in the record whenever an evaluation is conducted. This would include a review of bus screenings, prior mental health evaluations and any probation officers' reports in the central file. These documents should be referenced in evaluations. Supervisors should audit evaluations to ensure compliance.

Problem 2: This inmate had a history of not coping well when faced with possible imprisonment. While in prison on a relatively short sentence, he went out to court to face pending burglary charges and returned with a 21-year second strike. At the time of his death, he was facing a possible third-strike conviction and a life sentence for the two

batteries on correctional officers. Staff and inmates noticed a change in his behavior, but no mental health referral was initiated.

Recommendation: The institution needed to provide training for clinical and custody staff on the suicide risks associated with adverse legal proceedings and decisions and establish a QIT to develop a system to identify inmates receiving negative news about the length of their prison confinements, so staff can appropriately monitor and refer them.

Problem 3: The inmate had been in an administrative segregation unit for 11 months when he assaulted staff. He was initially placed in administrative segregation because he retuned from court with a 21-year sentence and needed to be transferred to a prison with a higher custody level.

Recommendation: The institution needed to review the length of the inmate's stay in administrative segregation to determine why it was so long and what could be done to prevent excessive length of stays in administrative segregation.

The Suicide Report, dated 7/9/04, was responded to by ASP staff on 11/01/04 with a follow-up report on corrective actions taken. The follow-up report indicated that the training recommended in the first problem had been conducted and attendance sheets were attached. The recommended audits would also be conducted. In response to the second problem, training for clinical and custody staff on the suicide risks associated with adverse legal decisions had been conducted. In addition, a QIT was established on 8/25/04 to develop and implement a new process for tracking such information and getting it to mental health staff. Minutes of the 8/25/04 meeting were provided. The QIT planned to review existing policies/procedures and/or training materials relative to suicide prevention/recognizing signs and symptoms of mental illness and discuss the establishment of a "critical information notice" for use by transportation teams and records of the court personnel. A follow-up meeting was scheduled for 9/31/04. No minutes from the follow-up meeting were provided.

In response to the third identified problem, a supervisory classification counselor reviewed the inmate's long stay in administrative segregation and concluded that he could identify no classification issues that required remedial action. He noted that each change in the inmate's case factors received prompt classification staff attention and classification committee reviews. He attributed some of the length of the stay to the inmate's refusal to attend his final two classification committee hearings. The review indicated that the inmate had been housed in administrative segregation for approximately 446 days and, with the exception of the delayed transfer to RJD, "the majority of the delay can be directly attributed to the inmate's nonconforming behavior."

Findings: This suicide did not appear to have been foreseeable because the inmate did not report to staff any intent to harm himself. However, his suicide might possibly have been preventable had, during his extended stay in administrative segregation, an appropriate and thorough mental health assessment occurred that included a review of his full recorded mental history with its report of a past suicide attempt prior to his first incarceration and his continuing difficulties involving a potential third-strike conviction.

7. Inmate K25394

Brief History: This 25-year-old Filipino male committed suicide by hanging in his single cell in the EOP administrative segregation program at the California Medical Facility (CMF) on 3/28/04. The inmate was admitted to CDC via the reception center at Richard J. Donovan Correctional Facility (RJD) on 10/24/96. He was transferred on 3/22/01 to the Department of Mental Health Acute Psychiatric Program (DMH/APP) at CMF and subsequently to the CMF EOP program or other DMH programs until the time of his death.

At approximately 12:25pm on 3/28/04, a clinical support officer was picking up library books from inmates on the P3 EOP administrative segregation unit. As the officer passed this inmate's cell, he observed the inmate hanging by a sheet from the rear window of the cell. The inmate's left foot and left leg were slightly bent and resting on the bed. His right foot was touching the floor. The officer notified the P3 housing officer, who retrieved the emergency cut-down tool and along with a third officer proceeded to the cell. The third officer activated his personal alarm and notified B1 emergency room medical staff via the institutional radio. The inmate's cell was opened and the inmate was cut down and lowered to the mattress, which was on the floor of his cell. The noose was untied. The inmate was not responsive to voice commands, did not appear to be breathing and a pulse was not found. When the sergeant entered the cell, an Ambu bag was passed to him, and CPR was begun. An MTA and a registered nurse arrived with the automatic external defibrillator (AED) and the sergeant placed the AED on the inmate's body and received an analysis of "no shock". The inmate was placed on a backboard, lifted onto a gurney, and transported to B1 emergency room. CPR was continued en route. The efforts were unsuccessful. The inmate was pronounced dead at 12:58pm by a doctor in the B1 emergency clinic. A 3/29/04 autopsy report from the Office of the Coroner for the County of Solano determined the cause of death as asphyxia due to hanging. The toxicology report showed the presence of Atropine, Benadryl, and other drugs, none of which were at toxic levels.

This inmate's first arrest was at age 14. He had subsequent arrests for vandalism, vehicle theft, receiving stolen property and failure to comply with conditions of parole. He was a ward of the juvenile court at age 15. He was committed to a residential treatment facility for approximately six months and was in juvenile hall for a short time. He had been kicked out of his parental home shortly before the instant offense at age 17. He was a member of the street gang called the "Oriental Boys." He reportedly supported himself by dealing drugs, primarily methamphetamine, which he also used. The instant offense involved the inmate having shot and killed a 20-year-old victim in April 1996, approximately three months before his 18th birthday, resulting in a conviction of first-degree murder. He was sentenced to 25 years to life with a ten-year enhancement for the use of a handgun. He was also involved in a gang-related drive-by shooting approximately six weeks prior to the instant offense. He went back to court and was convicted of 18 counts of attempted murder, as well as additional counts of assault with a semi-automatic firearm, conspiracy to commit murder, etc., resulting in a total of 57

counts and an additional sentence of three consecutive life terms. He was committed to the CDC and entered reception at RJD on 10/24/96. The inmate remained at RJD after his trial until March 1999, when he was transferred to SVSP. He was transferred to the DMH/APP at CMF on 3/22/01.

He had no history of mental illness, treatment for mental illness or outpatient psychiatric treatment prior to his incarceration. As noted, he did have a history of polysubstance abuse including methamphetamine, alcohol, and marijuana. The inmate denied a history of being sexually abused. He reported he quit school at about the tenth grade to run with his gang. After his incarceration, the inmate was diagnosed with Major Depressive Disorder, recurrent, severe with psychotic features, PTSD, Amphetamine Abuse and Antisocial Personality Disorder. The inmate was initially screened at RJD on 10/10/97. That screening indicated no mental illness. While still in the reception center, however, he was referred by staff for a mental health evaluation because of screaming and what appeared to be psychiatric symptoms. On 10/10/97 he was placed at the 3CMS level of care and prescribed Benadryl despite some concerns that he might have been feigning mental illness. His symptoms did not improve and in January 1998 he was placed at the EOP level of care. The inmate was transferred to SVSP on 3/23/98, where remained at the EOP level of care. He was noted to be improving, and his level of care was changed to 3CMS in August 2000.

In September 2000 the inmate was admitted to an MHCB after he was raped by another inmate and found in a fetal position. Following the sexual assault, the inmate was described as very depressed, unresponsive and bizarre, such that the diagnoses of Major Depressive Disorder with psychotic features and PTSD were added to the Antisocial Personality Disorder previously ascribed. The inmate returned to the EOP program in October 2000. He appeared to be adjusting until February 2001, when he attempted to hang himself at SVSP after he was placed in administrative segregation for assault on another inmate. The assault was reportedly precipitated by the way the victim had looked at him.

The inmate remained in the MHCB until 2/22/01 and was discharged as improved. However, he returned on 2/25/01 because of suicidal ideation and threats to harm himself. The inmate was transferred from the MHCB to the DMH/APP unit at CMF on 3/22/01, where he remained until 7/31/01. Upon his discharge to CMF he was placed on the P3 unit, which served as the EOP administrative segregation unit. He was returned to DMH/APP on 9/5/01 because he had become withdrawn. He remained at DMH until 3/20/02. The inmate had apparently stopped taking his medications. A Keyhea application was initiated on 9/11/01 on grounds of grave disability. This application was denied, but a subsequent Keyhea petition was upheld a year later. The inmate began to take medications voluntarily. He was transferred to Atascadero State Hospital (ASH) on 3/20/02 for further care at a sub-acute level.

The inmate remained at ASH for approximately two months. He was transferred back to CMF because he assaulted another patient and a female staff member. He was placed at the EOP level of care. He continued to report hearing voices that told him to hurt himself

and others and he remained depressed. In addition to his history of attempting to hang himself, as noted above, he cut his wrists in June 2002. His condition continued to deteriorate, and he was transferred back to the DMH/APP program on 8/23/02, where he remained until 11/26/02. His return was associated with his having been observed kicking an inmate who was lying on the floor. The inmate reported that he did this because he felt hopeless over never getting out of prison. He continued to report that voices were telling him to kill himself and others and stated that he could not contract for his own safety. Once again he had stopped taking medications.

On 10/3/02 the inmate was determined to be a danger to self. A Keyhea petition was approved for a six-month period of involuntarily administered psychotropic medications through 4/1/03. After the Keyhea order was issued the inmate engaged in self-injurious behavior. He cut himself and attacked another patient. Medication became more effective and he demonstrated some improvement. He was discharged back to the EOP program at CMF on 11/26/02. Keyhea orders were renewed every six months, and one was in effect at the time of his death on 3/28/04. Despite his improved functioning, the inmate at times did not participate in EOP program activities. He also assaulted or had conflicts with inmates and staff. The EOP staff referred him to ASH in December 2003. The referral was rejected in February 2004 because of the inmate's history of assault while at ASH. However, the staff at ASH suggested the inmate might be more appropriate for the DMH program at SVSP, i.e., the Salinas Valley Psychiatric Program (SVPP). Despite the ASH recommendation, the CMF team did not make a referral to SVPP. According to the records they did not think the inmate needed a higher level of care.

The inmate continued to exhibit assaultive behavior. He was placed in the EOP administrative segregation unit in January 2004 and again in February 2004 because of assaults on other inmates. His last placement in segregation was on 2/10/04. He remained there until his death. His participation in structured therapeutic activities was variable. While in administrative segregation, he continued to have weekly case manager contacts, and his Keyhea orders remained in effect. At the time of his death the inmate was prescribed Depakote, Effexor, Risperdal Consta, and Benadryl, with Haldol injectible and Benadryl injectible prescribed if he refused his Keyhea-ordered medications. A mental health assessment conducted pursuant to the disciplinary process found that the inmate's mental illness had contributed to his assaultive behavior. The mental health staff at CMF did not initiate a referral to a higher level of care, including SVPP. The last note in the inmate's UHR was dated 3/26/04. It indicated that the inmate was scheduled for 12 hours of structured therapeutic activities, but he was seen at the cell door because he refused to come out of his cell. The note indicated the inmate was not programming or attending groups at that time and that his participation had deteriorated. The note also indicated levels of risk. His risk for suicide was indicated as "medium," aggression as "medium," self injury as "medium," and his unpredictability was "medium."

The Suicide Report contained some conflicting information on whether CMF mental health staff made a referral to SVPP after the inmate was denied admission to ASH in

February 2004. The Suicide Report stated that the inmate had been endorsed to SVSP (unknown if to the SVPP) in early March 2004, but the endorsement was cancelled due to his pending RVRs.

The Suicide Report concluded that the inmate received appropriate mental health care. No recommendations were made to CMF.

Findings: This suicide did not appear to have been foreseeable because the inmate was not indicating imminent suicidal ideation or threats to harm himself. He had a history of suicidal behaviors and a clinical course that indicated he was very difficult to treat and manage, both because of his Major Depressive Disorder and related symptoms including suicidality and assaultive behaviors to others. The assaultive behavior preceded his incarceration and continued thereafter. His assaultiveness and symptoms of depression appeared to be exacerbated when he was not taking psychotropic medications. The clinical staffs at CMF and DMH pursued involuntary medication via the Keyhea mechanism, which was approved and documented as having been administered.

This inmate's death might have been preventable had he been referred and transferred to SVPP. Although the inmate was referred to ASH, the referral was rejected in February with a suggestion by ASH staff that he be referred to SVPP. The record is unclear as to whether or not a referral to SVPP was made. The Suicide Report indicated that the inmate was referred by CMF and endorsed for transfer to SVSP, but it was unclear whether the referral was to the SVPP. No documentation provided with the Suicide Report supported a referral to SVPP. In any event, the endorsement was cancelled due to the inmate's receipt of RVRs for assaultive behavior. His treatment and management appeared to have required an SVPP level of care. Had it been arranged, his suicide might have been prevented.

8. Inmate E55754

Brief History: This 32-year-old Caucasian male completed suicide by hanging at approximately 11:45am on 4/11/04 while housed in a single cell in administrative segregation at Folsom State Prison (Folsom).

At approximately 11:45am on Sunday April 11, 2004, the inmate was observed by a correctional officer making rounds hanging by a sheet attached to a light fixture/connector in his single administrative segregation cell. The officer sounded his alarm, and the responding officer was told to get the emergency cut-down kit. Three officers subsequently entered the cell, cut the inmate down and placed him on a gurney on which he was transported to the clinic. CPR was begun by an RN after arrival at the clinic. The inmate was pronounced deceased at approximately 11:50am. The inmate was noted to have tied his hands together at the wrists by a piece of torn sheet and left a suicide note. The note stated "I'm sorry for what I have done. Please forgive me. My wife didn't bring it in." An autopsy was conducted on 4/13/04 and the autopsy findings indicated the cause of death as hanging. A toxicology screen was negative for drugs and alcohol.

The inmate had an extensive criminal justice history beginning at approximately age nine in Oklahoma when he was arrested for burglary. He subsequently was arrested for burglary, theft and truancy and was placed with relatives. He was placed in group homes in California by the age of 13. He was committed to the CYA on three counts of burglary and received a commitment of seven years. He was paroled in April 1987 at age 15. He was on parole when he committed the instant offense in January 1989. That offense involved the stabbing of a drug dealer multiple times for which he was convicted of second-degree murder and sentenced to 15 years to life. The inmate was admitted to CDC on 5/31/90 via the DVI reception center. From June 1996 until the time of his death, he had served time at DVI, PVSP, North Kern State Prison (NKSP) and ultimately at Folsom. He married a former girlfriend's stepmother during his incarceration. His wife continued to visit him twice weekly and visited him the day before his suicide.

His institutional adjustment was unremarkable with the exception of his having been in administrative segregation in September 2003 for assault on an inmate. He was released from administrative segregation after an investigation, and no RVR was filed. The inmate's second administrative segregation placement occurred on 4/10/04, the day before his death. His placement in administrative segregation was for possession of approximately 14 grams of marijuana that was found secreted in his rectum after a visit from his wife and mother. Reports noted that his mother was not an eligible visitor as a convicted felon, but she was permitted on that date to visit with him. Prior to this he was at custody Level II with 19 points. He was actively involved in the pursuit of parole.

The inmate had a history of polysubstance abuse including marijuana, methamphetamine, and cocaine, but no history of mental illness. While housed in the CYA, he was noted to have met the criteria for Antisocial Personality Disorder with a history of substance abuse. He had not been diagnosed with any mental illness or mental disability and had no history of suicidal behaviors. The inmate had Board of Prison Terms (BPT) psychosocial evaluations in 1993, 1997, 1999 and 2002, all of which indicated no evidence of mental health problems. The evaluation on 2/19/02 indicated "there is still no evidence of any mental or emotional problems in this case." Further review of the records indicated the inmate had a mental health interview on 7/28/98 and was assessed as having a temporary problem but no need for further mental health services.

The inmate's only other contact with a mental health clinician appeared to have occurred on the morning of his death, when a psych tech making rounds indicated he had seen the inmate, who told the psych tech, "I'm fine get lost." This contact was documented on a CDC 114A. There was no progress note in the records reviewed reflecting any more extensive contact or observation by the psych tech. On neither of the admissions to administrative segregation in September 2003 or April 2004 was a mental health screening completed.

The inmate was quite concerned about finding that he had Hepatitis C in a liver biopsy in December 2003 and by one in February 2004 indicating that he had cirrhosis. He was not receiving any treatment for Hepatitis C.

The Suicide Report, dated July 9, 2004, identified one problem:

Problem: No mental health screening was administered when the inmate was earlier admitted to administrative segregation.

Recommendation: The institution should establish a procedure to ensure that all general population inmates entering administrative segregation without a mental health screening within the past year receive a screening within a week of the placement; create a log to track inmates entering administrative segregation in need of a screening; and submit a monthly audit of the log for the next three months to HCSD.

On October 21, 2004, Folsom submitted a corrective action plan on this inmate's suicide that included a draft policy and procedure for conducting mental health screenings shortly after inmates' entries into administrative segregation. It required custody to provide a daily movement sheet that would be reviewed by a LPT on the first day following an inmate's placement. It specified that general population inmates without a screening within the preceding year shall receive a mental health screening interview within seven days of placement in administrative segregation, using the reception center screening questionnaire. The LPT was to complete the screening and, where appropriate, refer inmates with positive screenings to the administrative segregation CCM for evaluation. Folsom also noted that its LPT staff was inadequate and a screening of all general population inmates in administrative segregation had not yet been completed. A draft copy of the local screening policy and an audit of the log were attached. The audit indicated that 26 inmates were admitted to administrative segregation between July 2003 and October 2004 but contained no further information.

Findings: This inmate's completed suicide did not appear to have been foreseeable because he presented no signs of an imminent threat to himself. There was some remote possibility it might have been preventable if he had been screened on his 2003 admissions to administrative segregation. He also had accumulated some recent complicating stressors, including his diagnoses of Hepatitis C and cirrhosis of the liver. He had apparently reported pain as a result of these illnesses, but was not receiving treatment. He had also just been discovered with a controlled substance on his person after a visit, a circumstance likely to have a pronounced negative impact on his pending efforts for parole. Even under the revised policy on administrative segregation screening, the inmate would not probably have received a screening prior to his suicide, which occurred the day after he was admitted. Finally, CPR was not initiated until the inmate was transferred to the clinic. Although the transfer reportedly took only five minutes, the first responders apparently undertook no efforts to perform CPR.

9. Inmate T43420

Brief History: This inmate was a 25-year-old Hispanic male who completed suicide by hanging at approximately 9:05pm on April 25, 2004 at Robert J. Donovan Correctional Facility (RJD). He was housed in administrative segregation in a single cell for safety reasons. He was admitted to CDC on 3/28/02 via the reception center at WSP for his first

prison term. He was at the 3CMS level of care for medical necessity at the time of his death. His anticipated parole date was May 8, 2004. He was scheduled to be released to the INS for deportation.

At approximately 9:05pm on April 25, 2004 a correctional officer conducting an hourly security check discovered the inmate hanging in his cell in administrative segregation. The officer notified a sergeant who retrieved the cut-down tool. The officer and sergeant cut the sheet that appeared to extend from the inmate's neck to the upper bunk. Two other officers responded, one with an ambu-bag and one with a gurney. The sergeant and discovering officer entered the cell and, after cutting the inmate down, initiated CPR. The inmate was subsequently transported via the emergency transport vehicle to the CTC, where CPR continued until the arrival of paramedics at approximately 9:33pm. The paramedics administered epinephrine and atropine and briefly reestablished a cardiac rhythm, but the rhythm flat-lined as the inmate was being moved from the CTC to the ambulance. Despite continued CPR, the inmate was pronounced dead at 9:56pm at Scripps Chula Vista Hospital. An autopsy was performed at the Office of the Medical Examiner of San Diego County on 4/26/04. The reported cause of death was hanging and the manner of death was suicide. Toxicology screens were negative for alcohol and illegal drugs.

The inmate was serving a three-year sentence on plea bargains to two counts of lewd acts upon a child. He entered the reception center at WSP on 2/04/02. The instant offense in this case involved the 12-year-old daughter of a friend of the inmate. Apparently the family of the victim, including the father, mother, brother and the victim all shared an apartment with the defendant and another couple.

Directly after his incarceration he had an R-suffix (sex offender) affixed and was transferred from WSP to California Men's Colony (CMC). Although the inmate's initial custody score placed him at Level I, it was subsequently raised to Level II due to the allocation of 19 points for cases involving violence/sex. While at CMC-West the inmate was assigned a staff assistant because a test of Adult Basic Education found a reading score of 4.0. He was subsequently transferred to CEN and had an immigration warrant filed as a detainer against him that required him to return him to Mexico upon parole. He was transferred to CEN on 3/12/04.

On 4/11/04 this inmate was admitted to the MHCB unit at CEN as a "danger to self" and placed on suicide watch. He received Ativan, and a SRA was completed the same day. Records revealed that someone "found inmate in the holding tank with left wrist cut actively bleeding." The records described the inmate as having slashed his left wrist with a razor as well as having attempted to slash the left side of his neck. He was determined to be at "high risk" for suicide. The SRA identified a number of suicide risk factors and indicated the inmate was talked out of a holding cell before slicing his neck.

He was treated in the emergency room of El Centro Regional Medical Center and returned to CEN's MHCB unit. The ER report indicated he also took approximately five grams of Tylenol in addition to making self-inflicted lacerations. The inmate was seen

on April 12, 2004 by the IDTT in the MHCB unit. The MH-2 recorded the inmate's concerns that other inmates might try to kill him because of his crime, as well as concerns about his INS hold and potential deportation. On April 13, 2004, he arrived at RJD's MHCB by special transport.

A health screening performed by an RN was incomplete in that responses to questions on mental illness and suicidal thoughts and behaviors were left blank. However, the RN concluded that the inmate did represent a danger to himself and others. The inmate was placed on suicide precautions. The psychiatric admission note made reference to the inmate's past behavior, including the self-inflicted lacerations while in a holding cell and his attempted overdose with Tylenol. The inmate was noted as Spanish-speaking only, although other notes in the record prior to this date indicated he was conversant enough in English to complete several tasks and provide information. The note also indicated that the inmate stated the reason he cut himself was "fear for my safety". The psychiatrist concluded the inmate's diagnoses were Adjustment Disorder vs. Depression with a GAF score of 50. Subsequent notes indicated the inmate continued to report his fear of other inmates harming him if he returned to CEN or the RJD general population.

On April 15, 2004 the inmate pulled out eight of the ten sutures that were sewn into his left wrist after the previous self-inflicted laceration. The inmate continued to report fears of being discharged and killed by other inmates. At this time he was again placed on suicide precautions in a safety smock and placed at the 3CMS level of care. The inmate continued to report his fear of other inmates on the yard although he was described as having essentially no known mental illness with the exception of poor insight and judgment at times. In other notes he was described as having disturbances in mood. He also told staff that he was not suicidal but that if he were to be moved back to general population he might as well kill himself because he would be killed by other inmates.

A note dated April 19, 2004 written by a psychiatrist indicated the inmate had done well over the weekend and that he continued to be afraid that he would be harmed by someone. The psychiatrist informed him that he would get "a 115 for further acts as he is attempting to stay at the MHCB 'until I leave CDC.' " His insight and judgment were reported as fair, but : "Despite being told numerous times that he can't live in CTC still asked that he can." The SRA administered on that date by a psychiatrist identified nearly identical risk factors. That SRA, however, did not provide an evaluation of the level of risk or a recommended plan to refer the inmate to his primary clinician/case manager. Nor did it contain any additional comments. The inmate was to be discharged from the MHCB on 4/20/04. He reported to custody staff that he was afraid for his safety given his sex-offender designation. Based on his safety concerns he was placed in administrative segregation. The inmate was subsequently discharged to the 3CMS level of care in administrative segregation with no medications or diagnosis noted.

Prior to discharge, the inmate spoke with the watch commander about his placement in administrative segregation and his 3CMS level of care. The inmate was noted to have been relieved and ready for discharge. He was scheduled for follow-up with psychiatry within two weeks. He was noted to have little insight and few coping skills, and the

record indicated his impulsivity including his having cut himself with a razor and attempting to overdose while in a holding cell. He was finally discharged from the MHCB and was seen on the first of five days of follow-up on 4/22/04. He reported occasional suicidal thoughts but no plan. He agreed and contracted verbally not to harm himself. He was subsequently seen for the next three days of follow-up with the assistance of custody staff who translated his statements. Each of the resulting notes recorded that he denied suicidal ideation or plan, contracted for safety and did not need to be readmitted to the CTC or reevaluated by a psychiatrist.

He committed suicide on the fourth of the five days of scheduled follow-up, after having been seen by a psychologist earlier that same day. At approximately 8:20pm, a correctional officer, who was walking the tier during an hourly round to check on suicidal inmates released from the MHCB, saw the inmate.

The Suicide Report identified the three problems and corrective actions:

Problem 1: The inmate was diagnosed as having an Adjustment Disorder with depressed mood and was most often described as anxious and fearful. Despite his obvious level of distress, medication for these symptoms was not ordered.

Recommendation: The institution should conduct peer review on the performance of the treating MHCB psychiatrist. Although the individual psychiatrist was no longer at RJD, the peer review should be held anyway to raise awareness among other psychiatrists of the need to address and medically treat such symptoms. This case represented the second instance within the year where untreated acute anxiety ended in suicide.

Problem 2: The inmate was placed at the 3CMS level of care following a MHCB placement of ten days, when he was demonstrably not yet stable, as evidenced by his self-injurious behavior and suicidal gestures just one day prior to his discharge.

Recommendation: The institution needed to conduct training emphasizing the importance of clinical judgment in determining stability prior to discharges from the MHCB unit and careful consideration of the level of care for suicidal inmates discharged from a MHCB, particularly those continuing to exhibit symptoms.

Problem 3: The inmate was experiencing threats due to his sex-related crime. Demands by other inmates for paperwork to prove the crime of commitment often results in threats and harm, greatly increasing the safety concerns of sexual offenders.

Recommendation: HCSD needed to work with Institutions Division to consider a system-wide change to eliminate references to crimes of commitment when that information is included in documentation accessible to inmates, reducing thereby the potential for threats and attacks against inmates with R-suffixes.

Staff at RJD responded to the Suicide Report of 9/21/04 with a memorandum that pre-dated the Suicide Report. Dated 5/03/04, the memorandum from the chief psychiatrist instructed psychiatrists, psychologists and social workers to review the MHSDS Program Guide Overview Section. In-service training (IST) sign-in sheets for training on the

program guides relative to levels of care and MHCB criteria were attached to the memorandum. The response provided a second memorandum, dated 6/02/04, which indicated that medical necessity criteria were discussed with psychiatrists on 5/24/04 within the context of the deceased inmate's treatment and care. The response also noted that the inmate was expected to be extradited to Mexico, and CDC had no policy on addressing continuity of care needs outside the jurisdiction of the state. The response indicated that the chief psychologist would look for alternative models for planning for parole in such circumstances, but current policy was being followed when the suicide occurred.

Findings: This inmate's suicide appeared to have been both foreseeable and preventable. The inmate had identified with particularity the stressors in his life, including his imminent and consistent fears of death should he be placed in general population and his relief at the safety he felt in the MHCB. He had also already demonstrated his impulsivity by taking an overdose of Tylenol and cutting himself while in a holding cell. Even after contracting for his safety, he repeated his threat to harm himself if he felt unsafe in general population. The follow-up cell-side interviews for this inmate after he was placed in administrative segregation, with a correctional officer acting as a translator, probably did not result in a particularly candid or full sharing of the inmate's concerns and fears, given the inmate's fear of other inmates.

The failure to consider referral to a higher level of care, such as DMH, or more comprehensive evaluations during the five-day follow-up period was not explained. Finally, despite the inmate's impulsivity, stated depression and escalating symptoms of anxiety, it did not appear that any consideration was given to the possible use of medication to ameliorate his impulsivity, anxiety and judgment.

10. Inmate T47210

Brief History: This 22-year-old Hispanic male committed suicide by hanging on 5/16/04 at approximately 12:01am at Deuel Vocational Institution (DVI). He had been housed in the administrative segregation unit in a single cell since the afternoon of 5/14/04, following a fight with another inmate. He was returned to CDC on 5/13/04. His original commitment to CDC occurred on 3/25/02 through reception at DVI. He was paroled on 12/2/03 and returned as a parole violator on 5/13/04. This inmate had never received any mental health services during his stay in CDC.

A correctional officer discovered the inmate at approximately 12:01am on 5/16/04 during a routine institutional count. The correctional officer notified other custody staff, who responded promptly. The inmate was cut down from the top rung of the bunk ladder and transported to the DVI infirmary at 12:03am. After his arrival in the infirmary medical staff began CPR, which was continued along with other medical interventions. At approximately 12:20am paramedics arrived at the facility and continued CPR. They telephoned a physician at Joaquin Hospital, who pronounced the inmate dead at 12:28am. The Incident Report indicated the inmate was last seen alive in his cell by custody staff at approximately 10:10pm on 5/15/04.

The inmate's first commitment to CDC on 3/25/02 followed his conviction on a charge of assault with a deadly weapon not a firearm with great bodily injury. The inmate stabbed and robbed an 18-year old male victim while seeking drugs. He received a three-year sentence. He was subsequently transferred to SCC. He was paroled on 12/2/03.

On 5/13/04, when he was returned to DVI for violation of parole, he was described as a Hispanic gang member with connections to the Mexican Mafia. The record indicated that he was interviewed by an assistant gang investigator to whom he described his involvement with the "Southerners," including his having been instructed to violate his parole and target specifically the inmate he fought with on the day after his return to DVI. The inmate told the assistant gang investigator that the targeted inmate was on a "hit list" of the Mexican Mafia because of illegal activities in the community. The inmate returned to prison to attack the targeted inmate. The attack took the form of a physical fight and resulted in the now deceased inmate sustaining injuries to his nose with "profuse bleeding." The inmate told the assistant gang investigator that he feared he himself would now be placed on the hit list because he had not attacked the targeted inmate with a weapon. Essentially he had not followed orders and had brought shame and disrespect to his father who was a member of the Mexican Mafia. The inmate was subsequently placed in administrative segregation because of the altercation and safety concerns related to his gang status.

After his death, a suicide note addressed to his girlfriend was discovered in the inmate's cell. The suicide note declared his love for her, apologized and stated he wished to be cremated and wanted his possessions to go to her. A coroner's report dated 5/16/04 indicated the causes of death as asphyxia and hanging and classified the death as a suicidal hanging. The toxicology screening revealed "no common acidic, neutral or basic drugs detected. No blood ethyl alcohol detected."

Bus screens on 3/25/02 and 5/14/02 were negative with the exception of allergy to phenosporin. A mental health screening on 6/24/03 indicated the inmate was cleared for general population with no restrictions. A brief screening report of 6/20/03 indicated the inmate was not suffering from a mental illness and referral to a mental health professional was not indicated. An undated mental health screening by a LPT indicated a "good adaptive functional assessment" and "routine mental health needs." There was no bus screening associated with his return to DVI on 5/13/04 in the materials reviewed.

The Suicide Report made reference to the inmate having been "cleared on all previous screenings" and that there had not been time for a mental health screening on his current admission. The Suicide Report also stated that the inmate should have been seen during rounds on 5/15/04 by the licensed psych tech, but the psych tech reported that she "walked past the cell but did not check him."

The Suicide Report identified two problems and recommended the following corrective actions:

Problem 1: Mental health rounds in administrative segregation for general population inmates reportedly were not properly conducted because one psych tech could not talk to all inmates and perform all other psych tech duties on the weekend.

Recommendation: During rounds the psych tech must make sufficient contact with each administrative segregation inmate to ascertain inmates' mental condition. This is particularly true for new arrivals to the unit, including inmates who are not MHSDS inmates. DVI needed to provide adequate mental health coverage on weekends, and all new arrivals needed to be identified and contacted by the psych tech doing rounds for the first five days after placement in administrative segregation.

Problem 2: DVI has had three suicides on J-Wing during the seven months from October 2003 to May 2004.

Recommendation: DVI should house new arrivals to J-Wing closer to the front of the unit on the lower tiers where they can receive closer custody observation and contact.

DVI provided a follow up report, dated 11/18/04, on the corrective action plan regarding this suicide. The Suicide Report was dated 8/16/04. The DVI response included a copy of a memo from a supervising registered nurse on the issue of clinical coverage on weekends and provided memoranda on policies and procedures from HCSD on mental health screening for administrative segregation inmates. The response reported that a psych tech reviews Daily Movement Sheets to identify new arrivals in administrative segregation and screen them. Psych techs reportedly now had the capability of managing the psychiatric needs of administrative segregation inmates seven days per week and can spend more time with inmates housed in administrative segregation because of more manageable housing placements. The memo further stated that psych techs were able to coordinate treatment with the case manager and a psychiatrist assigned to inmates in J-Wing.

The placement of new arrivals in J-Wing closer to the front of the unit on the lower tiers reportedly was not feasible because of the large number of new arrivals each day. Only two tiers in J-Wing are used for administrative segregation, all J-Wing administrative segregation inmates eventually must be transferred to L-Wing.

Findings: This inmate's death did not appear to have been foreseeable, but it might possibly have been preventable if an appropriate bus screening had been conducted on his return to DVI in May 2004. While the Suicide Report noted that the psych tech round conducted the day prior to his suicide was inadequate, it did not identify as a problem the absence of a bus screening upon the inmate's return to the DVI reception center on 5/13/04. In addition, the Suicide Report did not note that CPR was not initiated promptly by the first responders, the correctional officers who first discovered the inmate hanging in his cell. The Incident Reports indicated that CPR was not begun until after the inmate arrived at the DVI infirmary. Last, the DVI response asserted that the corrective recommendation to house newly arriving inmates in closer proximity to custody staff was not feasible. The materials received for review contained no further comment or response from HCSD on this issue.

11. Inmate J98320

Brief History: This inmate was a 32-year-old African American male who committed suicide by hanging at approximately 4:20pm on 6/11/04 in the administrative segregation unit at Pelican Bay State Prison (PBSP). The inmate was housed alone in administrative segregation. He was a general population inmate not enrolled in the MHSDS. The inmate was admitted to CDC on 3/11/96 via reception at WSP.

At approximately 4:20pm the inmate was discovered hanging from the air vent in his cell by correctional officers conducting an afternoon count. Upon discovery, a medical emergency was declared and when sufficient staff arrived at cell front the officers entered the cell and began CPR. The inmate was transported to the CTC. Despite continued CPR, he was pronounced dead at 4:48pm via communications between a Sutter Coast emergency room doctor and paramedics who arrived on the scene. An autopsy was performed on 6/15/04. It indicated the cause of death was asphyxia due to hanging and the manner of death was suicide. A toxicology screen revealed no evidence of alcohol or illicit drugs at the time of the inmate's death.

The inmate had a juvenile criminal record beginning with a conviction for burglary at age 13 and subsequent convictions for grand theft and assaulting a police officer with a firearm. After his release from CYA on parole in October 1991, the inmate was re-arrested in 1995 for threatening a store clerk with a firearm and taking $500. He received a three-year sentence for the robbery of the store clerk. He entered CDC on 3/11/96 at WSP and was subsequently transferred to PBSP on 4/3/96. In January 1997, the inmate was convicted of two counts of assault with a deadly weapon. He assaulted another inmate with a baseball bat and attempted to hit a correctional officer. He received an additional 17-year sentence for those offenses. The inmate had been transferred to CSP/Corcoran and placed in the SHU in June 1997. He was transferred to HDSP in December 1998 and eventually to PBSP in January 2002 because of enemy concerns.

He was not placed in MHSDS at any time during his incarceration and a developmental disabilities evaluation done in March 2004 indicated he had normal cognitive functioning. The inmate's record indicated he was preoccupied with religious themes that may have influenced the assault on an inmate that resulted in the additional 17-year term. In bus and mental health screenings, he consistently denied that he had any mental health problems or refused to cooperate with the screening process. Plaintiff's counsel questioned whether the inmate ever received an appropriate mental health screening after 1996 because of his refusal to cooperate.

The inmate refused a mental health screening at PBSP on 2/4/02 when he was admitted to the administrative segregation unit, but a screening was completed on 2/14/02. The inmate was referred by custody staff in November 2003 and was seen by mental health staff on 11/17/03 because he was having problems with his next-door neighbor. No Axis I diagnosis was made, and mental health follow-up was determined to be unnecessary.

A 11/26/03 initial ICC was completed based on what appeared to be an interview of the inmate and a review of the central file that determined that the inmate was not in need of mental health treatment. On 12/18/03, 2003 a clinician completed a SHU mental health screening utilizing information from the 1996 CDC reception center mental health screening because the inmate refused to participate in a repeat mental health screening for placement in the SHU. This screening also referred to the 2/4/02 screening that was refused by the inmate. The inmate again refused a mental health screening and mental health services on 1/24/04.

On 3/15/04, a mental health screening chrono was completed by a psychologist when the inmate was moved to the newly opened administrative segregation unit from the old administrative segregation unit. The chrono seemed to indicate that the psychologist neither interviewed the inmate nor reviewed his central file or UHR. On 4/14/04, a classification chrono was completed by a mental health clinician who indicated that no mental health treatment was needed at that time based on an interview of the inmate and review of his central file.

Based on an on-site review by one of the monitor's psychiatric experts, mental health assessments of the inmate were completed in July 2000 and on 11/17/03, although the March 2004 screening did not include a UHR review as required by policy. The inmate's UHR, moreover, contained progress notes relating to the SHU mental health screening assessments in which the inmate refused to participate.

Plaintiffs' counsel questioned the timeliness of the mental health assessment following a referral on 6/08/04, which was scheduled to be conducted by a senior psychiatrist on 6/14/04. The inmate was seen on 6/08/04 by an MTA who referred him to an RN, who subsequently scheduled the inmate to be seen for a routine mental health referral on 6/14/04. The inmate was scheduled to be seen for a routine mental health evaluation within five working days from the time of the referral as per policy.

The inmate's most recent SHU term began because of an RVR on 11/19/03 for an assault on an inmate. The inmate had numerous SHU terms, beginning in 1997, all involving threats, attempted battery or assault on other inmates. The inmate was known to have had 22 RVRs, 11 of which had to do with his refusals to accept a cellmate, threatening cellmates or assaulting cellmates. He was endorsed for an indeterminate SHU term in April 2004. The inmate was noted to have spent most of his time by himself and in single cells and appeared to be an extremely devout Muslim.

No suicide note was discovered in the property of this inmate. There were two notes, including one to his father from August 2003. They provided information about his difficult relationships with his father and with another individual.

The neighbor at whom the inmate was yelling in the early morning hours of 6/08/04 was moved by custody staff the following day, and the inmate's yelling through the night did not recur.

The Suicide Report dated 8/06/04 identified one problem and corrective recommendation:

Problem: Although a routine mental health referral was scheduled, the inmate committed suicide before the scheduled appointment.
Recommendation: Due to the high rate of suicides in administrative segregation units, a policy was needed to ensure that all mental health referrals in administrative segregation units are seen as soon as possible and, at least, within the same week.

In response to the Suicide Report of 8/06/04, PBSP provided a follow-up report dated 9/29/04. In that memorandum PBSP staff indicated that they had been instructed by HCSD to implement a corrective action to schedule administrative segregation inmates, who were not currently being seen by mental health but were referred for routine mental health evaluation, within three days of the referral. Referrals received on Fridays were to be seen the following Monday unless the referral was determined to be urgent. The policy was to go into effect immediately according to the memorandum dated 9/15/05 by the chief psychiatrist and chief psychologist at PBSP.

Findings: This inmate's suicide did not appear to have been foreseeable or preventable. The inmate had a difficult institutional adjustment particularly when it was necessary for him to be involved with other inmates in a potential housing situation. He had not received mental health services but was being treated in the chronic care clinic for asthma. The inmate was noted to have engaged in unusual or bizarre behavior several days prior to his completed suicide, but he was referred for routine mental health evaluation. He was scheduled to be seen within policy timeframes. Plaintiff counsel's questions regarding the screenings the inmate had received in the past were noted and reviewed, but the failed screenings did not appear to have contributed to this inmate's suicide.

12. Inmate P10904

Brief History: This inmate was a 27-year-old Hispanic male who committed suicide by hanging at approximately 12:55am on 06/16/04. The inmate was housed in a single administrative segregation cell at the California Men's Colony (CMC). The inmate was at the EOP level of care at the time of his death. This inmate was admitted to CDC via the reception center at WSP on 06/24/98.

At approximately 12:55am on 06/16/04, a correctional officer was conducting a security check in the administrative segregation units. In the annex overflow he discovered the inmate in a single cell hanging by a sheet tied around his neck and attached to a window latch. The officer attempted to call in a medical emergency on his radio but was not successful. He ran from the second floor of Building 4 to a foyer area and yelled down to the first floor officer who was able to contact control via radio and request an emergency transport vehicle. At approximately 12:59am, control called for the emergency transport vehicle and officers, including a sergeant, obtained a cut-down tool, secured the cells and cut the inmate down. The inmate was removed from his cell, and CPR was initiated by

custody staff. At approximately 1:02am fire department staff relieved custody staff and continued CPR while the inmate was transported to the emergency room where he arrived at approximately 1:15am. Life saving measures were continued but were unsuccessful. He was pronounced dead at 1:38am.

A coroner's report completed by the San Luis Obispo County sheriff/coroner's department on 06/16/04 determined the cause of death as asphyxia by hanging and the manner of death as suicide. Toxicology results indicated the inmate had Sertraline in his blood sample at a level of 0.18mg/L (therapeutic range 0.05/0.25mg/L). No suicide note found in this inmate's property after his death.

The inmate entered CDC on 06/24/98 at WSP. Later in 1998 he was transferred to Ironwood State Prison (ISP) and to Correctional Training Facility (CTF). He was admitted to CMC-East in January 1999, where he remained until the time of his death. He was serving his first incarceration in CDC, but had previous arrests for possession of a dangerous weapon, possession of marijuana and threatening a crime with the intent to terrorize. These offenses apparently did not result a state prison term. As a juvenile he had an arrest for vandalism and was involved with two street gangs. Other background information indicated that the inmate's mother and sister were both incarcerated at the time of his arrest at the age of 21. The inmate's incarceration in CDC followed his guilty plea to two counts of child molestation. He was originally charged with eight counts of child molestation and related charges, including procurement of a child for sexual purposes and petty theft. He was sentenced to a ten- year prison term.

During his incarceration the inmate was identified as being a member of a Hispanic gang and therefore was placed in administrative segregation at ISP because of enemy concerns. This inmate had five stays in administrative segregation, including 12/19-20/00 for battery on an inmate without serious injury; 05/23/01 for mutual combat; 10/18 through 22/02 for refusing to program; 5/23/03 secondary to being observed as being involved in a riot between rival gangs. His final placement in administrative segregation was on 06/15/04 at approximately 11:00am for mutual combat with another inmate. A medical report of injury or unusual occurrence form dated 06/15/04 indicated the inmate was in a fight and suffered abrasions or scratches on both hands but no other injuries. He was released to custody. The Suicide Report referred to a psych tech contact during the third watch on 6/15/04, but the inmate's UHR contained no notes from that visit.

The inmate was not receiving any medical services at the time of his death and a Developmental Disabilities Program (DDP) evaluation in October 2002 indicated he had normal cognitive functioning.

Mental health history indicated the inmate had reported depressive symptoms three times in the past including at ages 11, 16 and 18, when he was placed in foster care, broke up with a girlfriend and was rejected by the military, respectively. The inmate was seen for a comprehensive evaluation on 3/18/04 when he reported mild to moderate depression and was concerned about his future due to his sex offender status and registration. He requested to talk with a psychiatrist to get medications. He was seen that same day by a

psychiatrist who recorded that the inmate reported periods of depression but not suicidal ideation. The psychiatrist concluded that the inmate had "significant depression" but was hesitant to take any psychotropic medications, despite the psychiatrist's urging him to do so. He was not added to the MHSDS, and was advised to return for services if he needed them.

A note dated 04/20/04 by a psychiatrist indicated the inmate presented with sleep and appetite problems as well as anxiety over his possible parole in two years. The psychiatrist concluded that the inmate's diagnosis was Adjustment Disorder with anxiety, with a GAF score of 60, and needed supportive therapy through the 3CMS program. On 04/29/04 the inmate was seen on an urgent basis because another inmate reported to a staff member that the inmate was feeling depressed and might be at risk of hurting himself. The clinician indicated that the inmate said that he was not considering hurting himself but that he wanted to be seen as soon as possible. The inmate reported ongoing/worsening depression and anxiety, which he claimed had become "unbearable." The inmate was subsequently seen by clinicians on 05/04 and 05/07. He reported anxiety and depression related to possibly paroling and having no skills and agreed to take a trial of anti-depressants. During the 05/04/04 appointment with a psychiatrist, the inmate acknowledged he had "fleeting" suicidal thoughts and needed to be in an EOP. On 05/17/04, a treatment team meeting met. The IDTT meeting was attended by two psychologists and someone with an illegible signature, but no psychiatrist appeared to be in attendance. The IDTT changed the inmate's diagnosis to Major Depressive Disorder recurrent, mild, as well as Alcohol and Cannabis Abuse and Personality Disorder NOS, planned to place him at the EOP level of care, get him involved in group therapies and see him in individual contacts. No medication was recommended at the time of the IDTT meeting or included in his treatment plan.

The inmate was subsequently seen on 06/06/04 and 06/14/04 by a CCM, but he failed to appear for an appointment on 06/04/04 with a psychiatrist. A note of 6/14/04 by the CCM indicated the inmate denied suicidal ideation and was generally coping well. The note also indicated the inmate was starting to deal with his "underlying issues but still avoids his feelings." The conclusion was that the inmate was making slow progress and should continue at the EOP level of care. This was the last contact with mental health staff prior to his suicide.

The inmate was treated with Sertraline and Trazodone since May 2004 when he was placed in the MHSDS. There were notes at least once per week by the CCM and or psychiatrist from the time he was placed in the EOP program through his death on 6/14/04.

The Suicide Report identified one problem with corrective recommendations:

Problem: Evening medications were not provided to the inmate on his placement in administrative segregation.

Recommendation: The institution should audit continuity of medications for inmates placed in administrative segregation for the past three months, prepare an

analysis of the audit results, develop and implement a corrective action plan (CAP) for the problems identified in the analysis and audit medication continuity for three months after implementing the CAP.

The Suicide Report was dated 09/29/04. The follow-up report and corrective action plan provided by CMC was dated 03/11/05. It consisted of an audit of continuity of medication administration for inmates admitted to administrative segregation annex or administrative segregation central. The audit was conducted from November 2004 through February 2005. The audit indicated that there were a number of problems with medication administration. It concluded that only 57 percent of all medications ordered were received timely following a transfer to administrative segregation. Factors identified as contributing to interruptions in medications included the failure to notify nursing staff of transfers by custody, difficulties in transferring MARs, the need for additional psych techs and heavy reliance on contracted psych techs. All of these issues were targeted to be addressed through meetings among supervisors, examination of the reasons for the slow transfer of MARs, assessment of the need for additional psych techs and effort to reduce reliance on contract psych techs by recruiting a full complement of psych techs. No positions were budgeted for coverage in the event that any psych techs were absent.

HCSD indicated that additional follow up by CMC was to be provided by July 31, 2005. CMC requested an extension through September 30, 2005 to implement the CAP. Plaintiffs' counsel objected to the lack of diligence and urgency with which both CMC and headquarters have implemented the recommendations in the Suicide Report, citing the 180-day time frame for implementation of the corrective actions included in Suicide Reports.

Findings: This inmate's suicide did not appear to have been foreseeable or preventable. There were active efforts to evaluate and treat the inmate at the time of his placement in administrative segregation on the day prior to his suicide. The absence of psych tech notes in the documents provided suggested that notes were made in a log or other document, but they were not included in the UHR. Whether the evaluations were comprehensive cannot be determined. However, given the inmate's behaviors, his involvement with custody staff and observations made by custody staff, it cannot be determined whether he would have reported any suicidal intent, had he experienced it on 06/15/04.

13. Inmate E62410

Brief History: This inmate was a 34-year-old Hispanic male who committed suicide by hanging in his single cell in the Willis administrative segregation unit at CMF on 6/17/04. He was a general population inmate who was not receiving mental health services at the time of his death. He entered the CDC via the DVI reception center on 5/6/94, having been transferred from CYA, where he was initially committed on 8/2/90.

On 6/17/04 at approximately 12:58pm a correctional officer conducting a security check in the Willis administrative segregation unit at CMF walked past this inmate's cell and determined that she could not observe the inmate. As she moved closer to the cell she saw what appeared to be the inmate standing by his sink with his hands on the sink and a white noose around his neck that was attached to the air vent above the sink. The officer yelled to the inmate, who did not respond, and activated her personal alarm. A sergeant and additional officer responded and entered the cell, utilized the cut-down tool to cut the noose that appeared to be made from a bed sheet, lowered the inmate to the floor and began performing CPR. An MTA responded and assisted the sergeant in performing CPR. The inmate was subsequently placed on a gurney and taken to the B-1 clinic for medical treatment. Efforts at resuscitation were unsuccessful. The inmate was pronounced dead at 2:23pm. The temperature of his body was noted as 98.6 during his treatment in the B-1 clinic.

The inmate left a letter to his attorney in his property. He asked the attorney to tell his mother that the inmate had gone to heaven and would watch over her. The letter stated it was very important that the attorney tell the inmate's mother that he had been "reading my spiritual book every day and I pray every day. Tell her that I love her very much and my family. Not to worry about me and just let me go to heaven with God and I will watch over my mother and to protect my family." The letter added that the inmate could not write directly to his mother because he did not want to hurt her and he wanted the attorney to tell her for him. He concluded the letter with "at last I am in heaven. Just let me go now. Thank you." An autopsy report done by the Solano County Coroner on 6/18/04 indicated the cause of death was asphyxia due to hanging (minutes). A toxicology report was not provided.

The inmate had no criminal history prior to the instant offense. The instant offense occurred when the inmate and two friends were sitting in front of a house, and the victim approached and began speaking to them. One of the friends, a cousin of the decedent, indicated they should rob the victim. As they walked the victim home, the decedent began punching the victim and knocked him to the ground. The cousin stabbed the victim to death. The inmate was 18 at the time. He told his family about the killing. After he was arrested, he reported that his cousin actually committed the homicide. The cousin, who was a juvenile, was committed to CYA for three years, a girlfriend received probation, and this inmate, the only adult, was convicted of second-degree murder and grand theft. He received a sentence of 16 years and four months to life. He was committed to CYA on 8/2/90 and at the age of 24 transferred to CDC on 5/6/94. During his incarceration the inmate was transferred from DVI to CSP-LAC, SVSP, CMC and eventually to CMF on 3/15/01.

Since age five the inmate had a hearing impairment secondary to an ear infection and an associated speech impediment. He also had lost sight in his right eye due to a car accident. He had a history of marijuana, PCP, LSD and cocaine abuse. Alcohol appeared to be his drug of choice. He began using alcohol at age 15. A psychiatric evaluation in July 1993 described the inmate as having feelings of inadequacy and insecurity, a learning disability and showing remorse for his crime. The transfer

summary of April 1994 from CYA to CDC, however, indicated the inmate's performance in CYA programs was average to sub-standard largely because of his "using his handicaps" to avoid dealing with issues. For example, the inmate would turn off his hearing aid to avoid participating in group discussions. A BPT mental health evaluation conducted in August 1998 described the inmate as having low average intellectual capacity but found no evidence of mental illness. A bus screening conducted when he was transferred from CSP/LAC to SVSP left blank the question about any current mental health problems. He had a second bus screening at the time of his transfer from SVSP to CMC on 9/18/00, which indicated no mental health history, but gave a 'yes' answer to current mental health problems. No referral was generated based on this bus screening.

The inmate had another bus screening when transferred from CMC-East to CMF on 3/15/01. That bus screening indicated no mental illness and no mental health history. Also on 3/15/01, the inmate had a suicide prevention screening. The reason for the screening was not stated. Questions regarding drug or alcohol history on the psychiatric history were both checked yes, and the psych evaluation referral form was also filled out 'yes,' but, again, no follow-up resulted from this screening and referral. On 4/24/01 the inmate self-referred because of "sleeping too much." An evaluation by a psychologist found no Axis I mental disorder with the exception of alcohol and drug use/abuse by history. A psychiatric evaluation on 2/5/02 indicated no mental disorder and noted that the inmate "feels depressed because he has nothing to do." The inmate was seen by a psych social worker on 10/7/02 in the Willis administrative segregation unit because a MTA found a misplaced sick call slip that said the inmate/patient was suicidal. The inmate was referred to a psychiatrist and was seen on 10/9/02. Again, he was determined to have no mental health diagnosis, and no medications were prescribed.

On 5/1/04 a medical report of injury or unusual occurrence noted that the inmate stated he was suicidal in order to get out of a dormitory. The notation indicated the inmate appeared paranoid with bouts of anger, but an administrative segregation chrono written that same date (signature illegible) indicated the inmate reported suicidal ideation because he did not want to go to the J-1 unit because of fears for his life. The mental health staff member concluded the inmate was not suicidal, and the plan was to transfer him to a different unit. On 6/15/04, the CCM on call saw the inmate because he reported being depressed and feeling unsafe from other inmates in the Willis unit. The inmate had received an RVR for battery on an inmate, but it was subsequently thrown out. The inmate reported he believed the "institution" was against him. He was also concerned that other inmates thought he was a snitch because he was moved from J-1 to the Willis Unit on 5/1/04. The note indicated the inmate's sleep and appetite were disturbed, and the inmate asked the CCM to call Investigative Services. The CCM contacted the inmate's classification counselor, who informed her that the inmate had made allegations against custody staff and might have been self-medicating on the day that he was sent to Willis unit. The CCM opined the inmate was experiencing situational stressors and poor judgment but was not an acute risk at that time. The CCM contact of 6/15/04 was the last mental health contact with the inmate prior to his suicide other than daily psych tech rounds made in the administrative segregation unit.

In addition to his hearing, speech and visual impairments, the inmate was also positive for Hepatitis C and had been treated for MRSA (Methacillin Resistant Staff Aurias). This inmate was placed in administrative segregation on three occasions during his ten years of incarceration in CDC, including administrative segregation at CMC in March 2001 for refusing to stand for count and having a bad attitude that continued when he was transferred to CMF on 3/16. He was segregated a second time from 8/6/02 through 12/13/02, when he was placed in the Willis unit while being investigated for gang activity subsequent to a riot. His third placement in administrative segregation, again in the Willis unit, occurred on 5/1/04 because of reported fear for his safety in the J-1 unit. While in the J-1 unit, he requested correctional officers who entered the dormitory unit for a count that he be locked up. He subsequently became disruptive and exhibited bizarre behavior including kicking the holding cell door and refusing to cooperate with custody staff in the J-1 unit. Following medical and psychiatric clearances in the B-1 clinic, the inmate was placed in administrative segregation pending classification review for appropriate program and housing.

This inmate's central file indicated the RVR for battery which precipitated his transfer to the Willis unit was never written or given to the inmate, so no mental health evaluation was requested in connection with the disciplinary process. The description of the inmate's bizarre behavior in the administrative segregation placement note also recorded that the inmate was cleared psychiatrically for placement in administrative segregation. The inmate had a classification hearing on 5/7/04, during which an American Sign Language interpreter was present. Documentation of that hearing indicated the inmate was placed in administrative segregation because the battery charge against a peace officer was being investigated. Some additional annotations on the inmate's behavior and status while in administrative segregation were recorded in the administrative segregation Isolation Log. These indicated that the psych tech made daily rounds in the unit that usually lasted 45 minutes during the week and ten minutes a day on weekends. Lastly, the 6/15/04 clinician's note had the signature cut off of the bottom. The Suicide Report referred to the author as a psychologist, but interviewed staff members indicated the author was a psych social worker.

The Suicide Report identified two problems and associated corrective recommendations:

Problem 1: The psychiatrist wrote a note on the inmate's admission to administrative segregation that a p.r.n. was to be ordered, but no order was written. The signature on the note was illegible.

Recommendation: The institution should identify the doctor, find out what happened and form a QIT to devise a procedure to prevent such errors from recurring.

Problem 2: Psych tech staffing in administrative segregation units was insufficient to allow time individual psych techs adequate contact with inmates to establish rapport and elicit concerns with implications for suicidal behavior.

Recommendation: The HCSD Suicide Prevention and Response Focus Improvement Team (SPR-FIT) needed to forward a recommendation for increased LPT

staffing in administrative segregation units system-wide to the HSCD Quality Management Committee Mental Health Program Subcommittee.

On 12/13/04, a follow up corrective action plan was submitted by staff from CMF and distributed in a memorandum dated 1/25/05 in response to the Suicide Report of 9/22/04. The CMF response to the first problem reported that a review found that the psychiatrist's order was noted and written by nursing staff. That fact apparently was overlooked when the case was being reviewed. An attachment also indicated that an order for Vistaril 75mg p.o., dated 5/1/04, was written.

In response to the second problem, CMF indicated it needed enhanced psych tech staffing in all administrative segregations unit, but acknowledged that this was essentially a HCSD issue. Minutes were provided of a 1/3/05 SPR-FIT subcommittee meeting at HCSD, which recorded that HCSD was in the process of drafting a proposal to increase psych tech staffing in administrative segregation units, which would be forwarded to the MHQMS.

Plaintiffs' counsel submitted a letter on 10/4/04 on this inmate's suicide, asserting that the corrective action plan inadequately addressed problems identified in the Suicide Report. The inmate's placement in the Willis unit violated a court order prohibiting the placement of mentally ill inmates in the unit. Although the inmate was not technically in the MHSDS caseload at the time of his placement in the Willis unit, he subsequently expressed symptoms of depression to clinicians and should have been placed on the caseload and removed from the unit. The letter also referenced the Suicide Report's documentation of the inmate's reported symptoms during his earlier placement in the Willis unit in 2002, which should have precluded his placement there subsequently in 2004.

The plaintiffs' letter also pointed to the medication order that was apparently neither written nor filled. The MAR was not provided, and it was unclear whether the inmate ever received the medication, although the medication order appeared to have been written in the doctor's orders section. Finally, the letter complained that the CCM contact on 6/15/04

The letter from plaintiffs' counsel also referred to the Suicide Report's documentation of the inmate's decompensation and reported symptoms during his stay in the Willis unit in 2002 as an indication that he should not have been placed in the Willis unit in 2004. The letter also noted that the CCM contact on 6/15/04 should have included a sign language interpreter, and the failure to do so should have been noted and addressed in the Suicide Report. The plaintiffs' letter demanded modification of the Suicide Report in response to these various complaints.

Findings: This inmate's suicide did not appear to be foreseeable, but it may well have been preventable had his symptoms of depression and "bizarre behavior" prior to his placement in the Willis administrative segregation unit been thoroughly evaluated and addressed or had he been removed from the Willis unit when evaluated by the CCM on

6/15/04. The Suicide Report indicated the clinician who evaluated the inmate on 6/15/04 was the on-call psychologist, although subsequent review of the documentation indicated the signature was illegible. Staff on site reported that the clinician was a psych social worker. Regardless of the identity of the clinician who saw the inmate on 6/15/04, the inmate displayed signs and symptoms of acute mental illness and reported depression and feelings of being unsafe in the Willis unit. Because the court order in the Gates merger prohibited the placement of seriously mentally disordered inmates in the Willis unit, the inmate should have been placed in alternative housing and more thoroughly evaluated using an interpreter to help determine his mental health needs and appropriate housing.

14. Inmate E59943

Brief History: This inmate was a 34-year-old white male who committed suicide by hanging on 6/23/04 in his single cell in the Willis administrative segregation unit at the California Medical Facility (CMF). The inmate was returned to CDC and CMF on 8/06/02 as a parole violator with a new term. He remained at CMF until his death. The inmate's last commitment to the CDC was based on a 6/5/02 guilty plea to vehicle theft and possession of a controlled substance, for which he received a sentence of three years and eight months.

On 6/23/04 at approximately 6:35am, a correctional officer delivering breakfast in the Willis unit to first tier inmates discovered the inmate hanging by a sheet tied to the air vent at the rear of the cell. His feet were suspended approximately two feet above the floor. The officer activated her personal alarm and radioed for assistance. Three officers responded to the cell. These officers cut the inmate down and began CPR. An MTA arrived and staff placed the inmate on a gurney to transport him to the B-1 medical clinic emergency room. While en route two MTAs continued to perform CPR. The inmate was pronounced dead at approximately 6:50am in CMF's emergency room. The autopsy report dated 6/24/04 indicated the inmate's cause of death was asphyxia due to hanging. A toxicology screening was submitted, but no results were reported.

The inmate had a long and convoluted criminal justice history dating back to age 15. He served time in CYA, a county jail and CDC. He was committed to CYA in November 1985 at the age of 16 for burglary and car theft. He was subsequently committed to CDC for assault on another ward in CYA in July 1990. During his CDC tenure, he spent time in DVI, ASP, MCSP, SQ, CMC, CEN and CMF. He was paroled from CDC several times. His last parole in January 2002 from CMF ended with subsequent violations of conditions of parole and new charges that resulted in his return to CMF on 8/6/02. The charges included assault with great bodily injury and use of a deadly weapon, unlawful driving or taking of a vehicle, receiving stolen property, vehicle theft, possession of methamphetamine, possession of a controlled substance and failure to follow his conditions of parole.

Over the years the inmate received a number of health screenings and mental health reception center assessments, which indicated no need for mental health treatment but noted prior treatment for Adjustment Disorder and various descriptions of depression.

He was placed at the 3CMS level of care by reason of medical necessity in February 2003 after reporting to a mental health clinician his depression over the change in his release date from January 2003 to November 2004 because his parole violation and new conviction were running consecutively rather than concurrently. Vistaril and Celexa were prescribed. An IDTT in February 2003 indicated that the inmate's condition was improving with medication and anticipated a transfer to CIM. Two days later, however, the inmate reported that he was feeling depressed secondary to his separation from his wife and having to serve additional time. The inmate remained at the 3CMS level of care until he was removed by an IDDT on 4/29/03, based on his improvement and the determination that his Adjustment Disorder with depressed mood had been resolved. Based on evaluations in April 2003, his depression was diagnosed as in remission and Celexa was discontinued. At the time of his death, the inmate was not involved in the MHSDS and was not receiving any mental health treatment.

This inmate had a number of medical problems including being HIV positive since 1998 (he was receiving anti-viral treatments), seizure disorder secondary to a motor vehicle accident since August 2002, severe traumatic arthritis of the left shoulder, Hepatitis C and diabetes. The inmate was screened for the Developmental Disabilities Program (DDP) in May 2002 and found to have normal cognitive functioning.

The inmate had no further mental health contact until 6/21/05, when he was seen by a psychologist because of a custody referral. He had been found with six padlocks and keys in his possession. These items were considered contraband and potential escape paraphernalia by custody. The psychologist interviewed the inmate and determined that he did not have any suicidal or homicidal thoughts and "appeared almost cheerful and is under no distress." A psych social worker subsequently saw the inmate and apparently mistakenly marked the box on the resulting chrono that indicated the inmate was not psychiatrically cleared for administrative segregation placement. The clinician's note of the contact clearly recorded that the inmate was not currently a participant in the MHSDS. The inmate was placed in administrative segregation on 6/21/04. He was moved to a different cell on 6/22/04, where he committed suicide on the following day. It was noted in the records that he had refused his medical medications for the two days he was in administrative segregation.

The Suicide Report identified two problems and associated corrective actions:

Problem 1: Documentation for this inmate in different institutions contained numerous errors. Dates, times, signatures, titles, etc. were often missing.
Recommendation: Because this same issue had been noted in a previous suicide at CMF, future medical and mental health staff meetings needed to address the problem. HCSD also needed to discuss this issue in a future monthly suicide prevention video teleconference.

Problem 2: Openings in the mesh screens covering air vents in the Willis unit cells were large enough to allow inmates easily to tie something to them. In addition, the placement of the sinks in the cell allowed easy access to the vent.

Recommendation: All institutions should be directed by Institutions Division to retrofit the vents in administrative segregation cells to prevent something from being tied to them, and CMF should proceed with plans for retrofitting.

In response to the Suicide Report of 10/18/04, CMF submitted a follow-up report on its corrective action plan on 1/31/05. In its response, CMF indicated that discussions of proper documentation with clinical staff occurred on a regular basis and would continue to occur. The response reported also that the issue of modification of cell vents was being addressed by headquarters.

Findings: This inmate's suicide did not appear to have been foreseeable or preventable. Nothing in his long history, his own reports or observations made by others pointed to any change in his mental status indicative of an increased likelihood of self- harm. Retrospectively, it appeared that the possibility of receiving a third strike might have precipitated the suicide. Staff could not, however, have been aware of his distress regarding this issue without some voluntary indication from him.

15. Inmate W85854

Brief History: This 23-year-old Caucasian female committed suicide by an overdose of medication while housed alone in an administrative segregation cell at the Central California Women's Facility (CCWF). Her suicide occurred on 7/1/04. The inmate was at the 3CMS level of care at the time of her death. She had been admitted most recently to CDC and CCWF on 1/1/04.

On 7/1/04 at approximately 2:00am, a correctional officer conducting a security check in administrative segregation observed this inmate lying face down on the floor of her single cell. The officer knocked on the cell door, called the inmate's name, and ultimately went to the sergeant's office to notify the sergeant of the situation. The sergeant and officer returned to the cell and subsequently ordered an alarm to summon medical and additional custody staff. The cell was finally opened at approximately 2:18am. Medical staff, including an MTA and an RN, arrived on the scene at approximately 2:22am, and CPR was initiated. Emergency medical treatment continued until 2:39am, when EMS personnel arrived via ambulance. At 2:45am the inmate was determined to be dead by EMS medical personnel. It appeared that from the time of the inmate's discovery to her death, she was not removed from the cell or tier area to an infirmary or emergency room.

An autopsy and toxicology examination was conducted by the sheriff/coroner's office of the County of Madera on 7/3/04. Toxicology results were received on 7/19/04. Based on the autopsy and toxicology results, the cause of death was determined to be an overdose of Olanzapine. The toxicology results indicated Olanzapine levels of 863mg/ml (potentially toxic greater than 250mg/ml).

The inmate had a considerable adult criminal justice history. Her first incarceration in CDC was on 8/8/00 at CCWF on a two year-sentence for receiving stolen property. She paroled on 4/16/01 from CIW. She was returned for her second incarceration on 6/23/03

due to revocation of parole. She paroled again on 11/1/03. She was arrested on 11/30/03 for second-degree burglary. Another two-year term was imposed, which she began serving on 1/1/04.

She also had a juvenile history from the age of 13, including arrests for burglary, vehicle theft and battery, as well as a restraining order involving family members. She had a history of prior substance abuse including methamphetamine, marijuana and alcohol.

This inmate's disciplinary record during her last incarceration included several RVRs. She received a RVR on 2/25/04 for "arcing to light candle" related to her attempting to light a candle in the laundry room. She received a RVR on 3/19/04 for battery on a peace officer on the way to a medical appointment. She appealed the guilty finding on that RVR, but the appeal was denied. She received a nine-month mitigated SHU term with placement in administrative segregation from approximately 3/19/04 until the time of her death on 7/1/04.

She received two RVRs in May 2004 for breaking her cell window. There was a question as to whether she broke the window with her foot or head. Her last RVR was on 6/6/04 for battery (spitting) on a peace officer. These RVRs were pending at the time of her death. The district attorney had decided to prosecute her for the 6/6/04 battery on a peace officer as of 6/28/04, although staff reported that the inmate had not received notification of that decision prior to her death.

The inmate had two mental health evaluations in connection with the June RVRs. The resulting mental health assessments were completed on 6/18/04 and 6/25/04. The first found that her behavior was not attributable to her mental illness but she had poor coping skills, difficulty controlling her anger and limited tolerance for stress. The second evaluation indicated that her disorder had contributed to her behavior without further explanation.

Her history of mental health treatment while in CDC included two admissions to a MHCB unit and treatment at the EOP level of care. She was initially was placed at the EOP level of care in August 2003. She remained at the EOP level of care through October 2003. She had a history of cutting her wrists and head-banging as reflected in records from her placement in an MHCB from 10/25-27/03, immediately prior to her parole on 11/1/03.

Upon her return to CDC two months later on 1/1/04, she was placed at the 3CMS level of care at CCWF. While being treated at the 3CMS level of care, she engaged in a series of self-injurious incidents. She attempted to cut her wrists on 2/17/04. A treatment plan dated 3/29/04 gave diagnoses of Methamphetamine Dependence and Borderline Personality Disorder. Treatment was to be targeted at her poor coping skills and anger management. She had superficial scratch marks on both arms on 5/21/04. She was placed on "observation status" in administrative segregation after she broke the window of her cell on 5/26/04. That status was discontinued after 6/1/04, but no housing change occurred. She continued to be housed in administrative segregation after 6/**01**/04 as a

regular administrative segregation inmate without special precautions. After the discontinuation of observation status on 6/1/04, she attempted suicide by hanging on 6/6/04. A suicide note indicated that she was sorry, but she could not keep on living this way; she hated her life and did not understand why she was the way that she was. Subsequent to that attempt, she was sent to a community hospital where she remained for nine days.

As a result of that serious suicide attempt, the inmate was hospitalized at University Medical Center (UMC) in Fresno from 6/6-15/04. On her return to CCWF, she was admitted to the MHCB unit for roughly nine days. Provided records did not contain any information on her stay in the MHCB from 6/15 through approximately 6/24/04.

She was discharged from the MHCB on anti-psychotic medications but with no orders for anti-depressant medications. She was seen for five days of follow-up contacts from 6/25-29/04 that indicated she was adjusting appropriately but had medical complaints.

She reported difficulty breathing on 6/25, 6/26, 6/27 and 6/30/04 and was seen in the ER on at least two occasions. She was provided with two inhalers. She was also scheduled for x-rays, medical follow-up and psychiatric follow-up.

The inmate's last mental health contact was on 6/30/04, the day before her death. It occurred at cell-front because she was not feeling well and did not want to come out of her cell. She was reported as having no complaints or issues with the exception of an irritable mood. Her medications included Olanzapine and Albuterol (an inhaler for her breathing difficulties), and her Paxil and Trazodone had not been discontinued but did not appear to have been given after her suicide attempt of 6/6/04.

Although treated at the 3CMS level of care at the time of her attempted hanging, the records did not document that she was considered for a higher level of care, such as EOP or DMH. Reviewed records did not indicate that SRAs were conducted when she was placed on "observation status" in administrative segregation or after her attempted hanging precipitated admission to a MHCB and external hospitalization. Further, her anti-psychotic medication was continued, but her anti-depressant medication was discontinued without clear indications to the reasons.

In April 2004, the inmate requested multiple medical appointments because of various pains in her chest and for an HIV test. She received a brief intervention of prednisone secondary to her difficulty breathing after returning from UMC Fresno on 6/15/04. The inmate was noted to have been abusing the inhalers of Albuterol and Azmacort, which were provided to her secondary to her breathing difficulty. An order was written to take the inhalers away from her on 6/30/04 and have them nurse-administered, although no entries in the MAR reflected removal of the inhalers. No inhalers were found in her property, nor did any available documentation indicate that nurse-administered inhalers were provided.

Although the inmate overdosed on Olanzapine, her dosage was just 20mg per day while in administrative segregation, a setting in which she would have had limited contact with other inmates.

The Suicide Report identified six problems and associated recommendations:

Problem 1: There was an 18-minute delay in the emergency response after the inmate was discovered lying facedown on the floor of her cell.
Recommendation: CCWF should conduct a fact-finding inquiry and both institutional and HCSD Emergency Response Review Committees should conduct a review and make appropriate recommendations.

Problem 2: Faulty emergency equipment (defibrillator) may have added to the delay in the emergency response.
Recommendation: Procedures for regular equipment checks and maintenance needed to be reviewed.

Problem 3: The inmate was not improving at the 3CMS level of care and should have been evaluated for a higher level of care. The combination of prominent Axis II features and the chronic presence of depressive symptoms presented a challenge to clinicians. This combination possibly interfered with clinical judgment in the administration and analysis of SRAs.
Recommendation: Mental health clinicians needed training in evaluating the need for increasing levels of care, including the suicide risk potential of co-morbid Axis I and Axis II disorders, consideration of counter-transference issues and differentiating between Bipolar Disorder and Borderline Personality Disorder diagnoses.

Problem 4: Once identified as a danger to herself, the inmate was not placed in a closely supervised mental health setting, such as a MHCB unit. Placement on suicide precaution in the housing unit is a violation of CDC Suicide Prevention Policy.
Recommendation: The institution needed to conduct an investigation of this issue, review with all staff the department's relevant Suicide Prevention Policy and provide appropriate training.

Problem 5: On the mental health assessment form dated 6/25/04 for the RVR process, the clinician indicated positively that the inmate's mental disorder contributed to her behavior but did not explain the answer as required and did not recommend any mitigation.
Recommendation: A supervisor should ensure that the clinician involved is properly counseled and trained on this issue.

Problem 6: The inmate was in a MHCB from 6/15-24/04, but no inpatient record was in her UHR for this crisis bed stay.
Recommendation: A QIT should be formed to develop a responsive plan to ensure that UHR filings are current and complete and audits should be conducted with the results provided to demonstrate compliance.

The Suicide Report was dated 9/28/04. Institutional corrective responses to the Suicide Report were provided on 1/7/05 and 5/24/05. In the first response, while CCWF staff indicated that a medical response time of five to seven minutes was appropriate, the institution had initiated a category-two investigation into the circumstances surrounding this case. The facility also reported that the defibrillator used in this instance was not defective. Rather, staff had placed electrodes on a patient with no sinus rhythm and, in its absence, the AED would not deliver defibrillation. Materials and a signed IST attendance sheet for training in procedures for considering and referring for higher levels of care, evaluating the suicide risk potential of co-morbid Axis I and Axis II disorders, consideration of counter-transference issues and differentiating between Bipolar Disorder and Borderline Personality Disorder diagnoses were also provided.

In response to CCWF's initial rejoinder, HCSD required on 3/30/05 a follow-up report to include a copy of the warden's memorandum on the fact-finding inquiry regarding the custody response, a copy of the EERC minutes on the response, documentation of training on ER equipment maintenance and checks, documentation of the investigation into the placement of a suicidal inmate in a non-mental health unit, documentation of participation in the recommended Suicide Prevention Policy training and information on the charter of a QIT regarding timely UHR filings.

CCWF's second follow-up report on 5/24/05 provided additional documentation was complete with the exception of information on the pending investigation into the emergency response.

Findings: This inmate's death appeared to have been both foreseeable and preventable. She had a history of mental illness and suicide attempts and, on one occasion, was placed inappropriately on observation in an administrative segregation cell because of behaviors dangerous to self or others.

Although the inmate had been in an MHCB shortly before her death and the subsequent five days of clinical follow-up were appropriately provided, a referral to a higher level of care apparently was never considered. The inmate had been at the EOP level of care during a previous incarceration and had a number of stressors clearly known to staff, including medical complaints of difficult breathing, psychiatric complaints of depression and suicidal ideation, a suicide attempt by hanging that required outside hospitalization, discontinuation of her anti-depressant medications, the potential for a third strike for the battery on a peace officer and/or the possible imposition of another SHU term were all factors that should have alerted mental health and custody staff alike to the potential for further self-destructive behaviors.

In addition, the absence of information and documentation on the inmate's MHCB stay impeded the ability of clinical staff to manage her care and treatment after her discharge from the MHCB unit. Further, the lethal dosage of Olanzapine reported in the toxicology report following her death would have required the hoarding of over 40 days of her daily

20mg dosage of the drug, an issue that was not even addressed in the Suicide Report's list of problems and corrective actions.

Finally, the emergency response by custody staff on discovering the inmate apparently resulted in a substantial delay in the initiation of CPR, possibly a significant and preventable contributor to the inmate's successful suicide.

16. Inmate K59858

Brief History: This inmate was a 36-year-old Hispanic male who committed suicide by hanging on 7/4/04 at approximately 8:55am at Mule Creek State Prison (MCSP). The inmate was receiving services in the EOP program. His cellmate notified staff that the inmate was hanging. The inmate entered CDC on 7/15/97 via the reception center at NKSP.

The inmate was discovered by his cellmate when the cellmate returned from group therapy. There was some discrepancy in the actual timeline in the documentation. The Incident Reports indicated the cellmate began to yell "man down" at 8:55am on 7/4/04. The preliminary summary written by a psychiatrist stated the time of death as 8:45am, an approximate difference of ten minutes.

Reports filed by the involved officers indicated that two correctional officers arrived at Building 6 in Facility B, a SNY, in response to a man-down alarm. The officers reported they found the inmate on his back and unresponsive on the cell floor and a sheet was hanging from the air vent. The cellmate had just returned from an EOP group, discovered the inmate and yelled "man down." The cellmate reported to a MTA that he found his cellmate hanging in their cell, at which time he held the cellmate's legs, pulled the sheet from his neck and lowered him to the floor. A medical code was called and the fire department and an ambulance were summoned. The records indicated that CPR was not begun by first responding officers, who waited until medical personnel arrived at the cell.

The cellmate subsequently reported that when he lowered this inmate to the floor he thought the inmate might still be breathing, but when staff arrived within a few seconds they did not initiate CPR or take vital signs. The cellmate reported that vital signs were not taken for about ten or 15 minutes until medical staff arrived. A note dated 7/4/04 written by an MTA stated that, upon primary assessment, he found the inmate "unresponsive, with shallow respiration, and a faint pulse...urine and feces noted on garments."

The inmate was subsequently transported to the emergency room. CPR and respiratory support via an Ambu bag were started while en route to the emergency room. The MTA's report was not present in the documents provided. The Suicide Report referred to a request for the report, but it had not been received from MCSP at the time of the Suicide Report.

Notes written in the emergency room indicated the inmate arrived at 9:02am, and registered nurses "initiated" support via an Ambu bag and initiated CPR. The inmate was subsequently transferred to Sutton Amador Hospital, where he arrived at 9:55am. He was pronounced dead at 9:59am. An autopsy report by the Amador County Office of the Coroner, dated 7/6/04, indicated the cause of death as asphyxia (minutes), due to hanging (minutes). Toxicology screening revealed no alcohol or illegal drugs in the sample. The report was silent relative to psychotropic medications.

This inmate entered CDC on 7/15/97 having been found guilty of four charges of lewd acts by force upon a child under 14. The inmate received eight years for each of these counts, which were to run consecutively, resulting in a 32-year sentence. On arrival at CDC in the reception center at NKSP in July 1997, the inmate had a mental health screening and was cleared for general population. The inmate did not report, as has been reflected in other records, that his mother may have committed suicide.

In November 1997, the inmate had an INS hold placed on him. He was endorsed for a SNY placement based on his fears for his safety. Also in November 1997, a CCM referred the inmate to the SVSP MHCB because of depressed mood and suicidal ideation with plans to kill himself if he had to go back to court and face 17 additional counts of child molestation.

In the November 1997 interview with the CCM, the inmate admitted a history of multiple suicide attempts and a plan to cut his wrist, and also disclosed his mother's suicide in August 1983 by shotgun. His diagnoses at that time were rule out Major Depression and Adjustment Disorder NOS with a notation that the inmate was suicidal. The inmate also reported that a brother had attempted to commit suicide and that he had been sexually abused by his father and forced to have sex with his sisters. An MH-2 was completed in November 1997 with the same diagnoses shown above, but the inmate's GAF score was estimated at 27 by a social worker, 29 by a psychologist, and 64 by a psychiatrist. Antidepressant medication (Zoloft) and Benadryl were started at that time, and Haldol was subsequently added to his medication regimen. Prior to his discharge from the MHCB, the inmate's Haldol was decreased and he was placed at the 3CMS level of care. Although improved, the inmate was noted to have demonstrated vegetative signs of depression as well as suicidal ideation, and his diagnoses were revised to Major Depression, recurrent, Pedophilia and Borderline Personality Disorder, with a GAF of 50.

In December 1997, the inmate reported he no longer wanted to take psychotropic medications and signed a refusal slip. He was to have a follow-up by a psychiatrist within one week. There was no documentation in the record of whether the follow-up visit occurred. One stressor identified by the inmate was an anticipated court hearing in December 1997 that appeared to have been related to a loss of parental rights. He waived his right to be there and, therefore, did not have to attend. The inmate was seen for his 90-day follow up contacts by a CCM in March and August 1998, the latter some two months late. The inmate's condition was noted to have continued to improve. By December 1998, he had a GAF of 75 and was recommended for removal from the MHSDS.

He did not come to the attention of mental health staff again until September 1999, when he reported fears for his safety from other inmates. He was admitted to the SVSP MHCB with a diagnosis of Psychosis NOS and a GAF of 22. At that time, he was noted to be paranoid with delusions of telepathy and possible hallucinations. He was prescribed Zyprexa and placed on suicide precautions. He stabilized and was discharged from the MHCB to the EOP level of care with a diagnosis of Major Depressive Disorder with psychotic features and a GAF of 45. He remained in the EOP program at SVSP from October 1995 until his transfer to SATF at the 3CMS level of care in January 2000.

The change in level of care from EOP to 3CMS appeared to have been made to facilitate his transfer to a SNY. Some difficulties in medication compliance and administration emerged in February 2000, when the inmate reported he would like to stop taking psychotropic medications so he could work. In June 2000, however, he complained that he was not getting his Zyprexa and was having difficulty thinking. The record indicated the inmate's order for Zyprexa had been discontinued in May 2000. In July 2000, Zyprexa and Zoloft were reordered, but approximately three hours later his Zyprexa was discontinued by the same psychiatrist who had re-ordered it along with Zoloft on that same day.

In October 2000 the inmate had an IDTT. An MH-2 and MH-4 were completed. The notes indicated the IDTT was held in absentia. The diagnosis and plan were based on UHR review alone. The diagnosis at this time was rule out Pedophilia with a GAF of 65. The inmate remained at the 3CMS level of care and was seen by a CCM.

In March 2001 he was referred to a psychiatrist, but he did not show up for the appointment, and there was no indication that it was rescheduled. He subsequently reported that, although he was doing fine without medication, he had some depression. His level of suicide risk was estimated as low, although no SRA was performed.

Roughly two month later, this inmate had his third MHCB admission. In May 2001, he presented with abdominal pain and was subsequently diagnosed with Depression NOS with psychosis and placed on suicide precautions. He was seen by a psychiatrist who prescribed Zyprexa and Thorazine based on the inmate's agitated depression and nihilistic thoughts. At that time, the inmate's risk for suicide was estimated as high, but again no SRA was included in the documents provided. He was noted to have little insight into his mental illness and was referred to the EOP level of care. A psychiatrist subsequently noted the inmate had delusional thinking and suicidal potential because he stated he wanted family members to be notified in case of his death and indicated he should be buried alive because this was a "family tradition." The inmate was discharged from the MHCB unit in June 2001, placed at the EOP level of care and prescribed Zyprexa and Paxil.

Despite the inmate's endorsement for an EOP level of care and transfer to CSP/Lancaster, his assigned CCM erroneously believed the inmate was 3CMS and did not see him weekly as required in the EOP program. The inmate apparently did not have CCM

appointments for approximately two months until December 2001, when his medications were renewed by a psychiatrist, who found him to be stable. The inmate participated in EOP programming from January through April 2002, but requested a return to 3CMS and reportedly stopped taking psychotropic medications.

He continued to experience delusions about his food being drugged or tampered with and thought that prison officials would sell his body parts after his death. He was also noted to be showing more evidence of depression with suicidal ideation, but no SRA was apparently conducted during his appointments with CCMs and psychiatrists or in connection with IDTT meetings. His condition continued to deteriorate. He reported he had been hording medications in August and September 2002. A cell search revealed horded medications, which were removed. In September the inmate's Benadryl was discontinued by a psychiatrist. It was noted that the inmate was involved in a mutual combat incident with his cellmate in November 2002, but he did not receive an RVR.

Eventually, the inmate was endorsed for the SNY at MCSP and transferred on 1/9/03. He continued on Zyprexa and Paxil, but requested and obtained a decrease in both medications shortly after his arrival at MCSP. New diagnoses of Alcohol Dependence, Cocaine Dependence and Antisocial Personality Disorder were added after his arrival at MCSP. The inmate had a SRA that noted his risk for suicide was "none to minimal." He participated in EOP programming. His symptoms of depression appeared to wax and wane over time. He was evaluated as generally stable. His dose of Zyprexa was further decreased. He made inquiries relative to changing his level of care to 3CMS with a plan by staff that the change would be considered after some additional time in the EOP program. Despite the inmate reporting "odd ideas," which appeared to be delusional in content, along with levels of increased anxiety, his level of care was changed to 3CMS in May 2003.

The Suicide Report indicated that the change in level of care appeared to be based on the inmate's request and his CCM's imminent departure from the unit, rather than on his clinical picture. In June 2003, his medications were discontinued by a psychiatrist after the inmate reported he had not been taking them for one week. In September, the inmate was reporting physical pain. He was referred by custody staff to mental health because he refused medical attention. The inmate reportedly denied suicidal ideation but agreed to be placed back on Zyprexa and to start Remeron. At that time, the CCM noted that the inmate had visibly deteriorated without medication and also noted his non-compliance with the newly ordered Zyprexa and Remeron. The inmate was subsequently transferred back to the EOP level of care on 9/29/03, with diagnoses of Disassociative Disorder NOS, Depressive Disorder NOS, rule out Psychotic Disorder, Polysubstance Dependence and Personality Disorder NOS, with a GAF of 49. He was noted to have a minimal risk of suicide at that time. In October 2003, his medications were renewed, he participated in EOP programming and he was monitored for suicidal ideation. A psychiatrist noted in December 2003 that the inmate was improved and reported he was not hearing voices telling him to kill himself, which he had heard in the past.

In March 2004, the inmate was still participating in EOP programming. Notwithstanding the problems in September 2003 just described, progress notes indicated that he had not had any psychotic symptoms for the past 12 months. The inmate had an IDTT meeting in April 2004 and was given a diagnosis of Major Depressive Disorder with psychotic features in Remission with medications. The other diagnoses listed above were continued at that time.

In June 2004, his Paxil was reordered and Remeron was discontinued because of weight gain. At that time, the dose of Zyprexa was once again lowered by a psychiatrist. Based on improvement as noted by the psychiatrist, his Zyprexa was lowered once more a week later, and his CCM noted "great improvement." Based on continued improvement, on 6/29/04, a psychiatrist discontinued the inmate's Zyprexa and maintained his Paxil.

The inmate had an IDTT meeting on 7/1/04. He was continued at the EOP level of care. It was noted that he was compliant with his medication and was participating in the EOP program. His medications at that time were Vistaril and Paxil. He was not on an anti-psychotic since Zyprexa had been discontinued on two days earlier.

The Suicide Report made reference to the omission of SRAs performed during the course of the inmate's treatment. With the exception of one SRA in January 2003, clinicians repeatedly failed to administer SRAs despite constant changes in his level of care and his history of suicidal ideation and attempts.

Review of the records also suggested that MCSP staff may have reviewed only Volume II of this inmate's extensive UHR and, therefore, were unaware of some of his earlier functioning problems, particularly with regard to medication compliance and symptoms.

The Suicide Report identified two problems and associated corrective recommendations:

Problem 1: Conflicting documentation of and reports on the emergency response raised questions about whether life support measures were administered in a timely manner

Recommendation: The institution should conduct an investigation into the emergency response.

Problem 2: The recently revised and expanded SRA checklist was never used for this inmate. Its use might have focused the attention of staff on a chronically present moderate to high risk of suicide for this individual.

Recommendation: Staff training was needed on the use of the SRA Checklist in the intake procedure for all mental health inmates and at other appropriate times. Training should include the need for reviewing prior records including previous volumes of the UHR and central files to obtain complete information.

MCSP provided a follow-up response on 12/31/04 to the Suicide Report that was dated 9/28/04. The response indicated that the warden had initiated an investigation of the emergency response in the case on 12/17/04, which was still in progress, and that training

on the use of the SRA Checklist was conducted on 11/30/04. The training agenda and sign-in sheets were provided.

This inmate's death was reviewed on site by one of the Coleman monitors, who noted the inmate's regular pattern of extreme depression and psychotic symptoms followed by medication compliance and participation in treatment activities. References to some of the suicide risk factors were noted, including two important July anniversaries for the inmate. The monitor's review also raised questions about the timeliness and nature of the emergency response.

Findings: This inmate's death did not appear to have been foreseeable because he did not report suicidal thoughts or plan in the days immediately prior to his suicide. His death, however, might well have been prevented if SRAs had been administered during the frequent periods when he was symptomatic and non-compliant with his medications or in an MHCB. Moreover, if information about his suicidal history and his cyclical pattern of recovery and decompensation been documented and communicated by MCSP clinicians, effective intervention might have occurred. He also had documented periods of hoarding medication, along with wide variability in his diagnoses and GAF scores over time. Last, the emergency response to this inmate's hanging and the failure of the first responders to initiate CPR promptly may also have contributed to this inmate's completed suicide. Documentation indicated he had evidence of respiration and a pulse after he was discovered. Prompt emergency interventions might well have supported a successful recovery.

17. Inmate T69011

Brief History: This inmate was a 22-year-old Filipino male who completed suicide at Folsom on 8/4/04. He was single-celled in the administrative segregation unit when he completed suicide by hanging. At the time of his death, the inmate was in general population at Folsom and was not receiving mental health services.

At approximately 2:30am on 8/4/04, two correctional officers conducting an institutional count discovered the inmate hanging by a sheet tied to the top bunk in his cell. Artificial respiration was attempted and the inmate was transported by gurney to the Folsom clinic; full CPR, however, did not begin until after the inmate's arrival at the clinic. A paramedic pronounced the inmate dead at approximately 3:10am.

An Autopsy Report indicated the cause of death was asphyxia by hanging and the manner of death was suicide. The postmortem toxicology screen was positive for caffeine, but did not reveal any alcohol, medications or illegal drugs. The inmate left a suicide note addressed to his family, indicating his feelings of hopelessness and stating that "this life is no life." He thanked his family for their support, expressed sorrow for all he had done and asked their forgiveness.

This was the inmate's first incarceration in the CDC system and his only known criminal history. He had been charged with 108 felony counts, which consisted of 54 counts of

possession of explosive devices and 54 counts of possession of explosive devices with intent to injure persons or personal property. All but two of the counts were dismissed and the inmate received a seven-year sentence on 10/1/02. The inmate was admitted to the reception center at SQ on 10/4/02 after his conviction and transferred on 11/27/02 to Folsom. Reports indicated that the inmate had expressed a desire to surpass the Columbine High School killings, but following his incarceration he was reportedly a model prisoner.

The inmate was out to court from 5/11/04 thru 6/28/04. During this time, the appellate court decided that the dismissal of the inmate's other 106 felony counts had been inappropriate and a new sentence of 80 years was imposed on 6/23/04. The inmate was returned to Folsom on 7/8/04, where he was reclassified and endorsed for transfer to a Level IV prison. The inmate was placed in administrative segregation on 7/14/04 and was awaiting transfer to CSP/Corcoran or HDSP when he killed himself.

The inmate had been in the county jail for approximately 17 months prior to his admission to CDC. His diagnoses in the county jail included Major Depressive Disorder and Borderline Personality Disorder with a GAF score estimated at 50. The inmate experienced suicidal and homicidal thoughts, and even wrote a suicide note, while in jail. He was treated with Paxil, Wellbutrin and Benadryl in jail and his condition reportedly improved. These medications were continued, with an increase in Wellbutrin, while the inmate was in the reception center at SQ. The inmate missed his medications for approximately the first five days after his arrival in CDC.

Despite reported improvement through the use of anti-depressants, the inmate began refusing medications in December 2002, shortly after his arrival at Folsom. These refusals were noted by a MTA, who referred the inmate to a psychiatrist. The inmate did not, however, receive a timely psychiatric follow-up evaluation due, in part, to an institutional lock-down; the psychiatrist did not go to see the inmate on his yard during the lockdown period, although the inmate was seen by a case manager during this time. The inmate also failed to attend several scheduled appointments in December 2002 and January 2003. It appeared that the inmate's medications expired in early January 2003. The inmate remained at the 3CMS level of care for one year after the expiration of his medications and reportedly was stable.

The inmate's pre-trial mental health evaluations reported a four-year history of depression as well as the inmate's plans for committing suicide while in jail. Other records indicated that his depression actually began in childhood. There were also references in the inmate's file indicating that he hoped he would be discovered prior to implementing his plans for mass murder.

During his incarceration, the inmate was a tutor in English for other inmates. His DDP evaluation in October 2002 indicated normal cognitive functioning. The inmate did not report a history of significant alcohol or drug abuse. A MH-2 completed on 1/15/03 indicated that the inmate was stabilized off medications. His diagnoses were given as Major Depressive Disorder Single Episode and Rule Out Personality Disorder NOS, with

a GAF of 65. The MH-2 included signatures by the case manager and psychiatrist, although there were repeated notes by the psychiatrist who rescheduled the inmate's appointments because of lock-downs or fog. The inmate's last IDTT meeting was held on 2/27/04, at which his diagnosis was given as Major Depression in Full Remission, with a GAF of 90. A related chrono indicated that the inmate should be removed from the MHSDS. The records showed that the inmate had a classification hearing on 7/22/04, after having been placed in administrative segregation, with "terrorist threat" as the documented reason. The clinician noted "no mental health issues, or medical issues." The segregation log indicated that the inmate was seen by a psych tech while in administrative segregation from 7/14 through 8/3/04, the day prior to his death. This inmate had been treated with INH and Pyridoxine from July 2003 through January 2004 as prophylaxis for tuberculosis.

The inmate's Suicide Report, dated 9/28/04, identified three problems and recommended corrective actions for each of the problems as follows:

Problem 1: This 3CMS inmate did not receive a mental health assessment for 48 days after his arrival at Folsom, although the program guides required an assessment within five days.

Recommendation: The Suicide Report recommended that the institution provide documentation that the program guide timeline of five days has been met for at least 85% of the mental health assessments for arriving inmates during the past six months. If not, the institution should provide documentation on the steps undertaken to correct the deficiency.

Problem 2: The inmate refused his medications from the time he arrived at Folsom until his prescription expired 38 days later. The psychiatrist docketed the inmate three times for appointments, but the inmate was not seen reportedly because Folsom was on lock-down, and the psychiatrist never went to the inmate's housing unit to see him.

Recommendation: The psychiatrist had been counseled in June 2004 by the chief psychiatrist about seeing no-shows and reportedly had started to go to the housing units to see chronic no-show inmates. The institution needed to document that this practice was maintained.

Problem 3: The inmate returned from court under obviously stressful circumstances, with a drastically increased sentence resulting in an endorsement to Level IV.

Recommendation: Folsom should form a QIT to establish a mechanism for referrals to mental health of inmates returning from court with significantly altered case factors.

In response to the 11/12/04 Suicide Report, Folsom staff prepared a follow-up report on recommendations flowing from this inmate's suicide on 4/15/05. As for the first problem, a promptly organized QIT audit of MH-4s prepared of 17 newly arrived inmates found 82.4% compliance with the five-day timeline. Another QIT, chartered on 11/3/04, demonstrated that the 85-percent compliance target was met during the preceding six

months. The QIT planned to continue auditing the timeliness of mental health assessments for new arrivals. A QIT meeting on MH-4s was scheduled for 3/24/05.

With regard to the second problem, Folsom's response indicated that the facility was not on lock-down status when the psychiatrist failed to see the inmate who was a repeat no-show. The inmate was eventually seen in the psychiatrist's office on 3/5/03. According to the psychiatrist, the inmate refused his medications and the psychiatrist then discontinued them; the inmate's medication did not expire. While the psychiatrist who was counseled went as directed to see no-show inmates in their housing areas after June 2004 as ordered, psychiatrists did not routinely do so. Although Folsom was on several extended lock-downs from November 2004 to February 2005, the institution asserted that the senior psychologist was able to ducat the majority of inmates scheduled for appointments.

In response to third problem, Folsom reported that a QIT was chartered on 11/3/04 to address mental health referrals for inmates returning from court with drastically altered case factors. A memorandum was issued by the Associate Warden with modifications to the initial housing review form that required the questioning of inmates returning from court on any revisions to their sentences or legal status that might have occurred. This new form reportedly was put into effect on 3/22/05. A number of documents supporting the described responses were attached to the Folsom follow-up report.

Findings: This inmate's suicide did not appear to have been foreseeable because he failed to communicate suicidal thoughts or intent to staff. The inmate's bus screening on his entry to Folsom indicated that he had been treated for mental illness earlier, but he was then feeling well. The inmate's death, however, might have been prevented if he had received a more comprehensive screening when placed in the administrative segregation unit. His records indicated the inmate had not been involved in the MHSDS since early 2003. Policy required the administration of a mental health screening for inmates placed in administrative segregation who were not on the MHSDS caseload and had not received a screening within the previous year. Finally, while rescue breathing was begun while the inmate was transported to the Folsom clinic, CPR was not initiated until after the inmate's arrival at the clinic.

18. Inmate H49594

Brief History: This inmate was a 35-year-old Hispanic male who completed suicide at California Men's Colony (CMC) on 8/4/04. He was single-celled in the Transitional Living Unit (TLU) in CMC-East where he completed suicide by hanging. The inmate was treated at the EOP level of care at the time of his death. The inmate was admitted to the CDC system via the RJD reception center on 9/24/92.

According to institutional records, a correctional officer conducting a security check in the TLU at approximately 11:13pm observed the inmate hanging from a noose made from a bed sheet and tied to the steel mesh on the inside of the cell door window. The inmate was hanging with his face and upper torso facing the cell door, his head

approximately seven inches below the food port and his feet extended behind him towards the center of the cell. The officer called the control booth and requested an emergency transport vehicle. At approximately 11:14pm, the control booth contacted the fire department and requested the vehicle. The sergeant and an additional officer responded to the emergency, but the cell door could be opened only a few inches. The officer retrieved the cut-down tool and the sergeant reached into the cell, cut the sheet above the inmate's head and removed the noose from the inmate's neck. The inmate was taken from the cell, and CPR was initiated by the sergeant and officer. The incident report noted that the sergeant and a registered nurse provided compressions and ventilation. At 11:17pm, the emergency transport vehicle arrived. The fire department continued to perform CPR on route to the emergency room. The transport vehicle arrived at the emergency room at approximately 11:24pm and life-saving measures were continued without success. A physician pronounced the inmate dead at 11:59pm.

An Autopsy Report dated 8/5/04 indicated the cause of death as asphyxia by hanging. The postmortem toxicology screen found that the inmate had a blood level of 219mg/mL of mirtazapine, which was above the affective range of five to 90mg/mL and below the potentially toxic range of 300mg/mL or more. The report also found multiple superficial incised wounds on both of the inmate's forearms. The Suicide Report noted that the inmate had written a number of words and letters in blood on the walls of his cell, including "pride," "respect," "loyalty," "CDC" and possibly "M", which may have explained the superficial lacerations on his forearms.

The inmate had a history of minor arrests for public drunkenness, but this appeared to be the inmate's first incarceration in CDC. The inmate was serving a sentence of 28 years to life on charges of murder in the first degree and assault with a firearm. His conviction grew out of an incident in which he shot his supervisor and killed an assistant supervisor at his place of employment. According to the records, the inmate stated to police that he had been carrying a weapon to his job for two days, waiting for an opportunity to kill his supervisor and assistant supervisor because they were "harassing him." The inmate reportedly told witnesses he would shoot at the police so they would kill him as a "suicide by cop" death.

The inmate reported that he had a history of alcohol use, beginning at approximately six years of age, and of aggressive and violent behavior when intoxicated. He also reported a history of methamphetamine use, starting at around age 18, and admitted to using PCP. The inmate had been physically abused by both parents and had a positive family history for mental illness. The inmate gave a different mental health history, along with his drug and alcohol history, to different examiners. He reported having mental health problems as an adolescent, which included talking to himself, experiencing racing thoughts and hearing "God's voice"; he also reported being suicidal when he was ten. The inmate claimed he heard voices before the instant offense and, in a different evaluation, indicated that he had attempted suicide 20 times. The inmate indicated that he joined a street gang in high school. He claimed that he left the gang prior to the instant offense but that, while a member of the gang, he carried a gun and participated in drive-by shootings.

In January 1992, while in a detention facility prior to his incarceration in CDC, the inmate was diagnosed with a Paranoid Delusional Disorder; that diagnosis was changed to Atypical Psychosis versus Malingering in March 1992. After his admission to CDC, the inmate was diagnosed at RJD with Undifferentiated Schizophrenia. In addition to Schizophrenia, the inmate's medical records reflect a number of other diagnoses, including Schizoaffective Disorder, Malingering and Methamphetamine Dependence. The inmate was treated most consistently with Paxil, but his medication regimen had included Olanzapine, Seroquel, Benadryl, Depakote, Pamelor, Elavil, Trilafon, Desyrel, Navane, Lithium and Remeron. The inmate's most recent Keyhea order was dated 1/6/04, with an expiration date of 7/4/04.

The inmate was treated primarily at the EOP level of care. He was, however, transferred to the 3CMS program for a brief time and returned to the EOP level of care on 2/5/02. His symptoms at the time included depression, paranoid and grandiose delusions, suicidal ideation, suicide attempts and other self-injurious behaviors. On 4/15/02, the inmate was transferred to ASH, where he remained until 11/1/02. He was discharged from ASH to CMC-East and placed initially in the locked observation unit (LOU), where he reported hallucinations, racing thoughts and mood lability, as well as flashbacks from childhood involving abuse by his father, mother and siblings. Staff questioned whether his psychotic symptoms were "real," given that he had been able to function well in the therapeutic milieu at ASH.

A psychological evaluation, performed in April 2003, provided diagnoses of Adjustment Disorder with depressed mood, Methamphetamine dependence, Alcohol dependence, and Mixed Personality Disorder with antisocial, borderline and paranoid features and a GAF score of 50. As part of this evaluation, psychological testing concluded that the inmate did not show elevated scales consistent with his reported symptoms of psychosis. The evaluation recommended that the inmate be maintained at the EOP level of care, but indicated that he would be appropriate for 3CMS care "when his risk for self harm decreases."

The inmate did not remain stable and was admitted to different MHCB units on six occasions, all related to suicidal ideation, suicide attempts and self-injurious behaviors. Specifically, he was admitted to MHCB units in CSP/Corcoran in March 2003 because he cut his arm with a razor; in CSP/Solano in August for lacerating his arm and in September 2003 for suicidal ideation; in CSATF in February 2004 for suicidal ideations; and in PBSP in July 2004 because of lacerations to his neck. The Discharge Summary from PBSP indicated a diagnosis of Schizophrenia Paranoid Type, chronic, found the inmate improved with no overt delusions or hallucinations and indicated that he was "not suicidal." The inmate was discharged at that time on Depakote and Seroquel.

On his return to CMC on 7/27/04, the inmate was housed in the LOU for five-day follow-up and subsequently transferred to the TLU on 7/28/04, where follow-up continued. During the course of the follow-up, the inmate's mental condition deteriorated. He was seen in an IDTT meeting on 7/29/04 and found to have delusions, but no suicidal ideation. The following day, the treatment team noted that the inmate had continued to

have delusions and auditory hallucinations. A decision was made to refer him back to ASH and to continue housing him in the TLU until transfer. The inmate's last mental health contact on 8/4/04 reported a continued increase in auditory hallucinations and sleep disturbances. There was no documentation to indicate that a suicide risk assessment was performed during this inmate's stay at CMC after his return from ASH, despite his deteriorating condition. A review of the records indicated that the inmate's referral to DMH was not completed prior to his suicide on 8/4/04. The inmate appeared to be compliant with his medications of Lithium, Seroquel and Remeron. It was, however, unclear from the records whether there had been a renewal application of the inmate's Keyhea order, which was scheduled to expire on 7/4/04.

The inmate's Suicide Report, dated 11/12/04, identified four problems and recommended corrective actions as follows:

Problem 1: The inmate was inappropriately housed in the TLU at CMC after his discharge from a MHCB unit. According to MHSDS program guides, EOP inmates discharged from a MHCB unit or an OHU must be housed in a designated EOP unit and offered therapeutic activities.

Recommendation: The suicide report recommended that CMC develop a local policy signed by the warden and health care manager, indicating that EOP inmates will be housed and treated in accordance with the MHSDS program guides.

Problem 2: The inmate received five-day follow-up in the LOU and TLU at CMC after his discharge from a MHCB unit. According to CDC suicide prevention policy, contained in HCSD memo 03-113 dated 7/14/03, five-day post-MHCB follow-up is to be conducted in an inmate's normal housing unit in order to facilitate the transition back to regular housing. If possible, the primary case manager should conduct the follow-up contacts.

Recommendation: CMC should develop a local policy signed by the warden and the health care manager, requiring five-day follow-up to be conducted in an inmate's regular housing unit pursuant to departmental policy.

Problem 3: There was no discharge summary from the inmate's July 2004 MHCB admission at PBSP. According to program guides, discharge summaries must always accompany an inmate on return to the sending institution.

Recommendation: PBSP should conduct an inquiry to determine the extent of this problem and provide evidence of compliance with program guide requirements.

Problem 4: There was no physician follow-up to abnormal laboratory results from the inmate's February 2004 MHCB admission at CSATF.

Recommendation: CSATF should develop a local operating procedure clarifying the responsibility of the physician or psychiatrist to follow-up abnormal findings resulting from a MHCB admission physical prior to transferring the inmate to another institution.

In response to the Suicide Report, the warden and health care manager from CMC submitted a follow-up report on the institution's efforts to implement the recommendations included in the Suicide Report on 4/18/05. CMC indicated that it was in the process of verifying that its policies were in accordance with MHSDS program guidelines, including those related to the TLU and EOP guidelines for therapeutic hours in the TLU. No corrective action follow-up reports on the Suicide Report's recommendations for PBSP and CSATF were provided.

Plaintiffs' counsel submitted additional information from an inmate who claimed to have observed custody staff while they responded to the discovery of the deceased inmate. The information was provided to "aid investigators in their efforts to determine whether this death was preventable and whether responding staff acted properly in handling the incident." Plaintiffs' counsel reported the inmate as stating that the deceased was discovered by a MTA, who attempted to speak with him for approximately ten minutes before notifying custody staff. The observing inmate further alleged that a sergeant performed three sets of chest compressions over another ten-minute period while "cracking jokes with on-looking officers," resulting in a 30-minute delay between the discovery of the inmate and the arrival of an ambulance. The observing inmate also claimed that he was harassed and threatened by both clinical and custody staff. Plaintiffs' counsel requested "specific action" to ensure that the inmate did not suffer retaliation.

Findings: This inmate's death appeared to have been both foreseeable and preventable. The inmate was placed inappropriately in the LOU and subsequently in the TLU, where his mental condition continued to deteriorate. While the inmate was seen daily by a treatment team, he received no other therapeutic services consistent with his EOP level of care. Although he did not report imminent thoughts of harming himself, the inmate had a history of suicidal ideation, suicidal behaviors and self-injurious behaviors when his condition deteriorated in the past. No SRA, which would have required an assessment of both static and dynamic suicide risk factors, was conducted after the inmate's arrival at CMC. Furthermore, clinical staff decided to retain the inmate in the TLU and refer him back to ASH, rather than to a MHCB unit, a referral that might have been accomplished within 24 hours. In contrast, the referral to ASH was not completed prior to the inmate's death. Lastly, while the incident reports and Suicide Report indicated that the inmate was removed from his cell and CPR was initiated promptly, the letter from plaintiffs' counsel raised questions about the timeliness of these actions and the appropriateness of staff behavior. No documents indicating any review or follow-up to the issues raised by plaintiffs' counsel were provided.

19. Inmate V48794

Brief History: This inmate was a 38-year-old Hispanic male who completed suicide by hanging at North Kern State Prison (NKSP) on 9/13/04. He was single-celled at the time of his death due to reported safety concerns, but he was not in protective custody. The inmate was in general population and was not involved in the MHSDS. He was admitted for his first term in CDC on 8/27/04.

A correctional officer conducting a routine security check discovered the inmate sitting on the floor between the toilet and the lower bunk at approximately 5:28am. The inmate had a tee-shirt covering his eyes and a sock in his mouth; a sheet, tied around his neck but not attached to anything, was assumed to have been previously attached to the upper bunk. The inmate had dried blood on his face and there was blood on the wall between the toilet and lower bunk. A MTA at the scene began CPR when the inmate was removed from his cell and placed on a gurney prior to transporting him to the CTC. The inmate was subsequently taken by ambulance to the hospital where he was pronounced dead at approximately 6:33am.

An autopsy reported the cause of the inmate's death as "asphyxia" due to ligature strangulation. The postmortem toxicology screen indicated no presence of illegal drugs or alcohol. The Suicide Report stated that the inmate suffered bruises from assaults that had occurred in the county jail and after his transfer to the reception center at NKSP, which were not noted in the Autopsy Report.

According to the record, the inmate received an initial health screening on 8/27/04, which indicated that he had a blackened left eye and bilateral redness secondary to an altercation that occurred at the county jail five days prior to his admission to CDC. He was receiving antiviral medications, as he had been diagnosed HIV-positive in 1995. His medications were listed on a Confidential Medical/Mental Health Transfer Summary from the country jail, as was his allergy to penicillin. The inmate received a mental health screening on 8/31/04 and was cleared for general population placement. A developmental disability screening on that same date indicated normal cognitive functioning.

The inmate had a criminal history that included two convictions for disorderly conduct and an arrest warrant from 9/7/01 for a violation of the health and safety code. The inmate was arrested in February 2002 for inflicting injury to a cohabitant and in April 2002 for possession of a narcotic controlled substance. He was placed on probation for one year. He subsequently violated his probation and, in August 2004, was sentenced to 16 months in prison. The inmate was incarcerated in the reception center at NKSP for 17 days prior to his completed suicide.

Interviews with the inmate's family did not reveal any mental health history.

After his incarceration in CDC, the inmate had seven housing changes which appeared to be related to conflicts with other inmates and to the inmate's safety issues; the inmate was concerned that his homosexuality put him at risk of violence and he was afraid that other inmates might believe he was a child molester. Two days prior to the inmate's death, his last cellmate assaulted him. The inmate was housed alone after this assault.

The inmate left two suicide notes, which were described in the Suicide Report as "poorly written." The inmate referred in his notes to being gay and his fear that he could be

killed because he was gay. He requested that his father be called to talk to his mother and that his father be told that the inmate loved him.

The Suicide Report indicated that all policies and procedures were followed. There were no recommendations for corrective actions.

Findings: This inmate's completed suicide did not appear to have been foreseeable or preventable. The inmate had no history of mental illness or treatment for mental illness. He also had no history of suicidal ideation or behaviors and did not indicate to staff any intention to harm himself. The difficulties he encountered during his brief incarceration in CDC and the multiple moves related to his safety issues were matters of concern, but the inmate was not placed in protective custody because he did not identify any specific enemies.

20. Inmate B39303

Brief History: This inmate was a 59-year-old Caucasian male who committed suicide by hanging at Pelican Bay State Prison (PBSP) on 10/15/04. He was double-celled and was not receiving mental health services at the time of his death. The inmate was admitted to CDC on 11/21/90 with a life sentence plus six years and was transferred to PBSP on 1/29/91, where he remained until his death.

At approximately 2:35pm on 10/15/04, the inmate's cellmate returned from the exercise yard and reported to custody staff that he discovered the inmate dead in their cell. An ISD investigation reported that the deceased inmate had told his cellmate he would beat him in getting out of prison. The cellmate told investigators that he found this strange because the deceased inmate had a life term. The cellmate reported that the cell was dark when he returned from yard; the light was out and the cell window was covered with cardboard. When he turned on the light, the cellmate found the inmate slumped forward with a sheet around his neck and the other end of the sheet tied to the upper bunk. The cellmate reported that he was able to remove the sheet from the inmate and called for help to a control booth officer. The control booth officer indicated in his report that he had released both inmates to the yard on that day, but that the inmate did not have his identification and had to return to his cell to get it. The inmate then informed the officer that he did not want to go to yard and his cell was closed. Medical staff was called when the inmate was discovered and began performing CPR. The inmate was transferred to the hospital and pronounced dead at 3:31pm.

An autopsy report, dated 10/20/04, indicated the cause of death was asphyxia due to hanging. The coroner's report made reference to "a very faint scratch on the right cheek but no other evidence of trauma to the face, and a ligature mark about the neck typical for hanging." The postmortem toxicology screen showed no evidence of alcohol or illegal drugs. The inmate left a signed suicide note with the following statement, "Would like to give all my reasons for dieing-leaving this world for better or worse-but the only thing I have wanted to for many years. And I pray for the strength to success this time."

The inmate had a long criminal justice history, beginning at approximately age 13 when he attempted to kill his stepfather in Colorado. His first incarceration in CDC occurred in 1972 for burglary and rape. Records indicated that the inmate raped a female apartment manager, returned a week later and repeated the same crime against the same victim. Courtroom testimony indicated that at least four other women had similar experiences with him. Three of the four psychiatrists who examined the inmate before trial concluded that he was responsible for his criminal acts.

The inmate entered CDC in January 1972, serving an indeterminate sentence of three years to life, but was paroled from CMC in August 1977. He returned to CDC in April 1978 on a five-year prison term for robbery and threats against a number of women. He was paroled in May 1981, but returned to CDC in July 1981, with an eight-year sentence and another second five-year concurrent sentence for the robberies and threatened rapes of two women apartment managers. The inmate was paroled in October 1985 and returned to prison in September 1986 on a parole violation related to receiving stolen property. He paroled in February 1987, returned to prison again as a parole violator in September 1988 and was paroled a last time in January 1989. On 10/2/89, the inmate confronted a female apartment manager at gunpoint and shot her through the head, killing her. The case was profiled on America's Most Wanted, and the inmate turned himself into police on 10/4/90. He received a life sentence without parole plus six years and was returned to CDC on 1/29/91.

The inmate's record indicated that he spent five years from approximately age 16 to 21 in a mental health facility in Colorado related to his attempt to kill his stepfather, but no details on his treatment there were available. The inmate was admitted to CMC-East from 1/15/77 to 1/17/77, after he cut himself superficially on his left forearm. At that time, the inmate indicated that he had come close to hanging himself a few days earlier because he was heavily indebted and fearful for his safety. He reportedly wrote a suicide note and letter, but these were not included in the documents reviewed. The discharge summary from CMC-East listed a diagnosis of Depressive Neurosis Acute in remission. In addition, the inmate had physical health problems of diabetes and glaucoma.

The inmate was seen on September 2003 by a psychologist, after he was referred for refusing his diabetes and hypertension medication. The inmate was described as polite and cooperative. He was not receiving mental health services, and an assessment by a psychologist determined that no such services were needed because the inmate had no psychiatric diagnosis. The plan was for mental health staff to follow up any self-referrals.

The inmate was admitted to the MHCB unit from 3/26-29/04, after reporting that he had attempted to suffocate himself with a plastic bag. The inmate stated repeatedly that he would continue to try to harm himself. He subsequently informed staff that he owed money on the yard and did not feel positive about his life. Despite this, he improved over the course of three days and was discharged with no suicidal/homicidal ideation. He was given a diagnosis of Anti-Social Personality Disorder and Phase of Life Problem, with a GAF score of 70. The inmate did not receive a SRA before, during or at the conclusion

of this MHCB admission. The inmate's housing location was changed upon his discharge from the MHCB unit and five--day follow-up was conducted. The inmate was responsive, friendly and cordial; he denied suicidal ideation. His sleep also improved, and he no longer had debt concerns. Overall, the inmate was determined to be clinically stable and follow-up was terminated after the fifth day.

The inmate received five RVRs during the long course of his incarceration, for refusing to obey orders, altering personal property and failing to meet work expectations. The failure to meet work expectations resulted in the inmate losing his job in the kitchen in February 2004. Prior to the inmate's death, custody staff received confidential information indicating that the inmate's life might have been in danger because of his debts. The inmate was placed in administrative segregation at that time but, after a classification hearing on 4/14/04, he was returned to general population. Staff reported that they did not believe the inmate to be in any danger after his earlier housing change, and the inmate appeared to get along well with his cellmate. He was not placed in the MHSDS.

The Suicide Report identified two problems and corrective recommendations:

Problem 1: No SRA was completed when this inmate was discharged from the MHCB unit, although the inmate was admitted for an alleged suicide attempt.
Recommendation: According to departmental policy in HCSD memo DD-113-03, dated 7/14/03, the mental health manager should ensure that all mental health staff and physicians serving as POD or MOD are trained in when and how to administer SRAs.

Problem 2: A mental health screening was not done when this inmate was admitted to the administrative segregation unit although current policy requires a mental health screening on entering the administrative segregation unit for all non-MHSDS caseload inmates who have not had a screening within the previous year.
Recommendation: The institution should establish procedures to ensure that all general population inmates receive mental health screenings within one week of entering the administrative segregation unit, if they have not had a screening in the past year. A mechanism, such as a log, was needed to track inmates determined to require a screening and an audit of the log should be conducted within two months.

In response to the Suicide Report, PBSP staff submitted a follow-up report on the corrective actions recommended following this suicide. With regard to the first problem, PBSP indicated that the referenced memo "does not require a SRA to be completed when a patient is discharged from MHCB." Related training on SRA requirements, however, was provided to mental health staff and primary care providers, and attendance sheets were attached. With regard to the second problem, staff reportedly followed a memorandum, dated 8/16/04 and entitled, "Mental Health Screening for Administration Segregation Inmates." A copy of the mental health screening log for the prior two months was submitted. The senior psych tech provided additional review, and improved procedures were developed, resulting in a reported compliance rate of 96.5 percent.

Findings: This inmate's death did not appear to have been foreseeable or preventable. The utilization of SRAs and the timeframes for confidential mental health screenings for all newly admitted administrative segregation inmates have been the subjects of discussions among the Coleman parties, and changes are anticipated in the pending revisions to the provisionally approved program guides.

21. Inmate T04981

Brief History: This inmate was a 30-year-old Hispanic male who completed suicide by hanging at California State Prison, Sacramento (CSP/Sac) on 10/21/04. The inmate was housed in administrative segregation and was receiving an EOP level of care at the time of his death. The inmate was readmitted to CDC via the reception center at NKSP on 1/8/01 and transferred to CSP/Sac on 11/4/03.

At approximately 6:33am on 10/21/04, a correctional officer delivering the morning meal banged on the deceased inmate's cell door and received no response. The officer was initially unable to locate the inmate in his cell but, by using his flashlight, was able to make out the inmate standing and facing the double bunk. The inmate was the only occupant of the cell and, on closer observation, the officer noticed that the inmate's head appeared to be secured to the top bookshelf by a piece of cloth. The officer activated his alarm, and staff responded. Upon entering the cell, staff discovered that the inmate had a cloth noose, which had been partially obscured by his hair, wrapped around his neck and tied to the bunk. The cloth was pulled from the bookshelf and the inmate lowered to the ground and handcuffed. He was then placed on a Stokes litter and transported on a rolling gurney to the emergency room, where he arrived at approximately 6:37am. Medical staff began evaluating the inmate, cut the noose from his neck and started CPR at approximately 6:39am. An ambulance was called and arrived at around 6:55am. A paramedic subsequently pronounced the inmate dead at 6:59am. A suicide note was found in the inmate's cell written in Spanish. The translation of that note read, "I am going to kill myself for no process" and "I killed myself for no process or protection." There was also a crude drawing of what appeared to be a syringe with drops or footsteps coming from an extended needle.

An autopsy conducted on 10/22/04 determined the cause of death was hanging and the method of death was suicide. The toxicology screen indicated that no alcohol was detected in the inmate's blood specimen. The report, however, found that the inmate had an elevated level of Celexa in his blood, or 290mg/mL which was above the normal range of 9 to 200mg/mL. He also had a non-elevated level of Geodon, or 0.2mg/mL with a limit noted as 4.0mg/ml.

The inmate was not a legal resident of California and appeared to have entered the United States from Mexico at the age of 14 or 15. He reportedly obtained a legitimate California identification card from the Department of Motor Vehicles based on the use of an alias. The inmate had a criminal justice history beginning with two arrests for burglary at the age of 17, with a reported stay in juvenile hall. In 1992, he was arrested for attempted robbery and kidnapping to commit robbery and committed to CYA. The incident

involved three victims, one of whom he threatened with a knife. The inmate was transferred from CYA to CDC in February 1994 and paroled in September 1995. His original CDC number was removed in September 1998. The inmate had several other arrests for driving without a license, burglary, receiving stolen property and battery, for which he received either local jail time or probation. His current incarceration grew out of an incident in which the inmate assaulted and robbed three victims in a family home and threatened to kill them with a knife. He was charged with robbery, assault with a deadly weapon not a firearm with great body injury likely, threatening a crime with intent to paralyze, forging an official seal, trespass and destroying standing timber. He was committed to PSH in January 2000 and was found incompetent to stand trial. The inmate was subsequently restored to competency and convicted in December 2000 of first-degree burglary.

The inmate entered CDC at NKSP on 1/8/01 with a nine-year sentence; part of his sentence had been served while he was evaluated and treated at PSH. This was the inmate's second CDC admission and he was assigned a new number. Based on a mental health evaluation on admission, the inmate was placed in the MHSDS at the 3CMS level of care. He was prescribed Zyprexa, consistent with his medication prescription prior to his incarceration. Evaluation and treatment records from PSH for the period from January through October 2000 were not available for review. The inmate appeared to have some language difficulties, but this was not clearly reflected in the record, which contained only a few notes indicating that a translator was used during mental health contacts with this inmate.

The inmate apparently had two self-injurious or suicidal episodes prior to his CDC incarceration, cutting his wrist in 1999 and attempting to hang himself while in custody elsewhere in 2000. He was reportedly non-compliant with medication and signed a medication refusal form on 1/13/01. He was referred by a correctional officer to the emergency room on 1/27/01 with complaints of depression and suicidal ideation. He was admitted to the MHCB unit from 1/27 to 2/1/01 with a diagnosis of depression. There was some confusion in the admission notes with the psychologist indicating that the inmate had no history of psychiatric hospitalization or suicide attempts, while other staff appeared aware of the inmate's two past suicide attempts and his nine-month stay at PSH. At the time of his discharge from the MHCB unit, the inmate continued to comply with his medication. He was subsequently readmitted to the MHCB unit from 2/14-21/01 with complaints of suicidal ideation and a belief that someone was trying to harm him. At that time, the inmate was described as "extremely paranoid," and his diagnosis was Schizoaffective Disorder, depressed type. A SRA completed on 2/15/01 indicated that the inmate was at suicide level "0 = no ideation no plan no intent." The inmate was prescribed Zyprexa, Risperdal and Zoloft, but he continued to refuse medications and was discharged from the MHCB unit without any psychotropic medication. The inmate requested a transfer to DMH, but he remained at NKSP at an EOP level of care. Over time, the inmate had a number of diagnoses including Paranoid Schizophrenia and Psychotic Disorder NOS.

The inmate was transferred on 3/13/01 to RJD, where he continued to refuse his medications, experienced depressive symptoms and paranoia and requested a transfer to DMH. His level of care was changed from EOP to 3CMS in July 2001, with the notation that the inmate "refuses EOP." The inmate's level of care was subsequently changed back to EOP, then to 3CMS in July and to EOP again in August 2001. Notes by mental health staff during this time indicated that the inmate had a GAF score of 45 to 50, complained of suicide ideation and wanted to stay in the EOP program but was refusing to take his medication or participate in programming. A SRA on 7/19/01 indicated that the inmate was at moderate risk for suicide, one day after an IDTT meeting recommended referring the inmate to the 3CMS program because of his non-participation in the EOP program. A psychologist note on 11/7/01 reported the inmate as saying, "I feel like hurting myself- I'm depressed." The inmate went on to indicate that he wanted a single cell and asked whether he had to "go to administrative segregation or the infirmary" to get one.

The inmate received a MH-2 on 1/3/02, which reviewed the inmate's history of being placed alternately at 3CMS and EOP levels of care and concluded that he should be placed at the 3CMS level of care. The inmate remained at that level of care until March 2002, when he was admitted to the MHCB unit for suicidal ideation. He remained in the MHCB unit from 3/24 to 4/2/02, when he was returned to the 3CMS level of care. The inmate threatened suicide in June 2002 and was admitted to the MHCB unit in July 2002 for a two-week period. During that admission, he was medicated involuntarily and discharged to the EOP level of care although a referral to DMH was considered.

Between September 2002 and April 2003, the inmate was transferred to CCI, CMC and PVSP. From 4/16 to 4/28/03, he was housed in the MHCB unit at PVSP, reporting suicidal ideation and requesting a transfer to PSH. He was discharged to CMC and housed in May in the LOU, secondary to self-reported suicidal ideation if he were to be returned to administrative segregation. The inmate was subsequently treated in the MHCB unit at ISP and, in June 2003, transferred to the APP at CMF. He was discharged to the EOP program at CMF in August 2003. He promptly became non-compliant with his medications and his symptoms of paranoia, depression and suicidal ideation returned. The inmate was readmitted to the DMH/APP from 9/2 through 10/27/03. A Keyhea order was instituted on 10/9/03 based on the inmate presenting a danger to others.

The inmate was transferred to CSP/Sac in November 2003. He was initially placed in the OHU because of suicidal ideation and subsequently transferred to the EOP program. The inmate continued to have depressive symptoms as well as cognitive symptoms, including problems with memory and reported confusion. He assaulted an inmate in the EOP program and was placed in administrative segregation on 1/22/04, where he was reportedly depressed and isolated, but with no suicidal ideation. The inmate received a SHU term in April 2004 based on the assault charge and remained at the EOP level of care in administrative segregation. The SHU term expired before the inmate could be transferred to a PSU, but he remained in administrative segregation because of enemy concerns in the EOP program. Notes indicated that the inmate was depressed and continued to threaten to harm himself, if not placed in a hospital. The inmate continued

to refuse anti-depressant medications, although he was under a Keyhea order for anti-psychotic medications. On 9/16/04, the inmate received a second SHU term stemming from charges of sexual battery on staff.

Between September and November 2004, the inmate requested to be transferred to ASH or another DMH facility because of his depression and suicidal ideation; he also made requests for single-cell status. Approximately eight days after the sexual battery, the inmate's case manager noted that the inmate had attempted to kiss a female correctional officer. The inmate again reported suicidal ideation, but he was placed in a strip-cell in administrative segregation. The inmate reportedly denied suicidal ideation when told of the plan to strip his cell and was informed that he would have his sheets and other property returned to him on the following day. The Suicide Report references this interaction and states "since the clinician did not believe the inmate was in any real danger the only rational for this decision appeared to be to punish the inmate for making suicidal threats." The records demonstrated that SRAs were not routinely conducted when this inmate articulated suicidal ideation or intent.

The inmate's Keyhea order was renewed on 3/24/04, noting that the inmate was a danger to others. The inmate's MARs for 2004 indicated that he was prescribed Geodon and Benedryl. Celexa was also added to this regimen in July 2004. The inmate's last MH-2 dated 9/29/04, continued the diagnosis of Schizophrenia, but indicated that the inmate threatened to harm himself "if he doesn't get his way" and described the inmate as having "unprovoked assaultive behavior." His condition, however, was noted as improved.

A progress note by a psychologist dated 10/8/04 implied that the inmate had been considered for transfer to a DMH program and needed to cooperate with the treatment program at CSP/Sac "if such a request is to be expedited." The psychologist note indicated that the inmate had "strong symptoms of serious mental illness," continued to request hospitalization and talked "constantly…about suicidal ideation." The inmate subsequently reported to the same psychologist on 10/13/04 that he did not have suicidal ideation. On 10/15/04, however, the inmate reported to a different psychologist that, although he did not have suicidal ideation, he wanted to be hospitalized for the remainder of his term or for life because of his depression. According to the psychologist's note on 10/15/04, the inmate stated he would "bite hands to cause bleeding." When the psychologist saw him on 10/20/04, the inmate indicated that he would cut or hang himself, but he did not have a way to do it. There was no documentation in the records reviewed that SRAs were completed by clinicians at CSP/Sac in response to the inmate's reports of suicidal ideation.

The inmate had 11 RVRs for mutual combat, battery on another inmate, disrespect towards staff (masturbation) and two for sexual battery on staff. The inmate had a two-week stay in administrative segregation in November 2001 based on mutual combat at RJD, a two-month stay at the California Correctional Institution (CCI) SHU from September through November 2002 for sexual battery on staff, a longer stay in the CMC EOP administrative segregation unit from November 2002 to March 2003 and a stay in the EOP administrative segregation unit at CSP/Sac from January 2004 until the time of

his death. The inmate was single-celled and on walk-alone status during his last administrative segregation stay. The inmate had been endorsed for the PSU at CSP/Sac on 10/19/04, two days prior to his death. The inmate also had an INS hold placed on him in February 2001.

The Suicide Report noted that this inmate was sentenced to prison, rather than found insane or remanded to a state hospital, and concluded that, "unfortunately there is really no place within the current CDC MHSDS for an inmate patient such as this who probably required long term chronic inpatient care." There was no indication in the inmate's records that he had been referred at any time to an intermediate care program in DMH for a longer length of stay based on his chronic and severe mental illness.

The Suicide Report identified three problems along with recommended corrective actions, as follows:

Problem 1: It is not CDC policy to "strip" an inmate's cell to prevent self harm. If there is sufficient concern about the inmate's safety, he should be referred to a MHCB unit.

Recommendation: The institution should initiate corrective disciplinary action for the psychologist and psychiatrist who colluded in placing the inmate in a strip cell on September 24, 2004.

Problem 2: No SRA was conducted at CSP/Sac either when the inmate was placed in the OHU for suicidal thoughts or by general population, EOP or administrative segregation EOP clinical staff in response to the inmate's numerous suicidal threats. Furthermore, the inmate was never referred to a higher level of care, even though he became more depressed about receiving an extended SHU term and made clear statements that he wanted to hang or cut himself.

Recommendation: CSP/Sac should provide training to all clinical staff on the use of SRAs, determinations of suicide risk and referrals to higher levels of care. This training should be more detailed than the training on the suicide policy and SRAs provided on 10/29/04 at CSP/Sac. It was also recommended that HCSD provide training on SRAs.

Problem 3: Mental health staff never used a translator, even though this inmate clearly had limited facility with English. In addition, there was no evidence that cultural differences were considered in the evaluation and treatment of the inmate.

Recommendation: Training should be conducted with all clinical staff on the use of translators and on effectively addressing cultural issues in mental health assessments and treatment.

In response to the Suicide Report, CSP/Sac prepared a follow-up report on the corrective action plan for this inmate. With respect to the first problem, the follow-up report indicated that the clinicians responsible for placing the inmate in a strip cell were issued a "counseling record" on 3/2/05 and provided with CSP/Sac's current suicide prevention policy. In response to the second problem, training on suicide prevention was provided

by the institution in October/November 2004, while HCSD conducted training for suicide risk management in April 2005. The third problem reportedly was addressed by the provision of mandatory cultural diversity training in April 2005. Sign-in sheets for all of the aforementioned training were provided.

Plaintiffs' counsel submitted a letter stating they were "heartened by the improved quality of recent Executive Suicide Reports." They then raised several objections to the recommendations included in the Suicide report, including the absence of attention to the failure to initiate CPR more promptly, administer SRAs to this inmate or refer him to DMH. The letter further asserted that, while the training provided may have been appropriate to address the failure to administer SRAs, the failure to refer to DMH required "special training aimed at clinicians working in the CSP/Sac administrative segregation units." Counsel also expressed concern over the failure to address the inmate's excessively long stay in the administrative segregation EOP unit despite his apparent decompensation. Further, counsel pointed out that the Suicide Report did not address the IDTT's failure to assess in advance whether the inmate's continued placement in administrative segregation would result in decompensation. Plaintiffs' counsel concluded by commending CSP/Sac for its past suspension of SHU terms when the need for mental health treatment made it appropriate to do so, but suggested that this case raised concerns in this regard.

Findings: This inmate's suicide appeared to be foreseeable and preventable. The inmate made numerous reports of suicidal ideation, but clinicians at CSP/Sac apparently interpreted his reports as attempts to avoid placement in administrative segregation, obtain treatment in a psychiatric hospital or other higher levels of care or single-cell housing. SRAs were not completed for the inmate; no in-depth evaluation of the inmate's statements was made; nor was any longitudinal evaluation of the inmate's statements conducted. At the same time, the inmate was maintained on a Keyhea order for involuntary medication as a "danger to others." There appeared to be some confusion among staff at different facilities about what medications were covered by the Keyhea order until July 2004, when the inmate was placed on both anti-psychotic and anti-depressant medications.

Despite numerous MHCB, OHU and DMH/APP admissions and the inmate's extended stay at PSH prior to his CDC incarceration (the records from which were not obtained), clinicians apparently never considered sending the inmate to an intermediate level of inpatient care. The inmate's psychotic symptoms were described as "vague," but he was also said to have "extreme paranoia," depression and suicidal ideation. The inmate's "unprovoked attacks" on others apparently were not considered to be an aspect of his mental illness that required more aggressive treatment and referral to a higher level of care, but only as a justification for a Keyhea order for involuntary medication. Although this inmate expressed suicidal ideation, which waxed and waned over time, and a desire or need to be placed in a psychiatric hospital, the staff at CSP/Sac did not provide the level of assessment and coordinated treatment of the mental health and custody issues required by an inmate in need of involuntary treatment for severe and persistent mental illness. Lastly, the failure of the first responders to initiate CPR led to an approximately

six-minute delay in the application of CPR and may have been a preventable potential contributor to this inmate's death.

22. Inmate E66294
Brief History: This inmate was a 32-year-old African American male who completed suicide by hanging at California State Prison, Sacramento (CSP/Sac) on 11/7/04. The inmate was single-celled in administrative segregation and was not receiving any mental health services at the time of his death. The inmate had been in CDC custody since 11/24/92 with a sentence of life without parole.

At approximately 4:00pm on 11/7/04, a correctional officer making the count discovered the inmate hanging by a sheet that was braided and threaded through the air vent in his cell. The officer activated his alarm and several officers, along with a sergeant, responded to the area. The control booth officer, however, could not open the cell because paperback books were jammed under the door. When the books were removed, the officers were able to pull the cell door open. An officer first entered the cell with a shield and, after he received no response from the inmate, other officers entered, cut the sheet from the air vent and placed the inmate on a Stokes Liter and gurney. At approximately 4:05pm, a MTA and the sergeant began CPR on the inmate, who was then taken to the emergency room. CPR was administered to the inmate during transport and was continued by medical staff in the emergency room. Fire department paramedics attempted additional life-saving efforts when they arrived, but were unsuccessful. The inmate was pronounced dead at 4:24pm.

An autopsy conducted on 11/8/04 determined that the cause of death was asphyxia by hanging. The postmortem toxicology screen found no evidence of alcohol, medications, illegal drugs or caffeine. No suicide note was discovered.

The inmate's first involvement with the criminal justice system apparently occurred at the age of 13, when he was convicted of robbery and assault with a deadly weapon; he was housed in juvenile hall and placed in various community probation programs. Shortly after he turned 18, the inmate had a number of arrests related to his membership in the CRIP gang. His involvement with CDC began in August 1990 with a conviction for second-degree robbery, which resulted in a three-year sentence. The inmate escaped in February 1992 and was rearrested and charged with escape from CDC, grand theft auto and a first-degree murder he committed after his escape. The inmate received a life sentence without the possibility of parole.

The inmate had been in administrative segregation since January 2004. During his incarceration, he had received five SHU terms and 23 disciplinary infractions for serious rules violations, including assaults, attempted murder, the manufacture of alcohol and other violations that resulted in a classification score of 385 points. The inmate's most recent RVR involved the attempted murder of another inmate. This incident had been referred to the district attorney's office, but was declined. As a result, the inmate was cleared for possible transfer to a fifth SHU term.

The inmate had not received mental health services during his incarceration as an adult, although there was a reference in the records to his having received some group therapy as an adolescent. On the day of the inmate's suicide, custody staff referred the inmate for a mental health evaluation because he had stopped talking to staff for a week and had refused breakfast, lunch and yard that day. This inmate was described as polite to staff, quiet and "a righteous convict," who did not ask for anything. The inmate was also noted to have spent much of his time writing rap songs, reading and corresponding with family.

The records indicated that the inmate was seen for a mental health screening on 9/9/04, when the district attorney declined to file charges. The clinician who saw him reported "no mental health concerns." The inmate was also seen by the psych tech on daily rounds in administrative segregation. There was no indication that the psych tech noticed any of the changes in the inmate's behavior that were noted by the administrative segregation custody staff. There was no information in the documents clarifying the psych tech's observations on daily rounds.

In a letter dated 6/21/05, plaintiffs' counsel expressed their concerns that this inmate had "suddenly becoming mute and reportedly just stared ahead when officers spoke to him." Plaintiffs' counsel wanted defendants to provide additional training for custody staff and psych techs to recognize early signs of mental health decompensation for inmates housed in administrative segregation units. Counsel also suggested that defendants establish clear referral standards.

The Suicide Report concluded that all policies and procedures appeared to have been followed and accepted standards of care were met. No corrective actions were recommended.

Findings: This inmate's suicide did not appear to be foreseeable or preventable based on the documents provided and reviewed. There was some question about the absence of documentation of the psych tech's observations in administrative segregation during the last week of this inmate's life, when he exhibited a number of behavior changes. The suicide also raised the issue of the timeliness of referrals of inmates undergoing behavioral changes in administrative segregation.

23. Inmate K74084

Brief History: This inmate was a 30-year-old Caucasian male who completed suicide by hanging at Mule Creek State Prison (MCSP) on 11/12/04. At the time of his death, the inmate was being treated at a 3CMS level of care and was receiving five-day suicide prevention follow-up in the administrative segregation unit after being discharged from the MHCB unit. This inmate had been admitted to CDC via the reception center at NKSP on 11/12/97, with a 12-year sentence.

At approximately 10:50pm on 11/12/04, an administrative segregation officer was making welfare checks and observed the inmate sitting on the lower bunk with his back against the wall and a noose around his neck that was tied to the upper bunk. The officer

notified staff of a medical emergency and was brought a cut-down tool. The inmate did not respond to the officer's attempts to get his attention by knocking on the door. On entering the cell, the officer cut the inmate down. According to the officer's report, a MTA immediately began CPR on the inmate. The inmate was placed on a Stokes Liter and medical cart and transported to the CTC emergency room. He was subsequently moved to the hospital. A correctional officer assigned to hospital coverage noted that the inmate was admitted to the hospital at approximately 1:28am for attempted suicide. An incident report indicated that at approximately 3:51am a Code Blue was called for this inmate because of respiratory failure. The inmate was removed from the ventilator at approximately 6:00am and was pronounced dead at 7:07am by a physician at the hospital.

An autopsy conducted on 11/15/04 indicated the cause of death was asphyxiation due to strangulation. A postmortem toxicology screen detected Acetaminophen, but found no evidence of alcohol or illegal drugs in the specimen. The report noted that the inmate had regained a pulse and was intubated prior to his transfer to the hospital.

Records indicated that this was the inmate's first CDC incarceration. He entered CRC on 12/30/97 on charges of lewd acts with a child under 14 with force and violence and first-degree burglary, stemming from an incident in which he attempted to rape a seven-year-old girl in her bedroom. The inmate received an eight-year prison term for the sex offense and a consecutive four-year term for first-degree burglary. At the time of his suicide, the inmate had been in CDC for seven years.

The inmate did not receive mental health services until November 2001 when he referred himself for an assessment while at Calipatria State Prison (CAL). A mental health evaluation was conducted by a psych tech who noted vegetative signs of depression, but the inmate denied any history of suicidal behavior and suicidal ideation. Based on a subsequent evaluation in December 2001, the inmate was diagnosed with Anxiety Disorder NOS with Depression and was placed at the 3CMS level of care. He was also treated with Paxil and Benadryl. His Paxil was subsequently changed to Effexor because the inmate complained that he felt worse with Paxil. The inmate also reported his concern that he might be transferred to general population housing in another facility. The inmate was seen in January 2002 by a psychiatrist and requested that his medication be discontinued because he felt worse. The inmate also reported that he had been endorsed to MCSP. His medication was changed to Trazodone because he was not sleeping well.

The inmate was transferred to MCSP and received a mental health evaluation or MH-4 on 2/4/02. During this evaluation, the inmate reported his concerns about housing, particularly gym housing, and indicated that he wanted help from mental health in obtaining a single cell. He was subsequently diagnosed with Adjustment Disorder with Mixed Anxiety and Depressed Mood, Narcissistic Personality Disorder and Antisocial Personality Traits, with a GAF score of 68. A suicide risk assessment completed at that time noted his risk factor as "none." The inmate remained at the 3CMS level of care attributable to medical necessity. At that time, the inmate was housed on a SNY. In February 2002, the inmate's medication was discontinued at his request. Although the

inmate was supposed to remain on the MHSDS caseload for one year following the discontinuation of his medication, he was removed from the 3CMS caseload.

By January 2004, vegetative signs of depression had begun to recur. The inmate was demonstrating poor job performance and attendance and was referred by staff for a mental health evaluation. He initially saw a psych social worker but, in February 2004, saw both a psychiatrist and psychologist. The inmate also had an IDTT meeting, at which he was diagnosed with Generalized Anxiety Disorder and Major Depressive Disorder. He was placed on Prozac and returned to the MHSDS at the 3CMS level of care due to medical necessity. In addition to other depressive symptoms, his primary complaints were inability to sleep and "skin conditions." His Prozac was subsequently discontinued and Vistaril was prescribed in March 2004. Although the inmate's sleep improved, he continued to report being "stressed" and, in May 2004, his Vistaril was discontinued, despite his continued complaints of sleep difficulties and anxiety.

The inmate continued to have 90-day contacts with a case manager. On 9/30/04, the inmate indicated to his CCM that he was nervous and stressed about the possibly of being moved to gym housing. He said that he would figure "something out" so he did not have to go to the gym. The CCM noted no improvement in the inmate's condition since July 2004. He was found to have minimal current suicide and violence risks and was cleared to live with a compatible cellmate.

On 11/9/04, the inmate was seen by a psychiatrist who found that he was dysphoric and frustrated, but otherwise within normal limits; the psychiatrist noted that the inmate "denies suicidal ideation/plan." The inmate's diagnosis, at this time, was Adjustment Disorder NOS Rule Out Mood Disorder NOS. Remeron was prescribed for the first time, with a plan for follow-up in 90 days. The psychiatrist also noted that the inmate had made a statement on 11/20/01, "which indicated he may have been familiar with DSM criteria for mental health." On that same day, the inmate was seen by a CCM who indicated that the inmate had been moved to administrative segregation because he "does not want to go to gym" and "can't stand dayroom floor." The CCM noted that the inmate was nauseous and vomited and said he was "petrified of gym." The inmate was referred to mental health later that day by a psych tech and a custody officer when he repeated his fear of going to the gym stating, "They want me to move to an E-bed and I can't do it." He was further reported to have said, "CDC's putting me in a corner with no way out." The inmate was seen by a psychologist who noted his history and indicted that he currently "reports suicidal ideation, without clear, current and active plan," but with limited insight and judgment. The plan was to consult with psychiatry, return the inmate to his current cell location and assess him clinically each day.

The inmate was seen the next day in an IDTT meeting on 11/10/04, after his placement in administrative segregation. The IDTT noted that the inmate was in administrative segregation for "refusing assigned housing." Medications ordered on 11/9/04 were, according to the record, "N/A yet." A SRA was completed by the psychiatrist. Although the assessment did note that the inmate was Caucasian as an ethnicity risk factor, it did not make any reference to the inmate's history as a sex offender; the only protective

factor listed was the inmate's family support. According to the assessment, the inmate had affective instability, felt hopeless, had suicidal ideation and was agitated and fearful for his safety. There was a notation on the SRA indicating that the inmate was very angry and frustrated about being housed in a dayroom. Despite this, the estimate of risk was said to be "absent or trace."

Later that evening, the inmate inflicted a superficial laceration on his left arm and was described by treating medical staff as having severe depression, with no safety contract. The on-call psychiatrist placed him in the body cavity search cell on one-to-one suicide precautions because no MHCB beds were available in the CTC. The following morning, the inmate was seen in this holding cell by an on-call contract psychiatrist, but the records indicated that the inmate's UHR was not available. The psychiatric note indicated that the inmate had a "litany of complaints" and noted the inmate's objections to going to an E-bed. The inmate was described as alert, oriented times three, oppositional and calm, but calculating and agitated. His mood was described as angry and hostile. The psychiatrist indicated that the inmate "claims he has suicidal ideation." Despite this, the psychiatrist diagnosed Adjustment Disorder, Rule Out Malingering, and stated "no recent stressor or precipitant noted." The plan was to return the inmate to his living unit, continue his prescription for Remeron, adding Seroquel to his regimen, and follow up in one to two weeks.

A SRA was completed on 11/11/04 and, like the previous assessment, was incomplete in that it did not note the inmate's sex offense. The assessment did record the inmate's ethnicity, suicide ideation/threats, previous suicide attempts and the fact that this was his first prison term. It also noted the inmate's recent suicidal ideation, current insomnia and poor appetite, but no protective factors were noted. The estimate of risk was "absent or trace," with a comment that the "patient is low risk for suicide – no noted precipitant." According to the records, the psychiatrist ordered five-day follow-up after being informed by a nurse that such follow-up should be ordered.

On the first day of follow-up, 11/11/04, the inmate was seen by a nurse who indicated that he was reporting depression, which was assessed as "moderate." The nurse's note remarked on the inmate's recent stressor, indicating that he had just been informed by the IDTT of his impending return to the gym. The inmate continued to report sleep disruption and changes in appetite. While he denied suicidal thoughts, it was noted that he had evidence of a cut on his left wrist. The inmate was further described as experiencing hopelessness/helplessness. He reportedly remarked, "I'm just marking time." There was, however, no explanation for this statement, and no SRA was conducted following this interview. On the second day of follow-up, the inmate's behavior and mood were depressed, his sleep fair, his affect flat and his speech slow; the follow-up note indicated that the inmate denied suicidality "today" and referred to the fact that the inmate had been placed in the body cavity cell on 11/11/04 for "suicidal ideation." Less than two hours after this clinical contact, the inmate was discovered hanging in his cell.

In addition to his mental health issues, this inmate appeared to have dermatologic lesions, including a chronic scrotal rash and psoriasis. He also had knee and ankle pain, but the cause of these pains was unclear. The inmate had requested an exclusion from gym housing based on his skin lesions, some of which were subsequently determined to be Herpes Simplex. In seeking an exclusion from gym housing, the inmate requested assistance from the medical department. In search of the exclusion, he also requested assistance from custody due to his safety concerns and from mental health because of his depression and suicidal ideation. His request for exclusion from gym housing, however, was denied as not being clinically indicated.

The inmate had received RVRs on approximately seven occasions during his incarceration for being out of bounds, mutual combat, attempting to move contraband through a work area, failure to report to his job assignment and obstructing a peace officer. The charge of obstruction occurred on 11/2/04 and was related to the inmate's refusal to move to an E-bed in gym housing. He had been placed in administrative segregation on at least three occasions, all related to his safety concerns because of his crime and refusal to move to gym or dormitory housing. The inmate's IDTT meeting was apparently combined with his classification hearing as the warden, an assistant warden, correctional counselor, captain, sergeant and clinical staff were all in attendance.

The Suicide Report referred to the last evaluation by the contract psychiatrist who removed him from the body cavity search cell and returned him to housing. This psychiatric interview included information that was not recorded in the inmate's UHR. Specifically, the inmate's affect and behavior were described in the following manner, "Reluctant to talk with her much at all, wouldn't tell her what his charge was, stood in a corner of the cell, and looked at her out of the corner of his eyes without making direct eye contact." The psychiatrist also reported that, when questioned about suicidal ideation/intent, the inmate "would not give her a straight answer but rather would give her long and tangential responses", adding "yeah, I could do that if I were pushed to go to an E-bed." The inmate described to the psychiatrist his plan to cut his wrists "better than before." The psychiatrist indicated that it was her understanding that the inmate was going back to administrative segregation; had she thought there was any chance he would go to an E-bed, the psychiatrist stated that she would have admitted the inmate to the MHCB unit. The psych social worker, who had the last clinical contact with the inmate, believed the inmate understood and accepted that there would be an opportunity to meet with him and discuss his concerns again after the transfer.

The Suicide Report identified six problems and recommended the following corrective actions:

Problem 1: This inmate should have been placed in a MHCB unit at the time of his self-injurious behavior on 11/10/04, when he was observed as being obviously in distress. Even though a bed was not available, the doctor's order should have been to admit him to a MHCB when one became available, and Sacramento (Health Care Placement Unit) should have been contacted to help find a bed. Custody may place an

inmate awaiting a MHCB in the body cavity search cell overnight, but MHCB staff needed to be involved in clearing the inmate to return to a housing unit.

Recommendation: The institution should initiate a QIT to clarify local policies for admission to the MHCB unit, noting that physicians' orders cannot be written for custody placement. If an inmate requires MHCB care after hours and no bed is available, the physician should admit the inmate to the MHCB when a bed becomes available and contact HCPU. Such an inmate should be seen by the MHCB clinical team before being cleared to return to housing.

Problem 2: The contract psychiatrist who saw this inmate the morning after his placement in the body cavity search room failed to evaluate him adequately. The psychiatrist was new to CDC and did not understand the housing issue, did not know the inmate's crime of commitment and did not recognize his level of distress, with the result that she focused instead on characterological pathology.

Recommendation: In addition to ensuring, as noted above, that inmates held pending admission to the MHCB should be cleared by the MHCB clinical team before being returned to their housing unit, MCSP policy should require timely training for all new clinical staff, especially contractors, emphasizing the need to have records available whenever an assessment is made and encouraging consultation with other staff. HCSD should provide training materials to registries to train contract staff prior to commencing work at CDC.

Problem 3: A number of staff members evaluated the inmate for suicide risk without having the inmate's UHR available. Staff cannot adequately conduct an evaluation without background information.

Recommendation: The institution should develop local procedures through the QIT process to assure the availability of UHRs for clinical contacts.

Problem 4: The SRAs conducted for this inmate failed to address all risk factors. The conclusions reached by the assessments, that the inmate had only "absent/trace risk," moreover, were not supported by the clinical risk factors that were identified.

Recommendation: The institution should train all clinical mental health staff on the identification of suicide risk factors and the proper evaluation of risk. The institution needed to have a plan to train new staff arriving subsequently to the initial training session.

Problem 5: The inmate's interview and evaluation in the body cavity search cell lacked privacy because another inmate was present in the next cell. This may have impeded the assessment of the inmate, who was very fearful due to the nature of his crime and most likely would not have wanted to discuss it in a non-confidential setting.

Recommendation: Local policy needed to bring inmates held in the body cavity search cell pending MHCB admission back to the MHCB for evaluation by the MHCB clinical team. The evaluation should occur in an appropriate private setting, such as the IDTT room.

Problem 6: The inmate's IDTT meeting in administrative segregation and his classification hearing were held at the same time. IDTT meetings should be held separately and preferably prior to classification hearings. The clinicians who saw the inmate in the administrative segregation unit when he was in distress merely referred him to another clinician. There was no clinical recommendation or plan for relieving his distress

Recommendation: The institution should review its policy and procedures on IDTT meetings and classification hearings; a three-month audit should be conducted to ensure that IDTT meetings are conducted separately from classification hearings. Further training should be provided to staff on clinical problem-solving and treatment planning to develop effective responses to inmates in distress.

In its responsive report to the Suicide Report, MCSP cited with regard to the first and fifth problems its submitted copy of the new MHCB admission policy, dated May 2005, which was revised to incorporate the recommendations specified in the Suicide Report. Staff training on the revised policy reportedly was provided. As to the second problem, a copy of the institution's policy on contractor training and training attendance sheets were provided as evidence of implementation. In response to the third problem, an institutional memorandum dated 3/21/05 indicated that a key ring had been placed in the main control room to facilitate round-the-clock availability of UHRs to health care personnel.

As for the fourth problem, the institution provided training for the clinical staff on 11/30/04, which included information on the use of SRA forms, the facility's constant observation policy and the use of observations rooms for mental health inmates. Attendance sheets were attached. With regard to problem six, a memorandum dated 3/30/05 indicated that IDTT meetings at MCSP are generally held in conjunction with classification hearings, but the IDTT meeting usually precedes the classification hearing or is held separately if classification and IDTT schedules do not coincide.

Findings: This inmate's suicide appeared to have been foreseeable and preventable. The inmate had a history of static and dynamic suicide risk factors, which were directly related to fears for his safety if placed in a dormitory or gym housing. The inmate had requested placement in administrative segregation in the past for safety reasons because of his crime and, by his report, because he had a scrotal rash that required him to have some degree of privacy. The inmate had been identified by both custody and clinical staffs as having increased fears regarding possible placement in an E-bed or in gym housing. He did, in fact, describe himself to one clinician as "petrified." The inmate further reported that he felt CDC was backing him into a corner. These statements and the inmate's history appeared to be grossly underestimated by several clinicians. It seemed from comments made on the inmate's SRAs, as well as in progress notes, that clinicians focused on characterologic pathology, failed to review the inmate's UHR for historical references, were ignorant of the inmate's history as a sex offender and grossly underestimated his risk for suicidality.

Finally, clinical staff evaluating this inmate did not seem to understand the importance of his placement in the body cavity search cell and his subsequent return to housing, which the inmate anticipated would most likely result in his placement in an E-bed or the gym. Apparently, this placement was not seen as a relevant clinical and custodial issue during his final classification/IDTT meeting. The Suicide Report recommended corrective actions for these problems, and MCSP staff responded with corrective action plans that included training and revisions of applicable local operating procedures.

24. Inmate #V08244

Brief History: This inmate was a 35-year-old Caucasian male who completed suicide by hanging at the Eel River Conservation Camp on 11/17/04. At the time of his death, the inmate was housed in general population and was not receiving mental health services. He had been admitted to CDC via the reception center at SQ on 9/29/03 to serve a sentence of 76 months.

At approximately 5:30am on 11/17/04, a correctional officer conducting the morning count discovered the inmate hanging from a rafter in the exercise area at the Eel River Conservation Camp. The inmate was suspended by what appeared to be an exercise rope. Upon discovering the inmate, the officer ran across the yard to notify his commanding officer by telephone. After calling the sergeant and lieutenant, he retrieved a cut-down tool, cut the rope "without disturbing the knots and anchoring device" and lowered the inmate to the floor. The lieutenant arrived at the camp at 6:00am and notified the sheriff's office and county coroner. At approximately 8:10am, the deputy county coroner arrived at the camp and noted the body was still warm to the touch, with no rigormortis in the extremities. CPR was not initiated by any staff, and no call was made to 911. No suicide note was found in the inmate's property.

The coroner conducted an investigation into the inmate's death, but no autopsy was performed. The cause of death was found to be asphyxia, due to hanging, and the manner of death was determined to be a suicide. A postmortem toxicology screen found no evidence of alcohol or illegal drugs in the sample.

This inmate's criminal history started at age 18 with an arrest for vandalism. The inmate had a number of subsequent arrests, resulting in three felony and 13 misdemeanor convictions for crimes, including vandalism, hit and run, extortion, possession of controlled substance, transportation/sale of controlled substance, use of controlled substance and threats. At the time of his death, the inmate was serving a sentence for six years and four months on convictions for threats to commit a crime with intent to terrorize resulting in death or great bodily injury and for possession of a controlled substance.

The inmate had a history of multiple drug abuse, including marijuana, methamphetamine, heroin, cocaine, LSD, mushrooms and alcohol and reported having used methamphetamine and alcohol on the day of his arrest. The inmate received outpatient treatment and treatment at one inpatient program for his substance abuse and periodically

attended NA and AA meetings. He reported having checked himself into a "psych ward" for approximately eight hours when he had been abusing methamphetamine. According to his records, the inmate reported having symptoms of ADHD, but he apparently never received any treatment for ADHD or any special educational placements.

Pretrial evaluations found that the inmate had some left parietal neuropsychological damage of the brain that could have resulted from chronic drug and alcohol abuse, which was associated with his delusional beliefs that he had supernatural powers and with his possible participation in activities as a Satanist. The evaluation process also contained reports that the inmate, because of his brain damage, might have suicidal potential. The evaluation also suggested that his polysubstance abuse was associated with psychotic thinking, such that he might become a paranoid schizophrenic.

After entering CDC on 9/29/03, the inmate received an initial mental health screening at the SQ reception center, which was negative, and was cleared for release to custody. A physical examination found that he had hypertension, obesity and Hepatitis C and the inmate was referred for an abdominal ultrasound. The inmate was also referred for a psychiatric consultation, although the reason for the psychiatric consultation was not described. A developmental disability evaluation on 10/1/03 determined that the inmate had normal cognitive functioning. The inmate received a reception center mental health evaluation, or MH-7, also on 10/1/03, which determined that he was not in need of mental health services and did not meet the criteria for inclusion in the MHSDS. The inmate was given a diagnosis of Amphetaminmate Dependence as part of this evaluation, but no treatment services were recommended.

This inmate was transferred to California Correctional Center (CC) 11/19/03 and was cleared by a psychologist for camp placement on 11/26/03. In the interim, a correctional counselor referred the inmate to mental health on 11/24/03, after reviewing his central file and discovering that the inmate had reported symptoms of visual hallucinations, delusions, bizarre behavior and a history of psychiatric care. This referral was not received by the mental health department until 12/1/03. A re-evaluation by a psychologist on 12/5/03 indicated that the inmate had no mental illness and no need for mental health follow-up. The psychologist conducting the re-evaluation did not indicate on the MH-3 whether the inmate's UHR or central file had been reviewed, but the inmate admitted to the psychologist that he experienced hallucinations while intoxicated on methamphetamine. The inmate was trained as a firefighter and, on 7/27/04, transferred to the Devil's Garden Camp. Shortly thereafter, the inmate was described by his supervisor as a good worker.

The inmate's last mental health contact appeared to be on 9/29/04, when he was seen by a psychologist on a referral by the camp's sergeant. The referral was dated 9/18/04, but was not received at CCC until 9/27/04. The inmate received a mental health evaluation on 9/29/04, which described him as "bright, organized, responsive, and with stable mood"; he was noted, however, to have worrisome dreams. The psychologist conducting the evaluation concluded that the inmate had no signs or symptoms of mental illness and that he displayed insight. According to the psychologist, the inmate denied suicidal

ideation as well as perceptual and thought content disturbances. The psychologist indicated that he would see if the inmate could be cleared to return to camp. The sergeant who made the referral reported that the inmate had "deja veux of himself getting hurt or killed while fighting a fire on 10/7/04." The inmate had apparently requested a return to CCC and told the staff at the camp that he did not want to fight fires. He told the psychologist, however, that he wanted to return to the Eel River Camp instead of staying at CCC. On 10/21/04, the inmate received a chrono transferring him from the Devil's Garden Camp to the Eel River Camp.

According to the Suicide Report, a major stressor for the inmate was his fear that, once paroled, he might receive another felony conviction resulting in a third-strike sentence. The inmate's father reported that the inmate's appeal had been heard on 10/18/04 and that a decision would be forthcoming within approximately 30 days. The Suicide Report indicated that the inmate had told another inmate on the night prior to his suicide that his appeal had gone through, which "somehow meant that his daughter was going to be murdered." The inmate was visited by his father at the Eel River Camp on the weekend prior to his suicide and, according to the record, his father did not have any concerns about his son's safety.

The Suicide Report identified four problems and recommended corrective actions as follows:

Problem 1: Emergency response procedures were clearly inadequate. There was significant delay in obtaining assistance and in cutting down the inmate. No medical personnel were summoned, and 911 was not called.

Recommendation: The institution's emergency response committee needed to conduct a fact finding investigation to determine that adequate emergency procedures are in place. The associate warden for the camps should review and discuss correct emergency response procedures with the camp commanders and ensure that the staff is trained.

Problem 2: The psychotic nature of the inmate's crime and the psychosis described in his court competency evaluation were never taken into consideration by mental health clinicians evaluating the inmate because his central file was never reviewed, even though a correctional counselor found enough documentation in the central file to refer the inmate to mental health.

Recommendation: The institution should have a policy requiring a correctional counselor at CCC, who finds something of concern in an inmate's central file, to copy the relevant document and send it to the psychologist along with the referral. This procedure was adopted by the institution's suicide prevention response committee following the inmate's death.

Problem 3: The formatted mental health notes, or MH-3s, at CCC did not include notations, indicating whether the records were reviewed.

Recommendation: CCC needed to add this notation to the MH-3 format.

Problem 4: Although this inmate was returned from a camp specifically for a psychological evaluation, his evaluation seemed cursory.

Recommendation: When an inmate is referred for a mental health evaluation based on a behavioral concern, including inmates returned from a camp for this reason, the evaluation should be comprehensive and include file reviews and documentation on a mental health evaluation form. Mental health referrals of returned inmates should be audited to ensure that evaluations are documented on a MH-4 form. HCSD also needs to discuss this as a system-wide issue in an upcoming suicide prevention video conference.

In response to the Suicide Report, CCC staff submitted a follow-up report on the corrective action plan for this suicide. The CCC submission contained a number of attachments, including a 5/5/05 memorandum from a staff psychologist entitled "Clarification of Suicide Report," indicating that an undated letter from the inmate had been delivered after the Suicide Report was written; a 3/14/05 memorandum by an Associate Warden of the Camp Division entitled "Response to Medical Emergencies" that outlined the appropriate responsive reactions to a medical emergency; a 5/9/05 memorandum from the Deputy Director of Institutions Division entitled "Suicide Review of Inmate V08244"; minutes from suicide prevention committee meetings on 11/24/04 and 1/26/05; and information on the training provided for correctional counselors on 1/13/05.

There was also information on the initiation of investigations into the mental health evaluation of the inmate conducted on his arrival at SQ, the actions of the correctional officer who discovered the inmate and the actions of the two supervisors who were notified at their homes by the discovering correctional officer. As a result of these reviews, several changes had been initiated, including: (1) written directions were established on the responsibilities of camp staff when they discover a suicide; (2) training of all camp staff on the appropriate responsive actions expectations when discovering a medical emergency was provided; (3) the distribution of cellular telephones or appropriate mobile phones for staff at conservation camps was planned by June 2005; (4) first aid and CPR training was to be provided and updated for all conservation camp staff by June 2005; and (5) classification hearings were made mandatory for all inmates returned to CCC or Sierra Conservation Camp (SCC) for mental health evaluations, prior to returning inmates to a camp program.

This follow-up materials identified several departmental issues raised during review of this suicide, including: (1) the requirement for officers to conduct CPR; (2) the requirement for mental health providers regularly to review the central files of inmates; (3) the requirement that inmates who are returned to the institutions from camps must have a classification hearing prior to their placement back in a minimum setting; (4) requirements for correctional counselors on mental health referrals during the reception process; (5) the need for the program support unit and northern regional staff to analyze the budgeting rationale for assigning just one correctional officer to work in the camp settings on the first watch.

Plaintiffs' counsel's 1/27/05 letter raised many of these same issues, including the clinical failures during the inmate's processing in the reception center at SQ and later at CCC; the failure of the correctional officer who discovered the inmate to cut him down quickly and initiate CPR; and the failure of clinical staff to review the inmate's UHR and central file.

Findings: This inmate's suicide did not appear to have been foreseeable as he did not report suicidal or self-harming ideation or intent during the course of his incarceration in CDC, although he may have had a number of other possibly psychotic symptoms. The inmate had a substantial history of polysubstance dependence, suffered possibly from related brain damage and, in the opinion of an outside examiner, was or might become a paranoid schizophrenic. His death might have been preventable had the inmate received appropriate and adequate evaluations after he was identified as having difficulties and referred to mental health by custody staff. The inmate' mental health evaluations were incomplete and cursory, and significant information in both his UHR and central file was not reviewed. The Suicide Report identified a number of facility as well as systems issues, and the follow-up responses by CDC attempted to address those issues.

The most troubling circumstance in this inmate's completed suicide involved the first responder's reaction on discovering the hanging inmate. The correctional officer apparently had no equipment to sound an alarm without leaving the scene, did not immediately cut the inmate down and relieve stricture, did not try to access medical personnel via 911 and, after cutting the inmate down, did not perform CPR. The inmate's body was subsequently described as warm to touch with no rigormortis. The inmate's vital signs at the time of his discovery were not reported, and no efforts to provide CPR and/or obtain medical assistance to support this inmate's life were documented. This is an egregious example of individual, institutional and system-wide failures.

25. Inmate #W87924

Brief History: This inmate was a 42-year-old Caucasian female who completed suicide by hanging at the Central California Women's Facility (CCWF) on 11/19/04. At the time of her death, the inmate was single-celled in administrative segregation and receiving MHSDS services at the 3CMS level of care. She had been admitted to CDC via the reception center at CCWF on 12/4/00.

At approximately 12:29am on 11/19/04, a correctional officer conducting an institutional count in the administrative segregation unit discovered the inmate hanging by a sheet tied to a shelf in her cell. The officer activated his personal alarm, banged on the door to get a response from the inmate and, as other officers arrived, received the cut-down tool from a control booth officer. The cell was entered, the sheet cut and the inmate placed on the floor. An officer, a MTA and a nurse examined the inmate and found that she was cold to the touch and had no pulse or respiration. She was placed on a gurney, transported to the infirmary and pronounced dead by a physician at approximately 1:52am. The records indicated that no attempt was made to perform CPR.

An autopsy conducted on 11/20/04 determined the cause of death to be asphyxia due to hanging. Postmortem toxicology results were pending and not included in the documents reviewed.

This was the inmate's first incarceration. The inmate had been convicted in October 2000 of second-degree murder, arising out of an incident in which she shot her former boyfriend in a motel. The inmate reported a history of abuse by the victim and claimed that she had to kill him because he was going to kill her. The inmate also reported that the conflict with her former boyfriend concerned a child they had together and her giving the child up for adoption. The murdered victim's mother reported that the inmate had sold her eight-month-old child for $15,000. This, according to the victim's mother, was the cause of the argument. The inmate attempted to plead not guilty by reason of insanity based on a history of mental illness and Battered Spouse Syndrome, but was determined to be sane and convicted. She was given a sentence of 15 years to life, plus 25 years enhancement for use of a weapon, with the result that she had a 40 year to life sentence that began when she entered CCWF on 12/14/00. The innate was subsequently transferred to VSPW on 3/21/01 and returned to CCWF on 3/3/04.

On 12/18/00, shortly after her admission to the CDC, the inmate received a mental health screening. As noted in the screening, the inmate reported signs and symptoms of a possible mood disorder, major depression or thought disorder and indicated that she had been diagnosed with Schizophrenia and Bipolar Disorder. Her developmental disability evaluation of 12/18/00 indicated that she had normal cognitive functioning. Based on her mental health screening, the inmate was placed in the mental health program at the 3CMS level of care. The inmate was admitted to the CCWF MHCB unit on 1/4/01 because she claimed to be having visual and auditory hallucinations and said that she would "wind up harming herself or others." The inmate remained in the MHCB unit from 1/4/01 through 1/8/01. Staff reported that she was an unreliable source of information based on her "market suggestibility" regarding mental health symptoms, as well as her admission at the end of an interview "that she is in fact lying out of fear of not looking mentally ill."

The inmate reported that her first psychiatric symptoms began with "life," but subsequently changed the date to age "12" and later to "grade school." She described hearing voices that controlled her and reported that her mother and brother had the same symptoms. During her MHCB admission, she denied any history of inpatient psychiatric treatment, but said that she had been on "all" psychiatric medications. The inmate also reported a seizure disorder. A MH-2 conducted on 1/5/01 diagnosed her with Malingering and Alcohol Dependence in Institutional Remission as well as a Personality Disorder NOS with Antisocial and Borderline Traits, with a GAF of 65. The MH-2 concluded that her insight and judgment were extremely limited. With respect to a risk of suicide, the inmate stated, "I can't promise what I'll do." At the time of her discharge from the MHCB unit, treatment staff determined that the inmate did not require five-day follow-up. In an interview after the suicide, the inmate's mother and sister indicated that the inmate had received outpatient treatment at a mental health clinic and that she had reported hearing voices, seeing things and experiencing strange dreams. Her sister

recalled that these symptoms started at an early age, but her mother indicated that they began in high school.

After her transfer to VSPW on 3/21/01, the inmate began to report psychotic symptoms, including voices telling her to harm herself. She was placed on suicide precautions on 3/29/01 and transferred to the MHCB unit at CCWF, where she remained until 4/4/01. She was discharged back to VSPW with diagnoses of Personality Disorder NOS, Malingering and Alcohol Dependence. The inmate continued at the 3CMS level of care. She received Tegretol, ostensibly for reported seizures, and Neurontin. The inmate subsequently signed consents for Risperdal, Prozac, Trazodone, Mellaril and Seroquel. The inmate's working diagnosis at VSPW was Schizoaffective Disorder and she continued to report symptoms of psychosis, including hallucinations and paranoia as well as suicidal ideation, feelings of helplessness and hopelessness and anxiety over a possible nervous breakdown. Over time, her diagnoses included Schizophrenia, as well as Rule Out Bipolar Disorder, Major Depression and Malingering. The inmate continued to receive anti-psychotic and anti-depressant medications as well as Tegretol and Albuteral over the next two years without interruption. In addition, she also had trials of Lithium and Remeron.

The inmate obtained a job working in the school at VSPW. In August 2003, her supervisor requested a mental health evaluation and classification review because of the inmate's deteriorating condition; she was having difficulty following instructions and retaining information and she needed constant supervision. The referral was filed in the inmate's central file and did not come to the attention of mental health staff. The inmate, however, received a follow-up psychiatric appointment in September 2003 and had contact with a CCM in October 2003. In the course of these clinical visits, it was determined that the inmate was unable to work because of hearing voices.

In November 2003, the inmate was prescribed Zyprexa and Remeron. In December 2003, she first reported that she was "very suicidal" and the following day denied suicidal ideation or intent. A suicide risk assessment completed at that time listed a number of risk factors, including suicidal ideation/threats on the day before the assessment. The psychologist conducting the assessment concluded that the estimate of risk was low and referred the inmate to a psychiatrist for medication review. Additionally, the psychologist indicated that the inmate had denied "suicidality today but should be monitored at least weekly for changes. Consider for referral to EOP." Approximately one hour later, the inmate was seen by a psychiatrist who diagnosed Psychotic Disorder NOS, but opined that the inmate was "clinically not a danger to self or others at this time" and noted that the inmate signed a "contract of no self harm." The plan was to have the inmate to talk to staff when she felt suicidal and staff to monitor her carefully. There is no notation in the record to suggest that the psychiatrist conferred with the psychologist about the inmate's management needs.

In January 2004, the inmate was seen by a psychiatrist who reported that the inmate continued to hear voices and prescribed Zyprexa and Remeron. In February 2004, a psychiatrist assessed her as having Psychotic Disorder NOS and increased her Zyprexa.

The psychiatrist concluded "patient needs to be seen in IDTT to transfer her to Patton State Hospital via EOP." There is no indication in the record that the inmate was referred to PSH. An IDTT meeting on 2/24/04 reviewed the inmate's treatment and determined that she should be at the EOP level of care. On 3/3/04, the inmate was transferred to the EOP program at CCWF.

On 3/8/04, an IDTT noted that the inmate denied mental health concerns, but identified problems with low self esteem and depressed mood as well as poor concentration, lack of energy and social withdrawal. The IDTT diagnosed Rule Out Malingering and Personality Disorder and placed the inmate back in the 3CMS program. A MH-3 of that date indicated that the inmate was a "first termer: second degree murder...sentenced to two consecutive life terms." This note also referred to her extensive mental health history, her inconsistent reporting of information and her prescription for Remeron and Zyprexa. The note included the inmate's statement, "This is a big mistake. I shouldn't be here," and reported her assertion that she was transferred to an EOP level of care due to an "anxiety attack." The IDTT concluded that inmate was "very contradictory in current presentation from previous notes from VSPW clinician" and removed her from the EOP program. A note of 3/23/04 indicated the inmate was informed of her upcoming discharge from the EOP program and told that she would stay at CCWF. According to the note, the inmate was "elated", adding "I'm glad I'm staying here, I was tired of that place (VSPW) anyway." While at the 3CMS level of care at CCWF, the inmate was described as having some reported difficulties with sleeping and programming as an education porter; she also experienced periods of depression and anxiety, while denying suicidal and homicidal ideation. Her medications were changed to Trazodone and Risperdal.

In late August, the inmate began to report that she was experiencing increased symptoms, including voices that were more disturbing to her. Based on a correctional officer's referral, the psychiatrist increased the inmate's Risperdal and Vistaril. In September, the inmate had two episodes of physiological distress in which she could not move or was panting and could not stop. Each time, no physical basis was found for her complaints and she was referred to a psychiatrist. The inmate received four clinical contacts for medication non-compliance and signed a medication refusal form. As a result, her medication was discontinued on 10/1/04. The same day, the inmate asked a psychiatrist how she could get to PSH. On 10/2/04, the inmate presented herself at the clinic, stating that she was suicidal and planned to kill herself; the mental health staff believed that her statements were related to her question about PSH and she was diagnosed as Malingering. No SRA appeared to have been completed at that time. The inmate reported abdominal pain on 10/8 and 10/15/04, but the medical staff could find no physiological basis for her complaint. A 10/19/04 psychiatric note indicated that the inmate had been missing appointments "after she feigned suicidality to gain admission to PSH." The note also indicated that the inmate had stopped taking all her medications.

On 10/22/04, the inmate received a disciplinary infraction for attempted battery on a peace officer with a deadly weapon. The officer involved in the incident described the inmate as swinging a razor blade approximately eight inches from his face. According to the officer,

the inmate ceased swinging the blade when ordered to stop with pepper spray aimed at her face. A mental health assessment indicated that there were no mental health factors that would interfere with the inmate's ability to understand the disciplinary process. The assessment also concluded that the inmate's mental disorder did not appear to contribute to her behavior. The inmate was subsequently placed in administrative segregation pending her hearing. On interview, the inmate reported that she did not recall anything about the incident and had "blacked out." The inmate was charged with attempted battery and was facing a possible SHU term and referral to the district attorney's office. This was clearly the inmate's most serious infraction while incarcerated, but she had received earlier RVRs for refusing to report to work, possession of hot medications (cheeking medications) and conspiracy to manufacture alcohol to which she had pled guilty.

On 10/31/04, following her placement in administrative segregation, the inmate reported chest pain and asked to see the psychiatrist for a life or death situation. She was evaluated by a nurse who determined that there was no physiological basis for her complaints and by a psychiatrist who reported that the inmate was attempting to manipulate staff. She was seen by a case manager on 11/1, 11/4, 11/8 and 11/17/04 and by a psychiatrist on 11/9/04. In those appointments, the inmate reported that she had not been sleeping for several weeks and was "out of her mind" when the attempted assault occurred. During her month in segregation, the inmate came out of her cell for yard or showers only a few times. The administrative segregation psych tech reported that the inmate had a strong body odor and bad breath. The inmate also reported that she was hallucinating and threatened to harm herself if she did not get medication. Despite these reported symptoms and observations of her deteriorating condition, the inmate's medications were not restarted. Moreover, there was no documented consideration for a transfer to a MHCB unit during her stay in administrative segregation. A CCM informed the inmate, during her 11/19/04 meeting, that she would be scheduled to see the psychiatrist the following week, but the inmate committed suicide two days later.

According to the Suicide Report, three inmates reported that the deceased inmate had told the administrative segregation sergeant that she felt suicidal and needed help on the day prior to her suicide. The sergeant reportedly thought that she was manipulative and threatened to issue a disciplinary infraction. The institution was investigating the inmates' allegations. The Suicide Report also referred to an Investigative Services Unit (ISU) review of writings found in the inmate's cell. In the writings that she left, the inmate indicated that she had mental problems prior to her attempted assault on the correctional officer and requested leniency as she did not want to be sent to the SHU at VSPW. She also described "spirits" tormenting and controlling her, talked about her hallucinations and expressed suicidal ideation. Although the Suicide Report indicated that CPR was not attempted when this inmate was discovered, the inmate's Death Report, dated 11/19/04, noted that emergency procedures including CPR were administered promptly by a nurse.

The Suicide Report identified six problems and recommended corrective actions as follows:

Problem 1: Staff did not provide CPR after discovering the inmate hanging, and did not document rigormortis or morbidity as justification for not doing so.

Recommendation: The institution's emergency response committee should review this case and determine why CPR was not provided. Training should be provided to nursing staff regarding CDC policy and proper documentation.

Problem 2: The psych tech making rounds in the administrative segregation unit noted that the inmate had poor hygiene and other ADLs, but evidently did not recognize this as a sign of mental illness and did not refer the inmate to mental health.

Recommendation: CCWF should provide remedial training to mental health staff on the need to make contact with inmates during rounds, the signs and symptoms of mental illness and the importance of making referrals. The institution planned to provide training to all clinical staff on 2/17/05.

Problem 3: Some mental health staff viewed this inmate as a malingerer and manipulative. This made it more difficult for them to appreciate the evident symptoms of her mental disorder. Staff must realize that being mentally ill and being manipulative are not mutually exclusive conditions. Mentally ill inmates have poor coping skills and their cries for help, which can be manifested in odd ways like assaulting staff, must be recognized. This appeared to be an on-going issue at CCWF.

Recommendation: The chief psychologist needed continually to address this issue in suicide prevention meetings and staff meetings. Mental health staff should also make this issue a focus of on-going peer review.

Problem 4: The inmate's symptoms of psychosis were evidently discounted by the psychiatrist over the course of several meetings at a time when medications might have been helpful.

Recommendation: The senior psychiatrist should address this issue with the psychiatric staff at meetings and in the peer review process.

Problem 5: Two inmates reported that on the day the inmate attempted to assault an officer with a razor blade, her locker was searched and a torn sheet with a noose was found. In her writings, the inmate reported that she attempted to hang herself on the morning of this incident, although a MTA injury report, dated 10/22/04 and completed prior to the inmate's placement in administrative segregation, did not find any marks on the inmate's neck. The information about the hanging apparatus was not communicated to the mental health staff.

Recommendation: The ISU should continue its investigation of these reports.

Problem 6: Three inmates reported that on the day prior to the suicide, the inmate informed the administrative segregation sergeant that she felt suicidal and the sergeant threatened to issue a RVR when she did not stop saying this. Another inmate reported that the inmate would hold a piece of paper for staff to read when they walked by her cell door.

Recommendation: Here, too, the ISU should continue its investigation into these reports.

CCWF's response to the Suicide Report attached a number of documents, including a memorandum indicating that the corrective recommendations had been undertaken and were nearing completion and that further "proof of practice" documentation would be provided. With respect to the first problem, a memorandum dated 7/26/05 was submitted on a meeting of the emergency response committee to review this suicide. The memorandum referred to statements by the nurse and the MTA who failed to perform CPR. The nurse reportedly stated that CPR was "not continued due to the presence of lavidity/rigor." The MTA reported that she "discontinued CPR at the direction of the RN." The actual minutes from the meeting were still pending. As for problem two, sign-in sheets for the recommended training were provided. In response to problem three, minutes from suicide prevention committee meetings on 3/1/05 and 5/2/05 were attached. These minutes reflected a discussion of the need to do thorough clinical reviews of cases where both mental health and manipulation issues are present. The minutes also reflected a discussion of mental health assessments for disciplinary proceedings, five-day follow-up, repeat crisis bed admissions and attempted suicides.

Minutes from a psychiatry staff meeting on 4/28/05 were submitted in response to the fourth problem, which contained a detailed discussion of this inmate's suicide. No dispositive evidence had been collected on the incident described in problem five. Information about the noose found in the inmate's locker did not come to light until after the inmate's death, and the ISU "did not feel that a formal investigation would be likely to produce additional information." In contrast, the investigation of events described in problem six continued, but the estimated completion date had been extended.

Findings: This inmate's suicide was probably foreseeable and appeared to have been preventable. The inmate complained inconsistently but frequently of having suicidal ideation and suicidal intent, including such a statement during her stay in administrative segregation. ISU investigations were ongoing, and it had not yet been determined whether the alleged statements were actually made by the inmate to an administrative segregation sergeant shortly before her death. If such statements were made, the sergeant had a responsibility to notify mental health to see the inmate.

There were numerous occasions when the inmate reported a variety of symptoms and other occasions when she denied those same symptoms. The staff at CCWF consistently appeared to be of the opinion that the inconsistencies were indicative of malingering and, therefore, did not require active mental health treatment. The staff at VSPW, however, indicated that these symptoms required higher levels of care, including MHCB and EOP treatment. The inmate's placement in administrative segregation and her deterioration there, as indicated by her declining involvement with the mental health staff, her periodic complaints of psychotic and suicidal symptomatology and her worsening ADLs and hygiene, should have prompted a more complete evaluation and review by the IDTT. The Suicide Report recognized the need to develop treatment and management approaches for both mental illness and symptoms of malingering in the care of the same inmate. There seems to have been a fundamental failure on the part of the staff at CCWF to address both the inmate's symptoms of mental illness and her characterological

pathology. More comprehensive evaluations, information sharing and treatment interventions, such as medication management, should have been a part of this inmate's overall care and management. Lastly, the decision not to perform CPR and the conflicting documentation about this issue did not appear to have been adequately addressed by the institution's response to the recommended corrective action in the Suicide Report.

26. Inmate #D97784

Brief History: This inmate was a 35-year-old Armenian male who completed suicide by hanging at California Institution for Men (CIM) on 12/2/04. At the time of his death, the inmate was single-celled in administrative segregation and was not receiving any mental health services. The inmate had been returned to CDC via the reception center at NKSP on 6/5/01 and transferred to CIM on 8/9/04.

At approximately 5:55am on 12/2/04, two correctional officers observed the inmate slumped forward and sitting on the floor of his cell between the bunk and the cell bars. The inmate had a white cloth tied around his neck and the end of the cloth was tied to the upper bunk. One of the officers ran to the second floor of the administrative segregation unit and, using an institutional land line, alerted staff of the situation. A sergeant and other officers came in reply. The inmate was not responsive to the staff's verbal attempts to rouse him. He was then administered a one second burst of OC pepper spray, to which he also did not respond. A cut down tool was used to free the cloth from around the inmate's neck. The inmate was then restrained, removed from the cell and escorted out of the administrative segregation unit.

A MTA arrived at approximately 6:03am, while the inmate was being moved to an emergency vehicle for transportation to the CIM Hospital at 6:05am. According to the MTA, the inmate appeared to be "pulseless, warm to the touch, and had no evidence of respiration." The emergency room admission record indicated that the inmate arrived with no respiration and no pulse. A Code Blue was called and CPR was initiated. The inmate was unresponsive; his color pale and his skin cool to the touch. It appeared that CPR was begun at approximately 6:15am, but not prior to the inmate's arrival in the emergency room. The inmate was subsequently pronounced dead by a physician at 6:40am. The inmate's Death Report, however, indicated that emergency procedures following his suicide act were promptly applied.

An autopsy conducted on 12/3/04 determined the cause of death to be hanging and the manner of death to be suicide. A postmortem toxicology report found trace amounts of Benadryl in the inmate's blood sample.

The inmate first became involved in the criminal justice system as a juvenile at age 16. Between the ages of 16 and 18, he had four arrests for theft. As an adult, he was arrested for auto theft in 1988 and entered CDC as an adult for the first time on 10/4/88 with a three-year sentence. He was paroled and returned to custody on at least six occasions either as a parole violator or with new charges, including disregard for the safety of

others, illegal possession of tear gas, burglary, possession of marijuana and auto theft. The inmate's current term began on 6/5/01, when he was convicted of evading an officer with willful disregard and given a five-year sentence. The record identified the inmate as a foreign national. There was an INS hold on the inmate and it was likely that he would be deported if paroled again. His earliest possible release date was 5/12/05, approximately five months from the time of his death.

The inmate had a long history of polysubstance abuse and/or dependence, including use of marijuana, cocaine and heroin. It appeared that the inmate had entered at least one drug rehabilitation program, but his treatment was not completed. According to a sheriff's report dated 6/5/01, the inmate had been treated with Motrin and Zoloft while in the county jail. He did not, however, appear to have received any other treatment for mental illness prior to his return to the CDC system in June 2001. A mental health evaluation administered in the reception center at NKSP recommended treatment at the 3CMS level of care. The inmate was initially diagnosed with Major Depression and prescribed Motrin and Zoloft.

The inmate was transferred from NKSP to Folsom in August 2001. While at Folsom, the inmate attempted to hang himself as a result of gang problems. He was transferred to the MHCB unit at CSP/Sac from 8/2 to 8/29/2002. At that time, he was given a diagnosis of Mood Disorder NOS with a GAF score of 46, and his level of care was changed to EOP. His medications were changed to Wellbutrin and Lithium and he was transferred to RJD. The inmate remained at the EOP level of care at RJD. In August 2003, he was seen by a psychiatrist because he had stopped taking his medications. He was set to have a trial period of three months off medications with follow-up by the psychiatrist, but the inmate was transferred to CIM on 8/9/03, where he remained until his death.

At CIM on 8/25/03, a psychiatrist agreed with the inmate to change his medications back to Zoloft and Zyprexa, which the inmate felt had worked more effectively for him. In March 2004, an IDTT met and determined that, while the inmate's diagnosis remained the same, his level of care should be changed from EOP to 3CMS. A SRA completed prior to this level-of-care change indicated that the inmate had a history of several suicide acts, including the aforementioned attempted hanging in Folsom, as well as an overdose of pills and another attempted hanging in 2000. The SRA determined that the inmate was not in crisis and was not suicidal. By May 2004, the inmate was complaining that his Wellbutrin caused insomnia and appetite loss. In response, the psychiatrist decreased his dosage. The inmate stopped taking his medications in July 2004, as a result of which they were discontinued by the psychiatrist. The inmate appeared to be stable, with follow-up scheduled in three months.

The inmate was seen by a psychiatrist on 8/10/04. At that time, he denied experiencing any mood swings, depressive symptoms or suicidal or homicidal ideation and reported that his sleep and appetite were good. He admitted, however, that he had occasional auditory hallucinations, but the psychiatrist noted the inmate's statement that "he can live with it." The plan was to conduct laboratory work and follow-up the inmate in eight weeks.

On 9/13/04, the inmate made a self-referral to the CCM, requesting a transfer to "Central" (reception center central at CIM). He reported that he was feeling intolerant of other inmates and wanted to be removed from the 3CMS caseload since he had been off psychiatric medications for two months. The case manager followed up with the inmate four days later. At that time, the inmate asked, "What if I told you that I was faking it all along? I never heard voices and I faked the S/A's so I could get out of Folsom after my celly attacked me." According to the CCM's note, the inmate claimed that he had faked his symptoms so he could get into the EOP program. The inmate denied all depressive symptoms, as well as any mood lability. The CCM indicated that due to the inmate's "admission of malingering symptoms he is removed from CCCMS as of this date." His diagnosis was changed to Malingering and Polysubstance Dependence. His removal from the 3CMS caseload was to be completed as of 9/17/04.

The inmate was seen by a psychiatrist for a follow-up appointment on 10/8/04. The psychiatrist reported that the inmate seemed "a little disorganized and vague," but he denied any symptoms of Bipolar Disorder or psychosis. The psychiatrist also noted that the inmate was "very circumstantial and vague" and that he had lied in the past to get out of the prison he was in because "the place was haunted." The psychiatrist's plan was to observe the inmate without psychiatric medication and follow-up in two weeks.

The inmate was seen by a different psychiatrist on 10/19/04. During this appointment, the inmate reported that two weeks earlier he had experienced a panic attack, but he denied any depression or suicidal thoughts. The inmate's mental status was recorded as calm and cooperative, with moderately depressed mood and appropriate affect. He did not have hallucinations, suicidal ideation or homicidal ideation. The psychiatrist assessed the inmate as having a panic disorder. He planned to start Paxil 20mg and return the inmate to the clinic in three weeks. The psychiatrist did not comment on placing the inmate back in the MHSDS and may not have been aware that the inmate had been removed from the caseload in September 2004. This was the last mental health note in the inmate's record. There was no indication that the follow-up appointment to check on the inmate's Paxil was ever conducted. The inmate's MAR demonstrated that he had stopped taking his Paxil on 11/10/04 and had signed a refusal form. There was no documentation in the record that the inmate was referred again to the psychiatrist after he signed the refusal form.

An emergency admission sheet dated 11/20/04 indicated that the inmate had facial bruises and a small laceration on his back. The inmate reported that he had experienced a seizure, but the physical examination revealed a puncture wound in the middle of his back that did not require extensive treatment. The inmate was subsequently placed in administrative segregation for safety reasons. There was no documentation that he received a mental health screening on entering administrative segregation. The records indicated that the inmate was referred by a psych tech to a psychologist on 11/22/04 because he had been on psychotropic medications in the past. There was no documentation that a subsequent evaluation occurred.

The Suicide Report identified five problems and recommended corrective actions as follows:

Problem 1: Delays in filing medical documents and moving UHRs from the minimum support facility to the central records section may have impeded this inmate's care with regard to medications and his status in the MHSDS.

Recommendation: The institution needed to form a QIT to determine whether policies, procedures and practices for the maintenance of UHRs are effective. Weekly audits should be conducted for two months.

Problem 2: This inmate's MHSDS status was noted as general population on the administrative segregation placement document. All general population inmates are required to have a mental health screening within 72 hours of admission to the administrative segregation unit, but there was no indication that this was completed for the inmate.

Recommendation: The institution should form a QIT to ensure that current procedures for mental health screenings in the administrative segregation unit accurately reflect CDC policy. Staff should be provided with training in order to ensure that all general population inmates receive a mental health screening within the 72 hours of admission to the unit.

Problem 3: After being placed in the administrative segregation unit, the inmate was referred to a psychologist for an evaluation. The evaluation did not, however, take place. There may have been a systems problem with how referrals were tracked.

Recommendation: The institution needed a QIT to review procedures for making and tracking referrals and conduct an audit of mental health referrals and follow-up.

Problem 4: There was no indication that a formal IDTT meeting was held, as required, within five days of the inmate's arrival at CIM and no indication when the inmate was removed from the 3CMS caseload.

Recommendation: Staff should be trained on MHSDS guidelines for changes in level of care. A QIT should be formed to conduct a review of the procedures for tracking new inmates and scheduling IDTT meetings for them.

Problem 5: The psychiatrist who assessed the inmate as having a panic disorder made a note in the UHR for a follow-up visit within three weeks. There was no indication that this follow-up was scheduled or completed.

Recommendation: CIM should form another QIT to review procedures for tracking and scheduling follow-up appointments. The QIT should also conduct weekly inquiries of inmates who are on psychotropic medications but do not have psychiatric appointments scheduled.

Problem 6: The use of pepper spray on an inmate in distress seemed questionable.

Recommendation: The institution should review emergency response procedures and practices with regard to the use of pepper spray.

CIM did not provide a follow-up response to the Suicide Report in the documents received prior to the completion of this report.

Findings: This inmate's suicide did not appear to have been foreseeable because he neither reported suicidal ideation or intent nor requested any additional mental health services. Moreover, his behavior did not appear to change significantly prior to his suicide except for the reported panic attack prior to his placement in administrative segregation. The inmate's suicide, however, might have been preventable if he had received appropriate screening as a general population inmate placed in administrative segregation; the psych tech's referral following his placement in administrative segregation had been followed-up; or a follow-up psychiatric appointment had been conducted as planned three weeks after the 10/19/04 interview or when the inmate signed a refusal slip for psychotropic medications.

J. Michael Keating, Jr.
Office of the Special Master
Coleman v. Schwarzenegger

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May 9, 2006

Clerk's Office
United States District Court
for the Eastern District of California
501 I Street
Sacramento, CA 95814

Re: Ralph Coleman, et al. v. Arnold Schwarzenegger, et al.
No. Civ. S-90-0520 LKK JFM P

Dear Sir/Madam:

Please find attached for electronic filing the Report on Suicides Completed in the California Department of Corrections in Calendar Year 2004.

In addition to this electronic filing, I am sending two conventional hard copies by Federal Express to Haven Gracey, Staff Assistant to Magistrate Judge Moulds, for Judge Karlton and Magistrate Judge Moulds.

If you have any questions about this filing or its distribution, please call. Thank you for your assistance.

Sincerely yours,

/s/

J. Michael Keating, Jr.
Special Master

Enclosure

IN THE UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF CALIFORNIA

RALPH COLEMAN, et al.,

Plaintiffs, No. CIV S-90-0520 LKK JFM P

vs.

ARNOLD SCHWARZENEGGER, et al.,

Defendants. ORDER

_____/

On May 9, 2006, the special master filed a report on suicides completed in the California Department of Corrections in calendar year 2004. Therein, the special master recommends that defendants be required to

> develop by May 31, 2006 a plan for dealing with the escalating percentage of suicides occurring in administrative segregation units. The plan must be based on an analysis of the causes for the increasing rate and, depending on the outcome of the analysis, provide adequate resources of mental health and/or custody staff, create sufficient confidential interview space and/or enhance the quality of mental health services provided in administrative segregation units.

(Report on Suicides, filed May 9, 2006, at 13.) On May 19, 2006, defendants filed a response to the report and its recommendation. Defendants have no objection to developing the plan. They ask that the analysis of causes of the suicide rate be done in collaboration with one or more of

the special master's experts. Defendants would like, however, until August 31, 2006 to complete the plan.

On May 23, 2006, plaintiffs filed a response to the special master's report and defendants' response thereto. Plaintiffs object to giving defendants an additional three months to complete the plan unless there is a concomitant commitment by defendants to "obtain any necessary funding to implement elements of their remedial plan in September 2006." (Plaintiffs' Response, filed May 23, 2006, at 5.) Plaintiffs also request that defendants be required to collaborate with plaintiffs and their suicide expert in developing the plan, and that defendants be directed to include a schedule for implementing the plan that "reflects the urgency of the escalating suicide rate . . . and the need to address this crisis as an emergency." (Plaintiffs' Response, at 7.)

After further consultation with the special master, and good cause appearing, IT IS HEREBY ORDERED that:

1. On or before August 31, 2006, defendants shall develop a plan for dealing with the escalating percentage of suicides occurring in administrative segregation units. The plan must be based on an analysis of the causes for the increasing rate and, depending on the outcome of the analysis, provide adequate resources of mental health and/or custody staff, create sufficient confidential interview space and/or enhance the quality of mental health services provided in administrative segregation units.

2. The plan shall include, as appropriate, a budget and implementation schedule for any policy and procedure changes, staffing or budget augmentation, and, if necessary, include a mechanism for obtaining mid-year funding on or before September 30, 2006.

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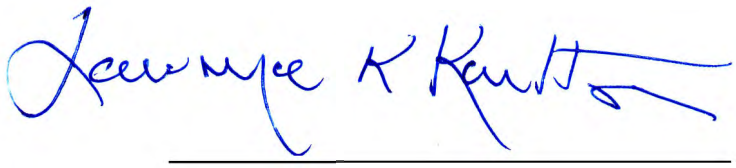
3. Defendants shall collaborate with one or more of the special master's experts, with plaintiffs' counsel, and with plaintiffs' expert, Lindsay Hayes, to develop the plan required by this order.

DATED: June 7, 2006.



LAWRENCE K. KARLTON
SENIOR JUDGE
UNITED STATES DISTRICT COURT

/coleman.sr04

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IN THE UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF CALIFORNIA

RALPH COLEMAN, et al., Plaintiffs, **v.** **ARNOLD SCHWARZENEGGER, et al.,** Defendants.	CASE NO. CIV S-90-0520 LKK JFM P **DEFENDANTS' PLAN TO ADDRESS SUICIDE TRENDS IN ADMINISTRATIVE SEGREGATION UNITS**

On June 8, 2006, this Court directed Defendants to develop a plan for dealing with the escalating percentage of suicides occurring in administrative segregation units. Defendants' plan

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is attached herein as Exhibit A. Defendants respectfully reserve the right to supplement or amend the plan, including and not limited to the topics of ventilation screens and intake cells.

Dated: October 2, 2006

Respectfully submitted,

BILL LOCKYER
Attorney General of the State of California

JAMES M. HUMES
Chief Assistant Attorney General

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ROCHELLE C. EAST
Supervising Deputy Attorney General

/s/ Lisa A. Tillman

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Deputy Attorney General

Attorneys for Defendants

30172106.wpd

RALPH COLEMAN, et al., v. ARNOLD SCHWARZENEGGER, et al.,

CASE NO. CIV S-90-0520 LKK JFM P

EXHIBIT A

DEFENDANTS' PLAN TO ADDRESS SUICIDE TRENDS IN ADMINISTRATIVE SEGREGATION UNITS

DIVISION OF CORRECTIONAL HEALTH CARE SERVICES
P. O. Box 942883
Sacramento, CA 94283-0001

October 2, 2006

J. Michael Keating, Jr.
Office of the Special Master
2351 Sussex Lane
Fernandina Beach, FL 32034

via: Lisa Tillman
Deputy Attorney General
Department of Justice
1300 I Street, Suite 125
P. O. Box 944255
Sacramento, CA 94244-2550

RE: ADMINISTRATIVE SEGREGATION UNIT SUICIDE REDUCTION PLAN

Dear Mr. Keating:

In compliance with the *Coleman* court order of June 8, 2006, please find enclosed the *Administrative Segregation Unit Suicide Prevention Plan*, which details the California Department of Corrections and Rehabilitation's (CDCR) plan to address the suicide trends in the administrative segregation units.

If you need clarification on any aspect of this plan, please contact me at (916) 327-0033, or Doug McKeever, Director (A), Mental Health Program, Division of Correctional Health Care Services (DCHCS), at (916) 327-1168.

Sincerely,

PETER FARBER-SZEKRENYI, DR., P.H.
Director
Division of Correctional Health Care Services

JOHN DOVEY
Director
Division of Adult Institutions

Enclosure

cc: James Tilton, Secretary, CDCR
Kingston Prunty, Undersecretary, CDCR
Bruce Slavin, General Counsel, Office of Legal Affairs, CDCR
Kathleen Keeshen, Chief Deputy General Counsel, Office of Legal Affairs, CDCR
Marisela Montes, Chief Deputy Secretary, Adult Programs, CDCR
David Runnels, Chief Deputy Secretary, Adult Operations, CDCR
Renee Kanan, M.D., MPH, Deputy Director, DCHCS, CDCR
Yulanda Mynhier, Deputy Director (A), Health Care Administrative Operations Branch, DCHCS, CDCR
George A. Sifuentes, Deputy Director, Office of Facilities Management, CDCR
Doug McKeever, Director (A), Mental Health Program, DCHCS, CDCR
Michael Stone, Staff Counsel, Office of Legal Affairs, CDCR
Vicki O'Shaughnessy, Staff Services Manager II, Clinical Programs and Policy Unit, DCHCS, CDCR

ADMINISTRATIVE SEGREGATION UNIT SUICIDE PREVENTION PLAN

I. OVERVIEW OF COURT ORDER

On May 9, 2006, the *Coleman* Special Master filed the Report on Suicides Completed in the California Department of Corrections [and Rehabilitation] in Calendar Year 2004. The Special Master recommended that the California Department of Corrections and Rehabilitation (or Department) be required to:

> "*...develop by May 31, 2006 a plan for dealing with the escalating percentage of suicides occurring in administrative segregation units. The plan must be based on an analysis of the causes for the increasing rate and, depending on the outcome of the analysis, provide adequate resources of mental health and/or custody staff, create sufficient confidential interview space and/or enhance the quality of mental health services provided in administrative segregation units.*"

The Department responded to the recommendation by requesting to collaborate with the Special Master's experts, and to extend the completion of the plan by requesting the Court adopt August 31, 2006, as the date for completion of the plan.

Plaintiffs' counsel filed a series of responses to the report and requested that the Department obtain the necessary funding to implement any plan in September 2006, collaborate with Plaintiff's suicide expert, and include a schedule for implementation within the plan.

On June 8, 2006, Lawrence K. Karlton, Senior Judge, United States District Court, issued an order adopting the recommendation of the Special Master and the timeframe of August 31, 2006, for completion of the plan. He ordered the Department to:

> "*...include, as appropriate, a budget and implementation schedule for any policy and procedure changes, staffing or budget augmentation, and, if necessary, include a mechanism for obtaining mid-year funding on or before September 30, 2006.*"

In the course of discussions with Plaintiffs' counsel, the Department submitted a draft plan by September 5, 2006, and Plaintiffs' counsel agreed to permit an extension of the deadline for submission of the final plan to October 2, 2006. The Court approved the request for an extension of the deadline for the following plan.

II. DESCRIPTION OF ANALYSIS OF CONTRIBUTING FACTORS RELATED TO SUICIDES IN ADMINISTRATIVE SEGREGATION UNIT

The Department's Division of Correctional Health Care Services Suicide Prevention and Response Focused Improvement Team met in early June and identified a methodology for the analysis of causes (contributing factors) of increased suicides in Administrative Segregation Units and the preparation of a plan for submission to the *Coleman* court. The process included an in-house analysis of identifiable common factors of all Administrative Segregation Unit suicides in 2004, and an external consultation with a panel including the Special Master's experts, the plaintiff's expert, and California Department of Corrections and Rehabilitation's experts. In addition, the Suicide Prevention and Response Focused Improvement Team undertook a review of ideas or initiatives focused on Administrative Segregation Unit suicide risk reduction that have not been implemented, and identified current policies that have been partially implemented.

The Suicide Prevention and Response Focused Improvement Team met to reach consensus about general areas to investigate in the analysis of contributing factors to Administrative Segregation Unit suicides. The Suicide Prevention and Response Focused Improvement Team identified five major areas (contributing factors) that can contribute to an Administrative Segregation Unit suicide, including: mental health treatment issues; family/external social issues; custodial factors; in-prison safety/social issues; substance abuse issues; and "other", (See Attachment A). Each factor had several components identified by the Suicide Prevention and Response Focused Improvement Team. Subsequently, acting as independent reviewers, two members of the Division of Correctional Health Care Services senior mental health staff read each report of a suicide in Administrative Segregation Unit during 2004. The reviewers identified and tallied the number of times a general factor and its secondary components appeared in the report as contributing factors leading to the inmate's suicide. The reviewers conferred to identify contributing factors that each had identified. Finally, the reviewers compared their findings to those in the Special Master's expert report for each suicide. At the end of the process the tallies for each major contributing factor and its components were totaled to identify the most prominent contributing factors that were identified in the reports (and in Dr. Patterson's reviews) as leading to the suicide of the inmate.

The most frequent factors identified by the reviewers were (listed from most to least frequently identified): Mental Health, Custodial Factors, In-Prison/Safety, Other Issues, Family/External Issues. Within the Mental Health factor the most frequently identified secondary factor was inadequate suicide risk or mental health assessments, underestimation of acuity, lack of referral to a higher level of care, decompensation, and poor follow-up. Custodial issues included change in commitment time, the fact of Administrative Segregation Unit placement, and other factors such as District Attorney referrals, long Administrative Segregation Unit term, imposition of Security Housing Unit term, or violent rules violation. In-prison Safety/Social Issues encompassed fearfulness, reports of being threatened by others, and removal of a peer group.

Simultaneously with the review of 2004 suicides in Administrative Segregation Unit, the Suicide Prevention and Response Focused Improvement Team reviewed its meeting minutes, Action Item Log, and suicide prevention policy memoranda from the past two years to identify practices and policies that either had not been implemented or had been partially implemented to be part of the presentation to the expert consensus panel.

III. DESCRIPTION OF EXPERTS MEETING

The expert panel was conceived as a method to bring together subject-matter experts in suicide prevention and to reach consensus on a number of areas and actions to assist the Department in developing the court-ordered plan.

The Department sponsored three experts from around the nation: John Stoner, Ph.D., Colorado Department of Corrections; Thomas White, Ph.D., formerly Federal Bureau of Prisons; and Bill Kissel, M.S., formerly Georgia Department of Corrections. All three have been involved in training in suicide prevention, correctional mental health service delivery, and prison litigation. Plaintiff's expert was Lindsay Hayes, M.S. of the National Center for Institutions and Alternatives, an acknowledged national expert on jail/prison suicide prevention. The Special Master's experts were Jeffrey Metzner, M.D. and Ray Patterson, M.D. Both are acknowledged experts in correctional mental health services delivery and prison suicide issues.

On July 14, 2006, the consensus panel met in San Francisco for eight hours. In addition to the expert participants, others included Special Master J. Michael Keating, Division of Correctional Health Care Services Mental Health Program staff (Drs. Chaiken, McAloon, Steenman, Canning, and Program Director Doug McKeever), Teresa Schwartz, Associate Director, General Population Levels III & IV from the Division of Adult Institutions; Michael Stone, Staff Counsel, of the California Department of Corrections and Rehabilitation Office of Legal Affairs; plaintiff's counsel Jane Kahn and Lori Rifkin.

After introductions and a review of the agenda, Drs. Chaiken and Canning presented background and statistical data on suicides in Administrative Segregation Unit, highlights of the Division of Correctional Health Care Services suicide prevention policy, mental health services in Administrative Segregation Unit, and current and recent initiatives to reduce the risk of suicide in Administrative Segregation Units. In addition, staff presented an overview and the results of the contributing factors analysis.

Discussion by the participants centered on a variety of issues: environmental/physical plant factors, screening and evaluation issues, custodial procedures, and monitoring and auditing of practices.

IV. PANELISTS' AND PLAINTIFFS/COUNSELS' RECOMMENDATIONS ON MEANS TO ADDRESS SUICIDE TRENDS IN ADMINISTRATIVE SEGREGATION UNITS

During the afternoon, the panel participants discussed the following recommendations that should be considered for inclusion in the plan submitted to the court.

A. Environmental/Physical Plant:

1) Intake Cells: A percentage of cells in each Administrative Segregation Unit statewide should be reserved for new arrivals. Inmates newly housed into Administrative Segregation Units would be housed in these intake cells. The expert panel recommended that inmates be housed in intake cells for two to three weeks. The Department

recommends that inmates be housed in intake cells for a minimum of 72 hours. These cells would be located in areas that afford more opportunity for observation and interaction between custody staff and the inmate. (Note: Subsequent to the expert panel, Suicide Prevention and Response Focused Improvement Team determined that if, on initial arrival in Administrative Segregation Unit, an inmate can safely be housed with a cellmate, then the inmate would not need to be placed into one of the designated intake cells, since having a cellmate has proven to be a protective factor against suicide risk.)

2) Intake Cells: All intake cells should be retrofitted to reduce availability of hanging attachment sites.
   - When possible, beds should be concrete slab construction.
   - Dangerous protrusions should be eliminated and if possible replaced with "pull away" fixtures.
   - Vent coverings should be installed to reduce use of vent openings as attachment sites for ligatures.
   - Light coverings should be retrofitted to prevent use as attachment sites.
   - If possible, cell doors should be retrofitted or replaced with doors having more window area to increase visibility of cell interior.

B. Custodial Procedures

1) Title 15 Requirements: During the time that inmates are housed in the Administrative Segregation Unit intake cells, or are within the first two to three weeks after placement into Administrative Segregation Unit, the Department should ensure they receive all Title 15 requirements for out-of-cell time and privileges.

2) Confidential Mental Health Interviews: All inmates housed in Administrative Segregation Unit who meet with mental health staff should have their interviews in private settings (affording confidentiality of sight and sound from other inmates and confidentiality of sound from staff). Custody should announce these interviews as "health appointments" to avoid stigmatization and possible retribution of other inmates.

3) Reduction in Length of Stay: The length of time inmates remain in Administrative Segregation Units should be shortened.

4) Return-from-Court ("Bad News") Information: Inmates returning from court dates often experience increased distress due to "bad news" such as additional incarceration time or adverse court proceedings such as loss of parenting rights. Several institutions have created standardized ways to capture this information and alert mental health staff about possible mental health crises. Division of Correctional Health Care Services Suicide Prevention and Response Focused Improvement Team should standardize a statewide system to capture such information and communicate that information to mental health staff utilizing a combination of methods developed at Folsom State Prison and the California Correctional Institution.

C. Mental Health Screening, Coordination, and Treatment

1) Pre-placement Suicide Prevention Screening: All inmates placed into Administrative Segregation Unit should have a brief suicide risk screening done as part of their pre-placement medical screening. Results of the brief suicide-risk screening should be used to determine any need for further mental health evaluation, and should be noted in the chart on a chrono.

2) Post-placement Screening: All inmates receive the 31-item screening according to Mental Health Service Delivery System Program Guide timelines. The information available in the Mental Health Tracking System regarding Suicide Risk Factors should be used in order to corroborate self-report from the 31-item screening. The screening interview should be administered in a private, confidential setting. If an inmate refuses screening, a mental health clinician should contact the inmate at cell-front, should review the Unit Health Record, and should contact custody staff in the Administrative Segregation Unit to gather additional information regarding the inmate's mental state.

3) Daily Coordination: By policy memorandum of May 2005, the Department requires that each morning an assigned Licensed Psychiatric Technician should meet with Administrative Segregation Unit staff (including a Sergeant) to solicit information about new arrivals in Administrative Segregation Unit or inmates who may require clinical attention. Henceforth, this meeting should include the assigned Administrative Segregation Unit mental health clinician (social worker or psychologist). Suicide risk data on new arrivals should be available at the meeting to alert custody staff. Clinical concerns should be discussed.

4) Minimum Stay at Enhanced Outpatient Administrative Segregation Unit Hub Institutions: When an inmate is referred to the Administrative Segregation Unit Enhanced Outpatient Program level of care, there should be a 60 day period of time before the receiving Administrative Segregation Unit Hub Institution can refer the inmate-patient back to Correctional Clinical Case Management System level of care.

D. Quality Management

1) Auditing Case Manager Review of Rounds Notes: Institutional mental health supervisors should regularly audit Administrative Segregation Unit case manager's assessment/review of the License Psychiatric Technician weekly notes including who needs referral for further evaluation for higher level of care.

2) Audit of Screening Refusals: Supervisory staff should regularly audit the percentage of inmates who refuse initial Administrative Segregation Unit mental health screening interviews. If the frequency of refusals exceeds 30% in a 30-day period, a Quality Improvement Team should be created to determine the cause of the refusals and a strategy to improve voluntary participation by inmates in the screening process.

3) Audit of Administrative Segregation Unit Suicide Prevention: Regional Quality Management Assistance Teams should regularly audit the quality of suicide prevention efforts statewide in Administrative Segregation Unit including adherence to all Mental Health Services Delivery System Program Guide requirements, evaluation of the quality of screening and rounds, quality of the daily staff meeting, adherence to suicide prevention measures such as provision of an inmate-orientation pamphlet, and compliance with out-of-cell contacts. A report should be sent through the chain of command to the Health Care Manager and Warden of each institution, and reviewed by the Suicide Prevention and Response Focused Improvement Team.

E. Non-Disciplinary Segregation

Inmates in Administrative Segregation Units for non-disciplinary reasons should be placed in different housing and/or receive more property than is allowed in disciplinary segregation.

F. Custody Welfare Checks

Custody hourly rounds standard, should be increased to include a welfare check every 30 minutes to determine that every inmate is alive, and accounted for.

G. Double Celling

Every effort should be made to double-cell inmates in Administrative Segregations Units, when possible.

H. Emergency Response – Continuous Quality Improvement

Continuous Quality Improvement in Emergency Response is critical to preventing suicides. The Department should make every effort to ensure compliance with current policies.

V. CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION'S RESPONSES TO RECOMMENDATIONS AND IMPLEMENTATION PLAN

The following describes the plan to implement suicide prevention recommendations in Administrative Segregation Units. Recommendations that were not fully adopted are discussed.

A1) Intake Cells:

A percentage of cells in each Administrative Segregation Unit statewide will be retrofitted to reduce the opportunity for inmates to commit suicide. The institutions have been surveyed to determine average intake by Administrative Segregation Unit building and the most appropriate location for the "Intake Cells" based upon proximity to staff traffic and ease of observation from control booths, where applicable. The number and location of cells to be retrofitted has been developed based upon the data received from the institutions, (See Attachments B and C). Inmates newly housed into Administrative Segregation Units will be housed in these intake cells, when they cannot be celled with a cell partner. Inmates that are double celled upon intake will be celled where the vacancy

exists. The Department recommends that inmates be housed in intake cells for a minimum of 72 hours. These cells will be located in areas that afford more opportunity for observation and interaction between custody staff and the inmate. (Note: Subsequent to the expert panel, Suicide Prevention and Response Focused Improvement Team determined that if, on initial arrival in Administrative Segregation Unit, an inmate can safely be housed with a cellmate, then the inmate would not need to be placed into one of the designated intake cells, since having a cellmate has proven to be a protective factor against suicide risk.)

A2) **Retrofit Intake Cells:**

The Division of Adult Institutions has identified 406 cells disbursed among 64 housing units at 33 adult prisons to be designated as Administrative Segregation Unit Intake Cells. To the degree possible, the proposed intake cells will be retrofitted to reduce availability of hanging attachment points. Proposed retrofit modifications include:

- the installation of concrete slab beds,
- the elimination of protrusions in the cell,
- the replacement of cell vents or the installation of cell vent coverings,
- the replacement of cell light fixtures or the installation of light coverings, and
- the replacement or modification of cell doors to increase visibility of cell interior.

Given the diversity (physical plant design, age, construction materials, etc.) of the Administrative Segregation Unit cells at each of the Department's prisons, the Department must be thoughtful, discerning, and deliberate in their planning and implementation of the proposed retrofits. The Office of Facilities Management must perform site-by-site Architectural and Engineering assessments (architectural, structural, mechanical) to develop project scopes, designs, project cost estimates and schedules. Architectural and Engineering design is imperative given potential impacts to: building foundations due to the weight of proposed concrete bed slabs; to Heating, Ventilation, and Air Conditioning systems; and air and smoke evacuation flows due to vent coverings/modifications, and to the integrity of cell security due to the need for increased cell visibility.

Based upon a priority list developed by the Division of Correctional Health Care Services, the Office Of Facilities Management has developed a three phase plan to assess, design and implement the proposed physical plant retrofit. The Office of Facilities Management estimates that the conversion of all 406 cells can be accomplished using a three-phased approach with the following schedule:

- **Phase one** includes 160 cells disbursed among 27 housing units at 11 prisons. The Office of Facilities Management will conduct site-by-site Architectural and Engineering assessments and associated design work during the 2007/2008 Fiscal Year, with construction modifications (special repairs) taking place during the 2008/2009 Fiscal Year.
- **Phase two** includes 132 cells disbursed among 21 housing units at 11 prisons. The Office of Facilities Management will conduct site-by-site Architectural and Engineering assessments and associated design work during the 2008/2009 Fiscal

Year with construction modifications (special repairs) taking place during the 2009/2010 Fiscal Year.

- **Phase three** includes 114 cells disbursed among 16 housing units at 11 prisons. The Office of Facilities Management will conduct site-by-site Architectural and Engineering assessments and associated design during the 2009/2010 Fiscal Year with construction modifications (special repairs) taking place during the 2010/2011 Fiscal Year.

B1) Title 15 Requirements:

The Department will ensure Title 15 requirements for out of cell time and privileges are a priority for all inmates during the first three weeks after placement in the Administrative Segregation Unit.

Institutions will be directed to develop methods to identify inmates in their first three days of Administrative Segregation Unit placement to staff in the units. An identifying marker, including date of intake, will be used on the cell front to indicate where newly placed Administrative Segregation Unit inmates are housed upon intake.

Within the constraints of physical plant limitations, every institution is expected to immediately ensure that inmates in the Administrative Segregation Units are offered access to the exercise yard for the departmental minimums, as identified in the California Code of Regulations, 3343(h). Institutions with Small Management Yard facilities should offer newly placed Administrative Segregation Unit inmates access to "Walk-Alone" yard as quickly as possible, within the guidelines of the classification process, and with safety and security as top priorities.

Staff shall account for out-of-cell time for inmates assigned to Administrative Segregation Unit, including, but not limited to, California Department of Corrections and Rehabilitation 114-D, Segregation Order and California Department of Corrections and Rehabilitation Rule Violation Report hearings, Unit Classification Committee, Institutional Classification Committee, medical ducats, interviews, visiting, showers, yard and all other out of cell periods. All out-of-cell time for inmates assigned to Administrative Segregation Unit shall be documented on the California Department of Corrections 114-A, Detention/ Segregation Record. Institutions shall continue to audit the California Department of Corrections 114-A, Detention/ Segregation Records on a weekly basis to ensure compliance with departmental mandates.

Presently, the Office of Audits and Compliance completes reviews throughout the year of administrative segregation and due process operations at various institutions. One portion of this audit evaluates institutional compliance with access to exercise yards for inmates housed in Administrative Segregation. These reports are submitted to the Directorate and assigned to the appropriate Associate Director for assessment and response.

No later than **October 30, 2006**, a survey will be distributed to every institution that maintains Administrative Segregation Units. Each institution will be directed to provide

current information regarding the number and location of Small Management Yards for inmates housed in Administrative Segregation Units. In addition, on a monthly basis each institution will be required to assess, record, and track the current yard access provided to inmates in Administrative Segregation Unit. Finally, each institution will need to provide a list of barriers to meeting the mandated hours of yard access, (i.e. staffing issues, physical plant issues, etc.). This information will be used to assess the need for additional resources to meet the mandated out of cell time.

For the past several years, the Department has been implementing a plan to increase the number of Small Management Yards available as part of the Department's Five Year Infrastructure Plan. A recent review reflects the Department's total Small Management Yard need at 1,342 yards, with 921 being constructed and/or funded as of Fiscal Year 2006/2007. This leaves 441 Small Management Yards that need to be funded and constructed in future years. The Division of Adult Institutions and Office of Facilities Management will continue to work collaboratively to assess current allocation and location of Small Management Yards at each institution and incorporate the findings of the aforementioned survey into the Small Management Yard planning process. The Administration will continue to request additional resources, to the extent needed, through the annual budget process, (See below Section VII *Fiscal Impact*).

B2) Confidential Mental Health Interviews:

Current estimates indicate that appropriate space in Administrative Segregation Units can be prioritized for the purpose of providing Confidential Mental Health Interviews. The Division of Adult Institutions and Office of Facilities Management will work collaboratively to assess current space availability for these interviews at each institution to validate these current estimates. In addition, Division of Adult Institutions and Office of Facilities Management will complete an assessment of additional resources needed (plant and staffing)[1]. The Administration will request additional resources, to the extent needed, through the annual budget process, (See below Section VII *Fiscal Impact*).

B3) Reduction in Length of Stay:

A Sensitive Needs Yard for Level IV inmates will be available at Mule Creek State Prison in January 2007, which is expected to reduce length of stay for qualifying inmates.

In December 2005, Mr. Dave Runnels, then Deputy Director of the Division of Adult Institutions, directed institutions in Administrative Segregation Overflow status to begin producing Corrective Action Plans outlining the institution's plan to reduce the number of inmates in Administrative Segregation Unit Overflow. These reports are submitted and reviewed on a monthly basis.

In addition, a separate weekly report is compiled by the Institution Support Division, detailing the status of all Administrative Segregation Unit buildings in terms of current

[1] This assessment will consider the appropriation recently approved by the Legislature for the Budget Change Proposal that was submitted in August 2006, which included dedicated custody personnel assigned to Administrative Segregation Unit mental health escorts, and additional clinical staff for Administrative Segregation Units statewide.

capacity, population and single-cell inmates, (See Attachment D). Issues related to Administrative Segregation Unit housing that are identified in this review are referred to the appropriate Associate Director for response and follow-up. Conference Calls with impacted Wardens are periodically scheduled to develop strategies for Administrative Segregation Unit reduction through timely release of inmates, completion of investigations and disciplinary proceedings.

On a monthly basis, the Office of Audits and Compliance completes an *Audit of Administrative Segregation and Due Process Operations* at a different prison. While this audit does not specifically address the issue of "Length of Stay", it does evaluate that institution's compliance with the 90 day review of cases. These reports are submitted to the Directorate and assigned to the appropriate Associate Director for assessment and response.

The Computer Statistics (or COMPSTAT) review process implemented in April 2006 by the Secretary of Corrections is an in-depth analysis of each institution's performance based upon statistical data. This information is compiled by the COMPSTAT unit and shared with the Secretary of Corrections and the Director of the Division of Adult Institutions, among others, during a formal presentation. The COMPSTAT format has been modified to include the Administrative Segregation Average Length of Stay for both Administrative Segregation Units and Administrative Segregation Unit Overflows.

The Division of Adult Institutions is working to identify barriers to the transportation of endorsed inmates to appropriate programs from Administrative Segregation Units throughout the State. The Director of Corrections will be issuing a memorandum to all institutions directing them to review the status of all inmates currently in Administrative Segregation Unit with stays beyond 30 days. Institutions will be required to identify inmates awaiting transfer, disciplinary hearings and District Attorney review. In addition, the memorandum will direct institutions to take aggressive steps to ensure the expeditious release of inmates from the Administrative Segregation setting, as soon as possible within Departmental policy.

The Department has reviewed and adopts each of the recommendations stated above in Section IV. subsections B4 through D3. In order to implement these recommendations the Department plans to complete the following:

B4) Return-from-Court ("Bad News") Information:
A policy change adopting the aforementioned recommendation will be implemented system-wide by December 2006. In addition, the Department will update the Mental Health Services Delivery System Program Guide to include this recommendation during the annual revision in January 2007.

C1) Pre-placement Suicide Prevention Screening:
A pre-placement suicide prevention screening in accordance with the aforementioned recommendation will be implemented by June 2007.

C2) Post-placement Screening:
Direction was provided to institutional staff via the following memoranda:

- *Transfer of Mental Health Tracking System Suicide History Information*, (Attachment E), and
- *Plan to Reduce Suicide Risk in Administrative Segregation Units*, (Attachment F).

In addition, the Department will update the Mental Health Services Delivery System Program Guide to include this recommendation during the annual revision in January 2007.

C3) Daily Coordination:
Direction was provided to institutional staff via the *Plan to Reduce Suicide Risk in Administrative Segregation Units* Memorandum, (Attachment F). In addition, the Department will update the Mental Health Services Delivery System Program Guide to include this recommendation during the annual revision in January 2007.

C4) Minimum Stay at Enhanced Outpatient Administrative Segregation Unit Hub Institutions:
Direction was provided to institutional staff via the *Plan to Reduce Suicide Risk in Administrative Segregation Units* Memorandum, (Attachment F). In addition, the Department will update the Mental Health Services Delivery System Program Guide to include this recommendation during the annual revision in January 2007.

D1) Auditing Case Manager Review of Weekly Rounds Notes:
Direction was provided to institutional staff via the *Plan to Reduce Suicide Risk in Administrative Segregation Units* Memorandum, (Attachment F). In addition, the Department will update the Mental Health Services Delivery System Program Guide to include this recommendation during the annual revision in January 2007.

D2) Audit of Screening Refusals:
Direction was provided to institutional staff via the *Plan to Reduce Suicide Risk in Administrative Segregation Units* Memorandum, (Attachment F), with an audit system to be developed by the end of October 2006. A memorandum will be distributed in November 2006 system-wide requiring an audit of compliance. In addition, the Quality Management Assistance Team will conduct an initial audit of compliance at selected institutions in January 2007, and at all institutions in March 2007.

D3) Audit of Administrative Segregation Unit Suicide Prevention:
The Quality Management Assistance Team will conduct an initial audit of compliance, as recommended above, at selected institutions in January 2007, and at all institutions in March 2007.

E) Non-Disciplinary Segregation

The Division of Adult Institutions believes the recommendation for separate housing and/or property retention by inmates placed in Administrative Segregation Unit housing for non-disciplinary reasons would compromise the safety and security of the institution, it's staff and inmates remanded to the custody of the Department.

Providing inmates who are in Administrative Segregation Units for non-disciplinary reasons with more personal property than those who are in Administrative Segregation Units for disciplinary reasons may lead to stigmatization and possible retribution of other inmates. The Division of Adult Institutions believes that inmates allowed additional property would be subjected to pressure in the form of threats of physical attack, and psychological torment. This pressure would be intended to influence those inmates to relinquish their personal property to other inmates placed in Administrative Segregation Unit for disciplinary reasons. In addition, this change would readily identify inmates processed into Administrative Segregation Unit with their property as being confidential informants or as needing special protection from General Population inmates. Any of these circumstances would make the non-disciplinary inmates difficult to house on any general population facility for the remainder of their prison term.

Attempting to accomplish this by separating inmates within the housing unit may work for short periods of time, but Administrative Segregation Unit populations vary too significantly to rely on the disciplinary/non-disciplinary qualifier as a secure and practical determinant of housing. Some institutions may be able to utilize different tiers or sections of housing units to separate these populations, however, the demands on bed-space would ultimately result in these populations being housed in proximity to one another.

Due to the Department's current housing crisis, separate housing for inmates placed in Administrative Segregation Units for disciplinary and non-disciplinary reasons is unreasonable. This modification would seriously reduce available bed space for both Administrative Segregation and General Population housing.

In addition, an inmate's placement status into an Administrative Segregation Unit is not usually as simple as disciplinary/non-disciplinary. Many inmates who do not have pending disciplinary issues, but fear for their safety, have this fear as a result of behavior that is inconsistent with State Law, Departmental Regulations, and Institution Policies. Examples of these behaviors are participating in narcotics activity for which the inmate fails to pay, or gang activity where the inmate is unable to follow through with activities the gang has ordered.

The Department maintains continued skepticism regarding additional property allowances for non-disciplinary Administrative Segregation Unit placement inmates. However, the Division of Adult Institutions will assess the success of the property portion of the Madrid court-ordered Pilot Project at Pelican Bay State Prison (Pelican Bay State Prison Administrative Segregation Correctional Clinical Case Management System Mental Health Management Program) following the one year anniversary of its implementation, beginning on **March 6, 2007**. The assessment will be submitted to the Court no later than **May 31, 2007**.

F) Custody Welfare Checks

The American Correctional Association standard for a "Welfare Check" is, *"All special management inmates shall be personally observed by a correctional officer at least every 30 minutes at an irregular schedule. Inmates who are violent or mentally disordered or who demonstrate unusual or bizarre behavior shall receive more frequent observation."* American Correctional Association 4-4257.

Currently, custody staff assigned to Administrative Segregation Units are required to perform *hourly* security checks to ensure inmates are accounted for and secured within their assigned housing. Requiring a 'Welfare Check' of all inmates housed in Administrative Segregation Unit *every 30 minutes* would further strain the resources available to the Department.

The Division of Adult Institutions is unable to proceed with the recommendations of the experts as they relate to hourly Welfare Checks at this time. However, Division of Adult Institutions will re-evaluate the impact of implementation of this proposal in terms of workload impact and resource allotment. Division of Adult Institutions will complete an assessment of resources necessary to implement this recommendation, and submit a request for resources to the Legislature through the budgetary process.

G) Double Celling

The California Department of Corrections and Rehabilitation currently double-cells inmates in Administrative Segregation whenever possible. Institutions with physical plant limitations (over/under cell design) house inmates in single-cell situations for extended periods of time. In addition, some inmates have classification criteria that prohibit double-celling. Wardens will be encouraged to place inmates into double-celled housing whenever possible, especially when the inmate is initially placed into Administrative Segregation Unit.

H) Emergency Response

The California Department of Corrections and Rehabilitation is reviewing and aggressively investigating failures by staff to initiate Cardio-Pulmonary Resuscitation during emergency response.

The Director of the Division of Adult Institutions will be issuing a memorandum directing Wardens to provide all assigned Administrative Segregation Unit staff with refresher training regarding their responsibility to immediately initiate Cardio-Pulmonary Resuscitation when the inmate's condition warrants Cardio-Pulmonary Resuscitation. This training will be ordered to be completed no later than **October 31, 2006**, with Proof of Practice submitted to the appropriate Associate Director.

VI. CLINICAL ROUNDING IN ADMINISTRATIVE SEGREGATION UNITS

The Department will continue to provide daily rounds by a Licensed Psychiatric Technician (or by a mental health clinician) for all inmates housed in Administrative Segregation Units. Resources to facilitate compliance with this requirement were included with the Budget Change Proposal that was submitted to the Legislature in August 2006. The Mental Health Services Delivery System Program Guide will be revised through the annual revision procedure in January 2007 to delete language that indicates possible future reduction in this requirement for inmate-patients not included in the Mental Health Services Delivery System.

VII. FISCAL IMPACT

To the extent that components in this plan are found to result in the need for additional resources, the Administration will submit a budget request to the Legislature for consideration through the annual budget process. Requests are made to the Legislature in January, and can also be made during the spring process. To the extent that resources are needed in the current fiscal year, these resources could be secured through either Item 9840-001-0001, Budget Act of 2006, or through a supplemental appropriation from the Legislature, whichever is determined to be most appropriate.

CONTRIBUTING FACTOR ANALYSIS – SUICIDES IN ASU

Reviewer: _____ **Institution:** _____ **CDC#:** _____

Inmate's Age at time of death: ___ **Ethnicity:** _____ **LOC:** _____ **Custody Level:** _____

Mental Health Treatment	Family/External Social Issues	Custodial Factors	In-Prison Safety/Social Issues	Substance Abuse	Other
Decompensation	Bereavement	Commitment time	Fearful	Type	Poor communication between custody and MH staff
Poor follow-up	Other loss	Change in commitment time	Assault victim		Poor identification of individual needs that should have over-ridden ASU rules. Rule _____
Non-compliance	Lack of support	Paroling	Received threats		Emergency Response
Inadequate treatment	Perceived threat to family	DA referral	Debts		Medical Condition
Emotional change in response to stress factors		RVRs – 90 days	Relationship		
Cognitive change in response to stress factors		Long ASU > 90 days	Other		
Inadequate Suicide Risk Assessment		SHU term			
		Fact of ASU placement			
		First time in ASU			
		Violent RVR			
		Single Cell			

LIST OF ACRONYMS

ASU	Administrative Segregation Unit
CDC	California Department of Corrections
LOC	Level of Care
MH	Mental Health
DA	District Attorney
RVR	Rules Violation Report
SHU	Secured Housing Unit

ADMINISTRATIVE SEGREGATION UNIT INTAKE CELL CONVERSION ANALYSIS CHART

PRISON	BUILDING DESIGN	SEPT '05 INTAKE	DEC '05 INTAKE	MAR '06 INTAKE	JUNE '06 INTAKE	AVERAGE MONTHLY INTAKE	AVERAGE 3-DAY INTAKE	# OF CELLS TO BE MODIFIED	CELLS TO BE MODIFIED
ASP - UNIT 140	270	30	70	100	120	80	7.87	8	124, 125, 126, 127, 224, 225, 226, 227
CAL - ASU #1	Stand Alone	24	26	24	26	25	2.46	3	100, 101, 102
CAL - A5	270	71	93	83	75	80.5	7.92	8	124, 125, 126, 127, 224, 225, 226, 227
CCC - LASSEN, Bldg 4	270	120	50	120	80	92.5	9.10	9	123, 124, 125, 126, 127, 224, 225, 226, 227
CCI - UNIT II	Old Style	39	29	19	49	34	3.34	3	
CCI - 4A ASU	180	87	143	78	125	108.25	10.65	11	111, 112, 113, 114, 115, 116, 212, 213, 214, 215, 216
CCI - 4B ASU	180	19	23	27	38	26.75	2.63	3	113, 114, 115
CCWF	270	33	38	58	42	42.75	4.20	4	124, 125, 126, 127
CEN - C6	Stand Alone	112	106	96	114	107	10.52	11	101 through 111
CEN - A5	270	99	56	73	77	76.25	7.50	8	124, 125, 126, 127, 224, 225, 226, 227
CIM - PALM HALL	Telephone	80	75	80	70	76.25	7.50	8	118 through 125
CIM - CYPRESS HALL	Telephone	70	80	75	80	76.25	7.50	8	110 through 117
CIW	270	20	130	110	30	72.5	7.13	7	124, 125, 126, 127, 224, 225, 226
CMC - B4 Annex	Quad	152	165	143	190	162.5	15.98	16	4151, 4152, 4197, 4198, 4254, 4255, 4256, 4257, 4295, 4296, 4297, 4298, 4302, 4303, 4345, 4346
CMC - Central ASU	Quad	9	9	16	21	13.75	1.35	1	102
CMF - UNIT IV	Telephone	29	35	14	35	28.25	2.78	3	101, 102, 103
CMF - I3	Telephone	20	20	20	20	20	1.97	2	301, 302
CMF - P3	Telephone	20	20	20	20	20	1.97	2	301, 302
CMF - S3	Telephone	20	20	20	20	20	1.97	2	301, 302
COR - 3A03	270	50	56	84	50	60	5.90	6	123, 124, 125, 126, 127, 128
COR - ASU1	Stand Alone	31	42	85	50	52	5.11	5	101 through 105
COR - 4B1R	180	29	29	29	29	29	2.85	3	113, 114, 115
CTF - O WING	Telephone	40	80	100	95	78.75	7.75	8	101 through 108
CTF - X WING	Telephone	20	40	50	45	38.75	3.81	4	101 through 104
CVSP	270	74	115	61	105	88.75	8.73	9	123, 124, 125, 126, 127, 224, 225, 226, 227
DVI - J WING	Telephone	300	300	300	300	300	29.51	30	101 through 130
FSP - UNIT IV ASU	Telephone	60	60	60	70	62.5	6.15	6	101 through 106
FSP - UNIT I ASU O/F	Telephone	18	14	14	26	18	1.77	2	101, 102

ADMINISTRATIVE SEGREGATION UNIT INTAKE CELL CONVERSION ANALYSIS CHART

PRISON	BUILDING DESIGN	SEPT '05 INTAKE	DEC '05 INTAKE	MAR '06 INTAKE	JUNE '06 INTAKE	AVERAGE MONTHLY INTAKE	AVERAGE 3-DAY INTAKE	# OF CELLS TO BE MODIFIED	CELLS TO BE MODIFIED
HDSP - Z UNIT	Stand Alone	14	20	21	20	18.75	1.84	2	101, 102
HDSP - D7	180	31	20	16	21	22	2.16	2	113 & 114
HDSP - D8	180	56	46	49	52	50.75	4.99	5	112, 113, 114, 115, 116
ISP - A5	270	41	46	36	79	50.5	4.97	5	123, 124, 125, 126, 127
KVSP - ASU #1	Stand Alone					0	0.00	5	101 through 105
KVSP - ASU #2	Stand Alone					0	0.00	5	101 through 105
KVSP - B1	180					0	0.00	10	112, 113, 114, 115, 116, 212, 213, 214, 215, 216
LAC - ASU1	Stand Alone	61	49	61	106	69.25	6.81	7	101 through 107
LAC - A5	270	61	49	61	106	69.25	6.81	7	124, 125, 126, 127, 224, 225, 226
LAC - A4	270	61	49	61	106	69.25	6.81	7	124, 125, 126, 127, 224, 225, 226
MCSP - Fac C, Bldg 12	270	24	30	32	43	32.25	3.17	3	124, 125, 126
NKSP - D6	Wing Nut	60	50	60	40	52.5	5.16	5	101, 102, 103, 143, 144
NKSP - A4	Wing Nut	30	40	30	50	37.5	3.69	4	101, 102, 103, 104
PBSP - ASU 1	Stand Alone	50	51	50	51	50.5	4.97	5	101 through 105
PBSP - A1	180	13	6	25	48	23	2.26	2	113, 114
PBSP - A2	180	13	25	0	25	15.75	1.55	2	113, 114
PVSP - ASU #1	Stand Alone	40	78	66	76	65	6.39	6	101 through 106
PVSP - Fac D	270	35	27	32	38	33	3.25	3	124, 125, 126
RJD - Fac 2, Bldg 6	270	120	120	120	120	120	11.80	12	123, 124, 125, 126, 127, 128, 223, 224, 225, 226, 227, 228
RJD - Fac 2, Bldg 7	270	120	120	120	120	120	11.80	12	123, 124, 125, 126, 127, 128, 223, 224, 225, 226, 227, 228
SAC - ASU	Stand Alone	41	49	47	64	50.25	4.94	5	101 through 105
SAC - A6	180	38	25	23	26	28	2.75	3	113, 114, 115
SAC - A7	180	0	0	31	48	19.75	1.94	2	113, 114
SATF - ASU	Stand Alone	48	54	42	63	51.75	5.09	5	101 through 105
SATF - Fac E	270	24	66	63	38	47.75	4.70	5	123, 124, 125, 126, 127
SCC	270	162	104	121	80	116.75	11.48	12	123, 124, 125, 126, 127, 128, 223, 224, 225, 226, 227, 228
SOL - FAC 2, BLDG 10	270	63	36	70	57	56.5	5.56	6	123, 124, 125, 126, 127, 128
SOL - FAC 2, BLDG 9	270	50	30	30	30	35	3.44	3	124, 125, 126

ADMINISTRATIVE SEGREGATION UNIT INTAKE CELL CONVERSION ANALYSIS CHART

PRISON	BUILDING DESIGN	SEPT '05 INTAKE	DEC '05 INTAKE	MAR '06 INTAKE	JUNE '06 INTAKE	AVERAGE MONTHLY INTAKE	AVERAGE 3-DAY INTAKE	# OF CELLS TO BE MODIFIED	CELLS TO BE MODIFIED
SQ - CARSON UNIT	Telephone	150	150	150	150	150	14.75	15	8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23
SQ - CARSON UNIT	Telephone	150	150	150	150	150	14.75	15	8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23
SVSP - D1	180					0	0.00	4	
SVSP - D2	180					0	0.00	4	
SVSP - D8	180					0	0.00	4	
SVSP - D9	Stand Alone	62	94	97	82	83.75	8.24	7	
VSPW	270	33	13	23	10	19.75	1.94	2	124, 125
WSP - D6	Wing Nut	120	120	120	120	120	11.80	12	101, 102, 103, 104, 105, 106, 143, 144, 145, 146, 147, 148
WSP - FAOR	270	30	30	30	30	30	2.95	3	124, 125, 126

ADMINISTRATIVE SEGREGATION UNIT INTAKE CELL CONVERSION ANALYSIS CHART

LIST OF PRISON ACRONYMS

Institution	
ASP	Avenal State Prison
CAL	Calipatria State Prison
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CCI	California Correctional Institution
CCWF	Central California Women's Facility
CEN	Centinela State Prison
CIM	California Institution for Men
CIW	California Institution for Women
CMC	California Men's Colony
CMF	California Medical Facility
COR	Corcoran State Prison
CRC	California Rehabilitation Center
CTF	Correctional Training Facility
CVSP	Chuckawalla Valley State Prison
DVI	Deuel Vocational Institution
FSP	Folsom State Prison
HDSP	High Desert State Prison
ISP	Ironwood State Prison
KVSP	Kern Valley State Prison
LAC	California State Prison, Los Angeles County
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PBSP	Pelican Bay State Prison
PVSP	Pleasant Valley State Prison
RJD	R.J. Donovan Correctional Facility at Rock Mountain
SAC	California State Prison, Sacramento
SATF	California Substance Abuse Treatment Facility
SCC	Sierra Conservation Center
SOL	California State Prison, Solano
SQ	San Quentin State Prison
SVSP	Salinas Valley State Prison
VSPW	Valley State Prison for Women
WSP	Wasco State Prison

PERCENTAGE OF ADMINISTRATIVE SEGREGATION UNIT CELLS TO BE MODIFIED TO INTAKE CELLS

PRISON	BUILDING DESIGN	# OF CELLS IN UNIT	# OF CELLS TO BE MODIFIED	% OF CELLS TO BE MODIFIED
ASP - UNIT 140	270	100	8	8.00%
CAL - ASU #1	Stand Alone	100	3	3.00%
CAL - A5	270	100	8	8.00%
CCC - LASSEN, Bldg 4	270	100	9	9.00%
CCI - UNIT II	Old Style	24	3	12.50%
CCI - 4A ASU	180	64	11	17.19%
CCI - 4B ASU	180	64	3	4.69%
CCWF	270	35	4	11.43%
CEN - C6	Stand Alone	100	11	11.00%
CEN - A5	270	100	8	8.00%
CIM - PALM HALL	Telephone	102	8	7.84%
CIM - CYPRESS HALL	Telephone	102	8	7.84%
CIW	270	32	7	21.88%
CMC - B4 Annex	Quad	151	16	10.60%
CMC - Central ASU	Quad	104	1	0.96%
CMF - UNIT IV	Telephone	150	3	2.00%
CMF - I3	Telephone	38	2	5.26%
CMF - P3	Telephone	38	2	5.26%
CMF - S3	Telephone	18	2	11.11%
COR - 3A03	270	100	6	6.00%
COR - ASU1	Stand Alone	100	5	5.00%
COR - 4B1R	180	64	3	4.69%
CTF - O WING	Telephone	144	8	5.56%
CTF - X WING	Telephone	84	4	4.76%
CVSP	270	100	9	9.00%
DVI - J WING	Telephone	143	30	20.98%
FSP - UNIT IV ASU	Telephone	138	6	4.35%
FSP - UNIT I ASU O/F	Telephone	36	2	5.56%
HDSP - Z UNIT	Stand Alone	100	2	2.00%
HDSP - D7	180	64	2	3.13%
HDSP - D8	180	64	5	7.81%
ISP - A5	270	100	5	5.00%
KVSP - ASU #1	Stand Alone	100	5	5.00%
KVSP - ASU #2	Stand Alone	100	5	5.00%
KVSP - B1	180	64	10	15.63%
LAC - ASU1	Stand Alone	100	7	7.00%
LAC - A5	270	100	7	7.00%
LAC - A4	270	100	7	7.00%
MCSP - Fac C, Bldg 12	270	100	3	3.00%

PERCENTAGE OF ADMINISTRATIVE SEGREGATION UNIT CELLS TO BE MODIFIED TO INTAKE CELLS

PRISON	BUILDING DESIGN	# OF CELLS IN UNIT	# OF CELLS TO BE MODIFIED	% OF CELLS TO BE MODIFIED
NKSP - D6	Wing Nut	100	5	5.00%
NKSP - A4	Wing Nut	100	4	4.00%
PBSP - ASU 1	Stand Alone	100	5	5.00%
PBSP - A1	180	100	2	2.00%
PBSP - A2	180	100	2	2.00%
PVSP - ASU #1	Stand Alone	100	6	6.00%
PVSP - Fac D	270	100	3	3.00%
RJD - Fac 2, Bldg 6	270	100	12	12.00%
RJD - Fac 2, Bldg 7	270	100	12	12.00%
SAC - ASU	Stand Alone	100	5	5.00%
SAC - A6	180	64	3	4.69%
SAC - A7	180	64	2	3.13%
SATF - ASU	Stand Alone	100	5	5.00%
SATF - Fac E	270	100	5	5.00%
SCC	270	100	12	12.00%
SOL - FAC 2, BLDG 10	270	100	6	6.00%
SOL - FAC 2, BLDG 9	270	100	3	3.00%
SQ - CARSON UNIT	Telephone	238	15	6.30%
SQ - DONNER UNIT	Telephone	152	15	9.87%
SVSP - D1	180	64	4	6.25%
SVSP - D2	180	64	4	6.25%
SVSP - D8	180	64	4	6.25%
SVSP - D9	Stand Alone	100	7	7.00%
VSPW	270	44	2	4.55%
WSP - D6	Wing Nut	100	12	12.00%
WSP - FAOR	270	100	3	3.00%
		5977.00	406.00	6.79%

PERCENTAGE OF ADMINISTRATIVE SEGREGATION UNIT CELLS TO BE MODIFIED TO INTAKE CELLS

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Weekly Population/Budgeted Capacity Division of Adult Institution Analysis

15-Sep-06

	Per Fiscal Year 05/06 May Revise Institution Activation Schedule				Weekly Population (Based on Classification Services Unit Weekly Population Report)		Division of Adult Institution Calculation		
Institution	# of Administrative Segregation Unit Cells (Design Capacity)	Staffed Capacity (Budgeted number of inmates)	Budgeted Number of Single Celled Inmates *	Overcrowding Percentage **	Weekly Population*	Weekly Inmates Single Celled	Average Number of Cells Required to House Population ((F-G)/2)+G**	Over Staffed Capacity	Overflow Status***
ASP	100	175	25	175%	141	5	73	NO	NO
CAL	200	300	100	150%	304	20	162	YES	NO
CCC	100	175	25	175%	170	0	85	NO	NO
CCI****	210	327	93	156%	277	114	196	NO	NO
CEN	200	350	50	175%	293	66	180	NO	NO
CIM/CRC	203	356	50	175%	290	44	167	NO	NO
CMC	226	226	226	100%	254	216	235	YES	YES
CMF	164	164	164	100%	173	173	173	YES	YES
COR****	307	460	154	150%	427	137	282	NO	NO
CTF	192	228	156	119%	282	183	233	YES	YES
CVSP	100	175	25	175%	122	3	63	NO	NO
DVI	235	303	167	129%	404	156	280	YES	YES
FOL	138	138	138	100%	188	143	166	YES	YES
HDSP	228	343	113	150%	294	102	198	NO	NO
ISP	100	175	25	175%	211	1	106	YES	YES
KVSP	264	396	132	150%	322	40	181	NO	NO
LAC	300	450	150	150%	410	160	285	NO	NO
MCSP	100	175	25	175%	179	79	129	YES	YES
NKSP	100	175	25	175%	123	36	80	NO	NO
PBSP****	164	246	82	150%	321	75	198	YES	YES
PVSP	200	350	50	175%	311	14	163	NO	NO
RJD	200	350	50	175%	344	162	253	NO	YES
SAC	292	406	178	139%	281	169	225	NO	NO
SATF	200	325	75	163%	290	103	197	NO	NO
SCC	100	175	25	175%	162	3	83	NO	NO
SOL	200	350	50	175%	410	52	231	YES	YES
SQ	379	379	379	100%	451	451	451	YES	YES
SVSP	292	439	145	150%	440	107	274	YES	NO
WSP	100	175	25	175%	205	68	137	YES	YES
FEMALE INSTITUTIONS									
CCWF	35	61	9	174%	40	10	25	NO	NO
CIW	32	56	8	175%	32	0	16	NO	NO
VSPW	44	76	12	173%	112	0	56	YES	YES
Total	**5705**	**8479**	**2931**		**8263**	**2892**	**5578**		

* Based on Classification Services Unit Population Management Weekly report. The single celled count reported may not accurately reflect operations at the institutions.

** The number of single celled inmates are subtracted from the population. The population is then divided by 2, providing the number of cells needed to double cell the population. To reach the total number of cells needed, add back in the number of inmate single celled.

*** Based on the numbers provided and the calculation of cells, whether your institution should be operating in overflow

****California Correctional Institute, California State Prison - Corcoran, Pelican Bay State Prison house some Administrative Segregation Unit inmates in Secured Housing Units. Those inmates, as reported on the Classification Services Unit Weekly Population report, who are Administrative Segregation Unit inmates in Secured Housing Units beds are backed out of weekly population numbers.

Weekly Population/Budgeted Capacity Division of Adult Institution Analysis

15-Sep-06

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Memorandum

Attachment E

Date : October 2, 2006

To : Health Care Managers
Chiefs of Mental Health

Subject : TRANSFER OF MENTAL HEALTH TRACKING SYSTEM SUICIDE HISTORY INFORMATION

Over the last year mental health clinicians have been providing suicide history data regarding their patients to be entered into the Mental Health Tracking System (MHTS) consistent with a *Coleman* court order. This data is then used to generate the Inmate Profile (IP) which includes suicide history and alerts.

Beginning October 2, 2006, whenever a Mental Health Services Delivery System inmate transfers from one California Department of Corrections and Rehabilitation (CDCR) institution to another CDCR institution, or whenever a confidential Medical/Mental Health Transfer Form 7371 is sent, the IP generated by the MHTS will be included in the transfer envelope.

At the receiving institution the IP will be reviewed by the Receiving and Release Registered Nurse (RN) for referral consideration based on current needs and then forwarded to the Mental Health Program for input into the institution's MHTS.

Your local Operating Procedure (OP) should include all points in this process including:

- How MHTS staff at the sending institution is informed that an inmate is transferring so they can generate the IP.
- How MHTS staff will ensure the IP gets to the nursing staff responsible for generating the transfer envelope.
- How the receiving institution will utilize the IP suicide history information in the bus screening process.
- How at the receiving institution the IP is routed to the MHTS staff for input.
- The Operating Procedure for referral of a positive bus screening to mental health clinicians should be reiterated consistent with the Mental Health Program Guides policy.

All inmates who are being placed in Administrative Segregation Unit shall have the IP generated and reviewed by the Licensed Psychiatric Technician (LPT) prior to their mental health screening (This will require LPTs to have access to the MHTS to generate IPs)

If you have any questions, please contact Margaret McAloon, Ph.D., Chief Psychologist, Clinical Operations, Mental Health Program, Division of Correctional Health Care Services (DCHCS) at (916) 324-6102.

PETER FARBER-SZEKRENYI, DR., P.H.
Director
Division of Correctional Health Care Services

cc: Brigid Hanson, Deputy Director, DCHCS
Christine Martin, Special Assistant to the Director, DCHCS
Yulanda Mynhier, Deputy Director (A), Health Care Administrative Operations Branch, DCHCS
Dwight Winslow, M.D., Statewide Medical Director (A), DCHCS
Regional Administrators, DCHCS
Regional Medical Directors, Clinical Services, DCHCS
Doug McKeever, Program Director, Mental Health Program, DCHCS
Andrew Swanson, Chief Psychiatrist, Mental Health Program, DCHCS
Shama Chaiken, Ph.D., Chief Psychologist, Mental Health Program, DCHCS
Margaret McAloon, Ph.D., Chief Psychologist, Clinical Operations, Mental Health Program, DCHCS
Senior Psychologist Supervisors and Specialists, DCHCS Headquarters
Susan Turner, Statewide Director of Nursing, DCHCS
Lisa Tillman, Deputy Attorney General, Department of Justice
Michael Stone, Staff Counsel, Correctional Law Unit, Office of Legal Affairs
Sharon Riegel, Health Program Specialist, DCHCS

State of California California Department of Corrections and Rehabilitation

Memorandum

Date : October 2, 2006

To : Wardens
Health Care Managers
Chiefs of Mental Health

Subject : **PLAN TO REDUCE SUICIDE RISK IN ADMINISTRATIVE SEGREGATION UNITS**

BACKGROUND

On June 8, 2006 the California Department of Corrections and Rehabilitation (CDCR) was ordered by the *Coleman* court to:

> *"develop . . . a plan for dealing with the escalating percentage of suicides occurring in administrative segregation units. The plan must be based on an analysis of the causes for the increasing rate and, depending on the outcome of the analysis, provide adequate resources of mental health and/or custody staff, create sufficient confidential interview space and/or enhance the quality of mental health services provided in administrative segregation units."*

In 2004, 69 percent of the suicides committed in CDCR occurred in Administrative Segregation Units (ASU), while only approximately five percent of CDCR inmates were in ASU at any given time. Over time data indicates that about half of the inmates who commit suicide in ASU are not included in the Mental Health Services Delivery System (MHSDS) at the time of their death. Inmates are particularly likely to complete suicides during the first weeks after placement in ASU, with a disproportionate number occurring in the first 72 hours.

Recognizing that housing in ASU places inmates at higher risk, the Department has implemented a number of initiatives to reduce suicides in ASU over the last two years. Currently, custody and clinical staff are required to hold daily morning meetings in ASU to discuss potential suicide risk of new arrivals to the unit, and to communicate about any inmates who demonstrate changes in behavior. Current policy also requires hourly custody security checks, and documentation of all pertinent information relative to ASU inmate services and activities on the CDCR Form 114-A. Additionally, all inmates who arrive in ASU must receive an orientation pamphlet, which describes some of the stressors related to placement in ASU, and contains information about how to request mental health services. Please ensure that all current policies and procedures regarding suicide prevention in ASU are in place.

In response to the court order, CDCR began to analyze causes of suicides in ASU in order to formulate a comprehensive suicide prevention plan. The plan integrates a number of initiatives and involves personnel, policies, and practices across the Division of Adult Institutions (DAI), the Division of Correctional Health Care Services (DCHCS), and the Office of Facilities Management (OFM).

Some elements of the plan can be implemented immediately, while others will be implemented over a series of months and years. CDCR has collected initial data required to develop a plan to create ASU Intake Units with cells retrofitted to reduce access to attachment cites for hanging and to increase visibility into the cells.

This memo details initial suicide prevention measures and gives direction on implementation of these policy changes. Additional changes in policies and procedures will be implemented via memoranda and will be incorporated into the MHSDS 2006 Program Guide on an annual basis. All institutions are expected to comply with the changes and implementation timetable, and will be held accountable for compliance and implementation.

POST-PLACEMENT SCREENING

Currently, all inmates placed into ASU receive the 31-item screening according to MHSDS Program Guide timelines.

Effective immediately, mental health staff shall conduct the screening interviews in private and confidential settings. The settings will afford confidentiality of sight and sound from other inmates, and confidentiality of sound from staff. All mental health appointments, including the screening interviews shall be announced by custody staff as a "health appointment" to avoid stigmatization and possible retribution by other inmates. Every effort shall be made to encourage inmates to attend these appointments.

If an inmate refuses the screening, the clinician shall contact the inmate at his/her cell-front, review the inmate's Unit Health Record (UHR), and contact custodial staff in the inmate's unit to collect information regarding the inmate's mental state. The clinician shall note the inmate's refusal and the results of the data collection on an Interdisciplinary Progress Note and place it in the inmate's UHR.

AUDITING OF ASU SCREENING REFUSALS:

Effective immediately, each institution will develop a local procedure to audit the rate of refusal of initial ASU mental health screenings. The institution's Chief of Mental Health, or designee, shall be responsible for conducting the audit and evaluating the results. The audit tool shall include, at a minimum: the number of inmates admitted to ASU in the last calendar month, the number of mental health screenings completed in that month and the number of inmates who refused to participate in the screening in a private, confidential setting. The procedure will identify a process for review and quality improvement if inmate screening

refusals exceed 30 percent. This procedure shall include a process to identify reasons for refusals, and a plan to encourage increased participation in screenings.

DAILY COORDINATION OF ASU

By memorandum of May 9, 2005, all institutions were directed to "develop a procedure for alerting Mental Health Staff to new arrivals in ASU within 24 hours". This policy included a morning 'check-in' meeting between (at minimum) an ASU Sergeant and designated ASU Mental Health personnel. During the meeting, involved personnel identify new arrivals, discuss current issues, and share any pertinent information regarding risk factors and prevention strategies.

Effective immediately, the morning meeting shall be attended by the assigned ASU mental health clinician (psychologist or social worker). Suicide risk data, from the Mental Health Tracking System Report, shall be communicated to custody staff, and relevant clinical concerns about inmates shall be discussed. Salient clinical information from this meeting shall be documented in the inmate's UHR and if necessary, a referral for mental health services shall be made at the appropriate level of urgency.

MINIMUM STAY AT ENHANCED OUTPATIENT PROGRAM ASU HUB INSTITUTIONS

Inmates transferred to Enhanced Outpatient Program ASU hub institutions for treatment of severe mental disorders and clinical decompensation can appear to be clinically improved and stable for up to several weeks after their arrival at the receiving institution. This may lead the hub institution to prematurely return the inmate to the sending institution without adequate treatment. Subsequently the inmate may return to their pre-transfer state of clinical decompensation.

Effective immediately, to avoid premature returns of inmate-patients and provide adequate time for observation and evaluation at EOP ASU hub institutions, all inmates transferred to EOP ASU hub institutions for treatment shall be held at the hub institution for no less than 60 days from the date of reception.

AUDITING CASE MANAGER REVIEW OF WEEKLY ASU ROUNDS NOTES

Currently, CDCR policy requires that a weekly summary of the daily clinical rounds of ASU MHSDS inmate-patients is placed in each inmate's UHR. It is expected that clinical case

managers assigned to the ASU regularly review the weekly summaries for inmate-patients on their clinical caseloads as part of their ongoing monitoring of inmate clinical condition.

Effective immediately, each institution will develop a local procedure to ensure the ASU case managers are regularly reviewing the weekly ASU clinical rounds documentation for their assigned inmate-patients.

The institution's Chief of Mental Health, or designee, will be responsible for conducting and evaluating the results of the audit. The procedure shall include a requirement that case managers document in the UHR that they have reviewed the weekly summaries of rounds for their caseload inmate-patients. The procedure will also include details of the audit of case managers' reviews.

The audit tool will include, at a minimum, information about the number of inmate-patients assigned to a case manager, the number of weekly reviews expected (number of inmate-patients on the case manager's caseload times the number of weeks the inmates were housed in ASU), and the number of weekly reviews documented by the case manager. The procedure will also include a process to correct deficient audits (i.e. training and/or progressive disciplinary action for clinicians who do not meet this requirement).

DOUBLE CELLING

Statistical information suggests that suicide risk is substantially reduced when inmates have a cellmate. Therefore, Wardens are encouraged to place inmates into double-celled housing whenever possible, especially when the inmate is initially placed into ASU.

MEETING TITLE 15 REQUIREMENTS

One of the contributing factors to inmate suicides is the restricted movement within the ASU environment. Inmates housed in the ASU, during the first three weeks after ASU placement, shall receive priority access to "Out-of-Cell" time, such as mandated exercise yard and showers.

Staff shall account for out-of-cell time for inmates assigned to ASU, including, but not limited to, CDCR 114-D, Segregation Order and CDCR Rule Violation Report hearings, Unit Classification Committee, Institutional Classification Committee, medical ducats, interviews, visiting, showers, yard and all other out of cell periods. All out-of-cell time for inmates assigned to ASU shall be documented on the CDC 114-A, Detention/ Segregation Record. Institutions shall continue to audit the CDC 114-A, Detention/ Segregation Records on a weekly basis to ensure compliance with departmental mandates.

Within the constraints of physical plant limitations, every institution is expected to immediately ensure that inmates in the ASU's are offered access to the exercise yard for the departmental minimums as identified in the California Code of Regulations, 3343 (h). Institutions with "Walk-Alone" yard facilities should offer newly placed ASU inmates access to Walk-Alone yard as quickly as possible, within the guidelines of the classification process, and with safety and security as top priorities.

In the near future, each institution will be asked to provide current information regarding the number and location of "Walk Alone" yards for inmates housed in Administrative Segregation Units. In addition, each institution will be required to assess the current yard access provided to inmates in ASU, and the tracking of that access. Finally, each institution will need to provide a list of barriers to meeting the mandated hours of yard access (i.e. staffing issues, physical plant issues, etc...). All of this information will be used to assess the need for additional resources to meet the mandated out of cell time.

CDCR is committed to implementing the recommendations described above, related to the prevention of inmate suicides. Each institution shall be responsible for revising their Local Operating Procedures to include the policy changes in this memorandum and to ensure that all staff assigned to ASU are provided On-the-Job (OJT) training regarding the directives above. The local institutions' Suicide Prevention and Response, Focused Improvement Teams shall review all policies, training materials, and audits, to ensure continuous quality improvement in ASU suicide prevention efforts. **Please send a copy of new ASU Local Operating Procedures and OJT sign in sheets on or before December 1, 2006:**

- For custody staff, to your respective Associate Director.
- For mental health staff to Sharon Riegel, Health Program Specialist (Fax number 916-324-6621).

The headquarters Quality Management Assistance Teams will audit compliance with all aspects of this memorandum by January 1, 2007.

If you have questions about this memorandum involving custody issues, please contact Mary Neade, Correctional Counselor II, Division of Adult Institutions, at (916) 322-7997. For questions regarding clinical issues, please contact Robert Canning, Senior Psychologist (A), at (916) 324-8050.

PETER FARBER-SZEKRENYI, DR. P.H.
Director
Division of Correctional Health Care Services

JOHN DOVEY
Director
Division of Adult Institutions

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Michael Stone, Staff Counsel, Correctional Law Unit, Office of Legal Affairs
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Attorneys for Defendants

IN THE UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF CALIFORNIA

RALPH COLEMAN, et al., Plaintiffs, **v.** **ARNOLD SCHWARZENEGGER, et al.,** Defendants.	2:90-cv-00520 LKK JFM P **DEFENDANTS' RESPONSE TO PLAINTIFFS' OBJECTIONS TO SUBMITTED PLAN TO ADDRESS SUICIDE TRENDS IN ADMINISTRATIVE SEGREGATION UNITS**

I.

INTRODUCTION

Defendants submit this statement in response to Plaintiffs' objections to their submitted plan to address the escalating percentage of suicides occurring in administrative segregation. Defendants have reviewed Plaintiffs' objections and now commit to undertaking additional measures to resolve certain issues asserted in Plaintiffs' objections.

//

//

II.

BACKGROUND

This Court has entered two orders addressing suicide issues in administrative segregation units. The first order, issued in June 2005, directed Defendants to develop a plan to address the hazard of large-mesh ventilation screens in administrative segregation cells in which caseload inmates are housed. Defendants submitted a plan in response to that court order in July 2005. On June 8, 2006, this Court ordered Defendants to develop a plan, in collaboration with the Court's and Plaintiffs' experts, to address the escalating suicide trends in administrative segregation units. The plan was submitted on October 1, 2006. In their objections to the plan to address suicide trends in administrative segregation units, Plaintiffs requested this Court enter an order mandating:

1. **Immediate Retrofit of 406 Intake Cells**: Defendants are to retrofit the intake unit cells as soon as possible, but no later than June 1, 2007.

2. **Pre-Screening Placement**: Defendants shall implement the pre-placement suicide prevention screening as soon as possible, but no later than January 1, 2007, and shall seek mid-year funding if necessary.

3. **Emergency Funding**: Defendants shall prepare and submit an emergency funding request for all necessary staffing and construction, to enable CDCR to provide all inmates housed in administrative segregation units with the out-of-cell time required by law and recommended by the expert panel as necessary to reduce the suicide rate as soon as possible, but no later than July 1, 2007.

4. **Property in Administrative Segregation**: Defendants shall develop and implement a plan as soon as possible, but no later than by January 1, 2007, to provide non-disciplinary inmates housed in administrative segregation with additional personal property, such as a television and radio, during their wait for transfer out of administrative segregation.

5. **Length of Stay**: Defendants shall develop a plan to substantially reduce the length of stay of inmates placed in administrative segregation to achieve the following measurable goals: reducing the length of stay in administrative segregation by twenty percent (20%) as soon as

possible, but no later than by June 1, 2007, and by an additional twenty percent (20%) by December 1, 2007.

6. **Welfare Checks**: Defendants shall implement 30-minute welfare checks in every administrative segregation unit within CDCR as soon as possible, but no later than July 1, 2007.

III.

LEGAL STATEMENT

A. Defendants' Proffer of Additional Measures to Reduce Suicide Trends Moots Most of Plaintiffs' Objections.

Defendants are committed to undertaking the following additional measures to address the suicide trends in administrative segregation units:

•**Retrofit of 406 Intake Cells**: In response to Plaintiffs' requested item 1, Defendants submit an enhanced timetable for retrofitting ventilation screens in designated intake cells in administrative segregation units, and for retrofitting other physical features of designated intake cells (Ex. A, Dec. George Sifuentes).

•**Pre-Screening Placement**: In response to Plaintiffs' requested item 2, Defendants submit their timetable for pre-placement screening of inmates endorsed for transfer to administrative segregation units (Ex. B, 11/22/06 letter to Special Master Keating with screening policies and procedures attached).

•**Property in Administrative Segregation**: In response to Plaintiffs' requested item 4, Defendants commit to reviewing and revising regulations to enable possession of certain amounts of personal property by non-disciplinary inmates in administrative segregation units (Ex. C, Declaration of Scott Kernan).

•**Welfare Checks**: In response to Plaintiffs' requested item 6, Defendants submit their implementation of 30-minute welfare checks of inmates in administrative segregation units (Exh. D, 10/31/06 memorandum of John Dovey to field).

Defendants respectfully request this Court find that these additional measures fairly meet the demands made by Plaintiffs, and so resolve those objections.

//

B. Plaintiffs' Two Remaining Objections Should Be Disregarded as Unnecessary.

Defendants object to the two remaining objections asserted by Plaintiffs. Defendants respectfully request Plaintiffs' demand for a court order requiring construction and staffing resources on an emergency basis to enable out-of-cell time be disregarded. That request does not consider that the submitted and pending bed plans will yield appropriate out-of-cell time. Defendants submit that Plaintiffs' request for certain measures to ensure a reduction in the length of stay in administrative segregation units does not account for the present oversight mechanisms described in the plan and so should be disregarded.

III.

CONCLUSION

Defendants respectfully submit that this statement of supplemental steps to address the suicide trends in administrative segregation units satisfies this Court's order and moots Plaintiffs' key objections to the plan.

Dated: December 1, 2006

Respectfully submitted,

BILL LOCKYER
Attorney General of the State of California

JAMES M. HUMES
Chief Assistant Attorney General

FRANCES T. GRUNDER
Senior Assistant Attorney General

ROCHELLE C. EAST
Supervising Deputy Attorney General

/s/ Lisa A. Tillman

LISA A. TILLMAN
Deputy Attorney General
Attorneys for Defendants

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RALPH COLEMAN, et al., v. ARNOLD SCHWARZENEGGER, et al.,

CASE NO. CIV S-90-0520 LKK JFM P

EXHIBIT A

BILL LOCKYER
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JAMES M. HUMES
Chief Assistant Attorney General
FRANCES T. GRUNDER
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Email: Lisa.Tillman@doj.ca.gov

Attorneys for Defendants

IN THE UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF CALIFORNIA

RALPH COLEMAN, et al., Plaintiffs, **v.** **ARNOLD SCHWARZENEGGER, et al.,** Defendants.	2:90-cv-00520 LKK JFM P **DECLARATION OF GEORGE SIFUENTES IN SUPPORT OF DEFENDANTS' RESPONSE TO PLAINTIFFS' OBJECTIONS TO DEFENDANTS' PLAN TO ADDRESS SUICIDE TRENDS IN ADMINISTRATIVE SEGREGATION UNITS**

I, George A. Sifuentes, declare:

1. I am employed by the California Department of Corrections and Rehabilitation (CDCR) in the position of Deputy Director of the Office of Facilities Management. I have served in this position since March 2004.

2. I have personal knowledge of the facts stated in this declaration and if called to testify upon those facts would do so competently.

3. I am familiar with this Court's order of June 9, 2005 requiring Defendants to

develop a plan for dealing with the hazard of large-mesh ventilation screens in administrative segregation cells in which mental health caseload inmates are housed.

4. I am familiar with this Court's order of June 8, 2006 to develop a plan for dealing with the escalating percentage of suicides occurring in administrative segregation units. The order further stated the plan shall include, as appropriate, a budget and implementation schedule for any policy and procedure changes, staffing or budget augmentation, and, if necessary, include a mechanism for obtaining mid-year funding.

6. I have reviewed Plaintiffs' objections to Defendants' submitted plan to address the escalating percentage of suicides occurring in administrative segregation units and understand Plaintiffs' desire to accelerate the retrofit of ventilation screens in administrative segregation as well as the retrofit of administrative segregation intake cell features that may create a suicide hazard.

7. I am also aware that the ventilation screens and their anchorage have to be designed and manufactured to meet CDCR's security design requirements: stainless steel, heavy gauge, security attachments- and that they have to be properly installed so that they do not present a security concern to staff or the inmate.

8. I am committed to implementing the following revised plan to address the ventilation screens in intake cells within administrative segregation units:

a. By April 2007, the ventilation screens 61 administrative segregation intake cells in stand-alone administrative segregation units will be completed at:

- Calipatria State Prison (CAL);
- Centinela State Prison (CEN);
- California State Prison, Corcoran (COR);
- High Desert State Prison (HDSP);
- Kern Valley State Prison (KVSP);
- California State Prison, Los Angeles County (LAC);
- Pleasant Valley State Prison (PVSP);
- California State Prison, Sacramento (SAC);

- California Substance Abuse Treatment Facility and State Prison at Corcoran (SATF)
- Salinas Valley State Prison (SVSP)[1/].

b. By July 2007, the following ventilation screens in 85 intake cells within non-stand-alone administrative segregation units will be completed at:

- Calipatria State Prison (CAL);
- Centinela State Prison (CEN);
- California State Prison, Corcoran (COR);
- High Desert State Prison (HDSP);
- Kern Valley State Prison (KVSP);
- California State Prison, Los Angeles County (LAC);
- Pelican Bay State Prison (PBSP);
- Pleasant Valley State Prison (PVSP);
- California State Prison, Sacramento (SAC);
- California Substance Abuse Treatment Facility and State Prison at Corcoran (SATF)
- Salinas Valley State Prison (SVSP).

c. By September 2007, the ventilation screens in 255 intake cells within administrative segregation units will be replaced all other (22) sites.

9. My office will also retrofit certain physical features of the non-stand-alone intake cells, including as necessary, construction of concrete slab beds; elimination of in-cell protrusions, replacement of cell light fixtures, and modification of cell doors to increase visibility of cell.

10. Design work on these physical features all non-stand-alone intake cells (340) if required will begin in January 2007 and be completed by July 2007.

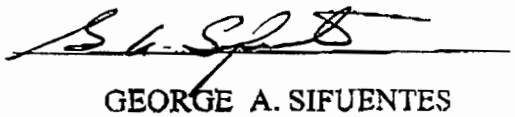
11. Construction on these physical features of the non-stand-alone intake cells will begin in July 2007 and be completed by July 2008. The construction work schedule will depend upon each building's construction scope of work.

---

1. The ventilation screens within the five intake cells within the stand-alone administrative segregation unit at Pelican Bay State Prison have already been completed.

12. These projects have not been classified as capital outlay and instead are classified as special repair projects, which do not have the same mid-year funding restrictions as do capital outlay projects. Therefore, this project may be funded from existing resources and the routine population increases available to the CDCR.

I declare under the penalty of perjury that the foregoing is true and correct.

Dated: December 1, 2006 By: 

GEORGE A. SIFUENTES

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RALPH COLEMAN, et al., v. ARNOLD SCHWARZENEGGER, et al.,

CASE NO. CIV S-90-0520 LKK JFM P

EXHIBIT B

From: Lisa Tillman
To: jmichaelkeatingjr@yahoo.com
Date: 11/22/2006 1:58:16 PM
Subject: ASU Pre-placement Screening

November 22, 2006

Re: Coleman v. Schwarzenegger

Dear Mr. Keating:

Please find enclosed for your review the pre-placement mental health screening procedures for inmates sent to administrative segregation units.

Sincerely,

Lisa Tillman
Deputy Attorney General
Office of the Attorney General
Telephone: 916-327-7872
Facsimile: 916-324-5205

CC: dcute@pld-law.com; DocKC99@aol.com ; DoctorKoson@aol.com ; dspecter@prisonlaw.com ; gasquetflat@msn.com; gmorrison@healthcaremediations.com; hammujones@comcast.net; harconwil@aol.com; itrujillo@prisonlaw.com.; Jeffrey.metzner@uchsc.edu ; jkahn@rbalaw.com ; jmichaelkeatingjr@yahoo.com ; lbuffardi@pld-law.com; mbien@rbalaw.com ; Melissa G. Warren; mlopes@pld-law.com ; paul_nicoll@msn.com ; rpattersonmd@earthlink.net

DIVISION OF CORRECTIONAL HEALTH CARE SERVICES
P. O. Box 942883
Sacramento, CA 94283-0001

NOV 2 0 2006

J. Michael Keating, Jr.
Office of the Special Master
2351 Sussex Lane
Fernandina, FL 32034

via: Lisa Tillman
Deputy Attorney General
Department of Justice
1300 I Street, Suite 125
P. O. Box 944255
Sacramento, CA 94244-2550

ADMINISTRATIVE SEGREGATION UNIT PRE-PLACEMENT MENTAL HEALTH SCREENING

On October 2, 2006, the California Department of Corrections and Rehabilitation submitted to you a plan to reduce the suicide risk in Administrative Segregation Units statewide.

One element of the plan is a brief mental health screening prior to Administrative Segregation Unit placement for the purpose of suicide prevention.

The Department's Division of Correctional Health Care Services (DCHCS) has drafted a revision of the Inmate Medical Services Policies and Procedures section detailing the procedure pertaining to medical clearance for Administrative Segregation Units. Medical personnel who clear inmates for placement in Administrative Segregation Units will be required to ask inmates a series of questions and, when indicated, to refer them for further mental health evaluation. Enclosed with this letter are the revised medical policy and the form for your review.

If you have questions regarding this policy and procedure draft, please contact Shama Chaiken, Ph.D., Chief Psychologist, Mental Health Program, DCHCS, at (916) 445-4114.

PETER FARBER- SZEKRENYI, DR. P.H.
Director
Division of Correctional Health Care Services

cc: Shama Chaiken, Ph.D., Chief Psychologist, Mental Health Program, DCHCS
Doug McKeever, Director (A), Mental Health Program, DCHCS
Andrew Swanson, M.D., Chief Psychiatrist, Mental Health Program, DCHCS
Margaret McAloon, Ph.D., Chief Psychologist, Clinical Operations and Forensic Unit, Mental Health Program, DCHCS
Tim Rougeux, Project Director, Medical Programs, DCHCS
Christine Martin, Special Assistant to the Director, DCHCS
Dwight Winslow M.D., Statewide Medical Director (A), DCHCS
Brigid Hanson, Deputy Director, DCHCS
Susan Turner, RN, Ph.D., Statewide Director of Nursing, DCHCS
Supervising and Senior Psychologists, Mental Health Program, DCHCS
Michael Stone, Staff Counsel, Office of Legal Affairs
Lisa Tillman, Deputy Attorney General, Department of Justice

CHAPTER 16

Medical Report of Injury or Unusual Occurrence, CDCR Form 7219

I. POLICY

The California Department of Corrections and Rehabilitation (CDCR) health care staff shall document each inmate-patient report of an injury or unusual occurrence on a CDCR Form 7219, Medical Report of Injury or Unusual Occurrence.

II. PURPOSE

To document each inmate-patient injury or unusual occurrence in a standardized format for custody reasons and, when seeing an inmate prior to placement in Administrative Segregation, screen for mental health problems which may increase the risk of self-harm.

III. PROCEDURE

1. A Medical Technical Assistant (MTA), Registered Nurse (RN), Licensed Psychiatric Technician (LPT), Licensed Vocational Nurse (LVN), or Physician shall complete a CDCR Form 7219 for any of the following inmate-patient events:
   - On the job injury
   - Any inmate-patient physical contact with a staff member during an incident
   - An inmate-patient report of any injury whether self-inflicted or an altercation
   - An Administrative Segregation Unit placement
   - Use of Force
   - Other medical emergency situations

   (For additional information regarding on the job injuries, refer to the *Department Operations Manual*, Chapter 3, Sections 31020.7.5.1 and 31020.7.5.2.)

2. The MTA shall contact an RN and/or physician for clinical direction when completing the CDCR Form 7219. The CDCR Form 7219 shall be legible using concise language. Use of medical abbreviations is not acceptable. The narrative shall be brief and factual. An "N/A" shall be written in any area that is not applicable. The name and title of the individual preparing the CDCR Form 7219 shall be legible.
3. When an inmate is evaluated for placement in an Administrative Segregation Unit, a MTA, RN, LVN, LPT, or physician shall always complete a CDCR Form (number to be assigned): Administrative Segregation Unit Pre-placement Mental Health Screening Chrono.
4. The medical personnel completing the Chrono shall print their name, provide a signature, and date and time of the evaluation. The completed chrono shall be placed in the Mental Health section of the Unit Health Record. If an immediate mental health evaluation is required a copy of the chrono shall be delivered to institutional mental health staff along with a CDCR Form MH-5: Mental Health Referral Chrono.
5. Clinical information shall be documented by the RN one of the following:
   - A CDCR Form 7403, Emergency Care Flow Sheet, for medical care that is rendered in the Triage and Treatment Area (TTA)

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- A CDCR Form 7230, Interdisciplinary Progress Note, for medical care that is not rendered in the TTA

6. The CDCR Form 7403 or CDCR Form 7230 shall include a Subjective, Objective, Assessment, Plan, and Education (SOAPE) note with relevant clinical information. The CDCR Form 7403 and CDCR Form 7230 shall be filed in the Unit Health Record (UHR).
7. The original CDCR Form 7219 shall be distributed to custody staff. A copy of the CDCR Form 7219 shall be forwarded to the Health and Safety/Return to Work Coordinator for inmate-patient work-related injuries.
8. A copy of the CDCR Form 7219 is not filed in the UHR. Information regarding completion of the CDCR Form 7219, physical findings, and/or medical care rendered to the inmate-patient related to the incident must be recorded on the CDCR Form 7403, Emergency Care Flow Sheet, or CDCR Form 7230, Interdisciplinary Progress Note, which must always accompany completion of a CDCR Form 7219.
9. Inmate-patients with physical findings must be reported to an RN or a physician before they are released from the clinic or TTA.
10. Refer to Volume 4, *Medical Evaluation of Inmate-Patients Involved in Assaults, Cell Extraction, or "Use of Force"* for additional information.

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ADMINISTRATIVE SEGREGATION (ASU) UNIT PRE-PLACEMENT CHRONO

Inmate Name:	Inmate CDCR Number:

CURRENT MENTAL HEALTH LEVEL OF CARE: ☐ **EOP** ☐ **CCMS** ☐ **GP**

ASK THE INMATE-PATIENT THE FOLLOWING QUESTIONS:

1. **Have things reached the point that you've had thoughts of harming yourself?**

   ☐ If **YES** – Suicide Risk Assessment **REQUIRED**. Refer for **EMERGENT** (immediate) mental health evaluation. Inmate cannot be placed in ASU until mental health evaluation is completed.

   ☐ **NO**

   ☐ **REFUSAL OR INAPPROPRIATE ANSWER** – Refer for **EMERGENT** mental health evaluation.

2. **Have you ever, in your whole life, tried to harm or kill yourself?**

   ☐ If **YES** – Refer for **URGENT** (24 hour) mental health evaluation.

   ☐ **NO**

   ☐ **REFUSAL OR INAPPROPRIATE ANSWER** – Refer for **URGENT** (24 hour) mental health evaluation.

3. **Are you worried about the safety of yourself or other people?**

   ☐ If **YES**, ask:

   Are you concerned about your safety, or the safety of others, in the next 24 hours? ☐ **YES** ☐ **NO**

   If **YES**, refer for **EMERGENT** (immediate) mental health evaluation.
   If **NO**, refer for **URGENT** (24 hour) mental health evaluation.

   ☐ **NO**

   ☐ **REFUSAL OR INAPPROPRIATE ANSWER** – Refer for **EMERGENT** mental health evaluation.

4. **Is the inmate:**

a.	**Speaking incoherently?**	☐ **YES**	☐ **NO**
b.	**Expressing bizarre or paranoid thoughts?**	☐ **YES**	☐ **NO**
c.	**Unable to sit still or pay attention?**	☐ **YES**	☐ **NO**
d.	**Showing evidence of hearing voices or seeing things that are not there?**	☐ **YES**	☐ **NO**
e.	**Disoriented to time, place or person?**	☐ **YES**	☐ **NO**

If YES to any of the above questions, refer for EMERGENT mental health evaluation.

IF ALL ANSWERS ARE "NO," A MENTAL HEALTH REFERRAL IS NOT NEEDED BEFORE PLACEMENT IN ASU.

Form Completed By: (Print Name)	Signature:	Date:

STATE OF CALIFORNIA
CDCR 128-? (01/06)

DEPARTMENT OF CORRECTIONS AND REHABILITATIONS

INSTRUCTIONS FOR ADMINISTRATIVE SEGREGATION UNIT PRE-PLACEMENT CHRONO

WHO SHOULD FILL OUT THIS FORM?

Any medical personnel who medically clears inmates for Administrative Segregation placement (Refer to IMSP&P Volume 4, Chapter12: CDCR Form 7219).

WHEN SHOULD IT BE FILLED OUT?

At the time of medical clearance for ASU placement – when a CDCR Form 7219 is completed.

HOW TO FILL IT OUT

Check the box that describes the inmate's mental health level of care (GP, CCCMS, EOP). Ask the inmate each question as it is written. Check the box that corresponds to their answer. (YES, NO, REFUSAL or INAPPROPRIATE).

IF A MENTAL HEALTH REFERRAL IS REQUIRED:

- EMERGENT (Immediate): Contact the institutional mental health staff responsible for evaluating inmates prior to placement in ASU (clinician-on-call or psychiatrist-on-call) for immediate evaluation of suicidal ideation and possible mental health crisis bed placement.

- URGENT (24 hours): Fill out a CDC 128-MH5, Mental Health Referral Chrono, mark the referral URGENT and deliver to the institution's mental health program.

- ROUTINE (Within 5 days): Fill out a CDC 128-MH5, Mental Health Referral Chrono, mark the referral ROUTINE and deliver to the institution's mental health program.

WHERE TO FILE THE FORM

The form should be filed in the mental health chrono section of the Unit Health Record

OTHER DOCUMENTATION

Please document that this form has been completed, and any additional clinical information, on the CDCR Form 7403, Emergency Care Flow Sheet, or the CDCR Form 7403, Interdisciplinary Progress Note..

NOTE: IF YOU HAVE ANY DOUBT ABOUT THE INMATE'S INTENTIONS TO HARM OR NOT HARM HIM/HERSELF, CONSULT A MENTAL HEALTH CLINICIAN.

RALPH COLEMAN, et al., v. ARNOLD SCHWARZENEGGER, et al.,

CASE NO. CIV S-90-0520 LKK JFM P

EXHIBIT C

BILL LOCKYER
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JAMES M. HUMES
Chief Assistant Attorney General
FRANCES T. GRUNDER
Senior Assistant Attorney General
ROCHELLE C. EAST
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Attorneys for Defendants

IN THE UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF CALIFORNIA

SACRAMENTO DIVISION

RALPH COLEMAN, et al.,

Plaintiffs,

v.

ARNOLD SCHWARZENEGGER, et al.,

Defendants.

2:90-cv-00520 LKK JFM P

DECLARATION OF SCOTT KERNAN IN SUPPORT OF DEFENDANTS' RESPONSE TO PLAINTIFFS' OBJECTIONS TO SUBMITTED PLAN TO ADDRESS SUICIDE TRENDS IN ADMINISTRATIVE SEGREGATION UNITS.

I, Scott Kernan, declare:

1. I am employed by the California Department of Corrections and Rehabilitation (CDCR) in the position of Deputy Director of Division of Adult Institutions. I have been employed by the CDCR since March 6, 1983.

2. In my position as Deputy Director of Division of Adult Institutions, I am responsible for overseeing the management and operation of the adult correctional facilities within CDCR. My duties often involve developing policies to ensure compliance with court orders.

3. I have personal knowledge of the facts stated in this declaration and if called to testify to those facts would do so competently.

4. I have reviewed the plan submitted by Defendant CDCR to address the suicide trends in administrative segregation units.

5. I have reviewed Plaintiffs' objections to this submitted plan, particularly Plaintiffs' objection that CDCR should permit inmates who are placed in administrative segregation for non-disciplinary matter be issued some amount of personal property. I have also reviewed the declarations and exhibits proffered by Plaintiffs in support of this particular objection, including the declaration of Walter L. Kautzky and the declaration of Lindsay M. Hayes.

6. I have recommended that CDCR review any regulations stating a complete bar against the possession of property by inmates placed in administrative segregation units for non-disciplinary matters is not appropriate. I recommend some amount of property should be permitted consistent with the safety and security of the institution, fellow inmates, and staff.

7. I discussed my recommendations with David Runnels, Chief Deputy Secretary of CDCR. He approved my recommendations and directed me to assign staff to the project of preparing proposed changes to the regulations governing the possession of property in administrative segregation units.

8. I have directed staff to have these proposed revisions ready for review and approval by CDCR executive staff by December 29, 2006. Upon approval by CDCR executive staff, the proposed revisions will be forwarded to Regulations and Policy Management Branch for the regulatory change process and to CDCR Labor Relations for appropriate union notifications.

I declare under the penalty of perjury that the foregoing is true and correct.

Dated: NOV 3 0 2006

By: _____
SCOTT KERNAN

[illegible]
[illegible]

RALPH COLEMAN, et al., v. ARNOLD SCHWARZENEGGER, et al.,

CASE NO. CIV S-90-0520 LKK JFM P

EXHIBIT D

From: Lisa Tillman
To: jmichaelkeatingjr@yahoo.com
Date: 10/31/2006 2:59:14 PM
Subject: Checks

October 31, 2006

Re: *Coleman v. Schwarzenegger*

Dear Mr. Keating:

In further compliance with the court order to develop a plan to address suicide trends in administrative segregation units, Defendant CDCR has prepared the attached memorandum to the field directing the commencement of thirty-minute checks on inmates newly-placed in administrative segregation units. A form for staff to record the checks is also attached for your review.

Mr. Dovey has already directed the wardens to commence these checks. Your expeditious review of the attached form and memorandum would be very much appreciated.

Sincerely,

Lisa Tillman
Deputy Attorney General
Office of the Attorney General
Telephone: 916-327-7872
Facsimile: 916-324-5205

CC: dcute@pld-law.com; mlopes@pld-law.com

Memorandum

Date :

To : Wardens

Subject : **30 MINUTE WELFARE CHECKS OF INMATES PLACED IN ADMINISTRATIVE SEGREGATION UNITS**

The California Department of Corrections and Rehabilitation (CDCR) is continuing its efforts to reduce inmate suicides within CDCR. During recent discussion, the recommendation to commence with more frequent welfare checks of inmates during the first three weeks of placement in Administrative Segregation Units (ASU) was approved.

Currently, custody staff assigned to ASU on First and Third Watch are required to perform hourly security checks to ensure inmates are accounted for and secured within their assigned housing units.

In keeping with the October 2, 2006 memorandum titled, "Expectations Regarding Administrative Segregation and Suicide Prevention", all inmates shall have the "INTAKE" identifying marker on the outside of the cell door for the first three weeks of ASU placement.

Additionally, CDCR will immediately begin 30 minute "Welfare Checks" of inmates during the first three weeks of ASU placement. Welfare checks are the "personal observation" of newly placed ASU inmates by Correctional Officers at least every 30 minutes, at irregular intervals, for the first three weeks of ASU placement. These Welfare Checks shall be recorded on the attached "ASU 30-Minute Welfare Check Tracking Sheet".

When possible and practical, ASU new arrival inmates should be housed in cells in close proximity of each other and near high traffic areas or control booths that allow for better observation by staff. The "clustering" of newly placed ASU inmates will better allow for existing resources to complete the Welfare Check function.

If you have any questions, please contact Joseph Moss, Correctional Captain at (916) 323-3578.

JOHN DOVEY
Director
Division of Adult Institutions

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF CALIFORNIA

RALPH COLEMAN, et al.

Plaintiffs,

vs. **No. CIV S-90-0520 LKK JFM P**

ARNOLD SCHWARZENEGGER, et al.,

Defendants.

SPECIAL MASTER'S REPORT AND RECOMMENDATIONS ON DEFENDANTS' PLAN TO PREVENT SUICIDES IN ADMINISTRATIVE SEGREGATION

On May 9, 2006, the special master submitted his Report on Suicides Completed in the California Department of Corrections in Calendar Year 2004 to the Court. Among other findings, that report noted that in 2004, 69.2 percent of all California Department of Corrections and Rehabilitation (CDCR) suicides (18 of 26) occurred in administrative segregation, representing a substantial increase over the number of suicides that took place in administrative segregation in 2003, when 17 of CDCR's 35 suicides were completed in administrative segregation units.

The special master's report recommended that the defendants be required to develop a plan by May 31, 2006 specifically to contain or prevent the escalating number of suicides in administrative segregation. On May 19, 2006, the defendants

responded to the special master's Suicide Report, indicated their commitment to developing the suicide prevention plan and sought the collaboration of the special master's experts in conducting their analysis and generating the required plan. The defendants also sought an extension of the proposed timeline for submission of their plan to August 31, 2006. Plaintiffs' counsel agreed to the extension and requested that any collaborative effort to analyze and address the causes of suicide in administrative segregation include input from their expert.

In a June 7, 2006 order, filed on June 8, 2006, the court ordered the defendants to develop a plan to address the rising rates of suicide in the administrative segregation units of the CDCR. The order granted the defendants until August 31, 2006 to develop their plan and specified that it must include a budget and implementation schedule for any policy and procedure changes, staffing or budget augmentation, and if necessary, include a mechanism for obtaining mid-year funding on or before September 30, 2006. The order further directed the defendants to collaborate with the special master's experts and plaintiffs' counsel and their expert in their effort to analyze the causes of and methods for preventing suicides in administrative segregation units.

On July 14, 2006, defendants and their experts met with the special master and his experts and plaintiffs' counsel and their experts to discuss CDCR's analysis of suicides in administrative segregation and preliminary proposals for dealing with suicide in administrative segregation. The open and fruitful discussion that followed during this meeting provided defendants with a broader range of potential options for preventing suicides in administrative segregation, some of which involved significant policy changes and a potential need for substantially enhanced resources. The complexity of some of the

discussed options prompted the defendants to seek yet another extension to explore fully the obstacles to their adoption and the extent of resources required for their implementation. The plaintiffs agreed to the extension, which was granted by the court while giving the defendants until October 2, 2006 to file their plan.

On September 5, 2006, the defendants submitted to plaintiffs and the special master a draft of their proposed suicide prevention plan for administrative segregation units. A written critique from the plaintiffs followed, along with multiple telephone conferences among and between defendants, plaintiffs, special master and experts. On October 2, 2006, the defendants submitted their final plan. On October 31, 2006, plaintiffs' counsel filed objections to the plan. The court on November 2, 2006 gave the defendants until November 15, 2006 to respond to those objections and ordered the special master to report to the court on the adequacy of the defendants' plan by December 1, 2006. The defendants subsequently sought an extension of the time within which they might respond to the plaintiffs' objections. On November 16, 2006, the court allowed the defendants until December 1, 2006 to file their response to the plaintiffs' objections and directed the special master to file his report on the plan's adequacy by December 18, 2006. This report on the defendants' plan for suicide prevention in their administrative segregation units is filed pursuant to the court's November 16, 2006 order.

The Plan

After a brief description of the genesis of the planning process, the defendants' October 2, 2006 suicide prevention plan identifies and categorizes some of the key factors that contribute to suicides in administrative segregation. The categories include failures or breakdowns in the delivery of mental health services and custody care

to inmates who have committed suicide, as well as the personal issues and concerns that seem to drive inmates in administrative segregation to commit suicide. The identified factors were winnowed from a broad and interdisciplinary review of suicides in administrative segregation during 2004, supplemented by an examination of suicide prevention policies and memorandums and minutes over the past two years of CDCR's Suicide Prevention and Response Focused Improvement Team. The resulting list of key factors was unremarkable and was readily accepted by parties, counsel and experts. .

The defendants' plan next provides a brief description of the July 14, 2006 conference of parties, counsel, special master and all of their respective experts and the various recommendations and proposals presented and discussed during that meeting. The bulk of the proposed actions listed came at the suggestion of the defendants and were based on sound common sense. Most involved changes in policies and practices that could be accomplished relatively quickly and economically. The proposals emerging from that conference, whether generated by the defendants or the experts, provided the framework for the defendants' subsequent planning efforts. Three principal issues emerged from the July 14th conference that became the focus of much of the subsequent discussion of the preventive plan:

1. Intake measures: Data collected by the defendants and the special master's expert on suicides confirm that a high percentage of suicides occur within 72 hours of an inmate's confinement in administrative segregation. Suicides, moreover, occur more often among newly arrived inmates in administrative segregation who are single-celled, rather than double-celled. Past efforts to address the need for some sort of intake process in administrative segregation had foundered on obstacles arising from

security and population management considerations. Out of the July 14th meeting came a general agreement among experts that a special intake section in each administrative segregation unit, where newly arriving inmates would be held for an initial period of time for more intensive observation, was absolutely critical. Physically, the intake cells needed to be made as suicide proof as possible and located in an area of the unit conducive to increased observation by custody staff. The requisite physical renovations would require removal of dangerous protrusions from which inmates might hang themselves; installation of vent covers and retrofitted light fixtures, similarly to prevent hangings; new cell doors with better visibility; and, where possible, the installation of concrete slab beds. The experts thought that the intake period for each new arrival should last two or three weeks.

The defendants adopted the proposal but also made some major changes in its particulars. First, they reduced the intake period of intensive observation to 72 hours; they also decided that newly arrived inmates capable of being double-celled safely would not need to be placed in a designated intake cell because the double-celling itself would serve as a prophylactic measure. The defendants' reduction was based on the data from the analysis of suicides in administrative segregation in CDCR, which indicated that the first 72 hours, rather than the experts' suggested two to three weeks, was the critical initial period. That reduction, along with the exception from placement in intake cells of double-celled new arrivals, reduced considerably the number of intake cells needing to be set aside and retrofitted in each administrative segregation unit.

The defendants forthwith made a calculation of the number of intake cells that would be required to meet the reduced need, identified 406 administrative

segregation cells for the required renovations and developed a three-phased plan for retrofitting those cells incrementally over the next three fiscal years with completion scheduled in FY2009/10. The defendants' most recent December 1, 2006 submission to the court, however, contained an accelerated commitment to complete the recommended renovation of physical features in all of the intake cells by July 2008, a reduction of two years in the original schedule.

Plaintiffs' counsel and the special master's experts have expressed serious concerns over the reduction of the formal intake period from two to three weeks to 72 hours. In some measure, those concerns have been addressed in the most recently proposed resolution of the following issue.

2. Welfare checks:

At the July 14th meeting, the experts urges the defendants to adopt the American Correctional Association's standard for welfare checks in an administrative segregation unit, which requires that inmates in such units "be personally observed by a correctional officer at least every thirty minutes at an irregular schedule." At first, some confusion arose over whether the defendants' presently required hourly "security" checks constituted *bona fide* welfare checks. The dispute focused on whether the rounding correctional officer needed to awaken each inmate to ensure that he was alive. That dispute was resolved, and CDCR's security checks were found to be "welfare" checks. Subsequent memorandums to custody staff confirmed the agreed-on nature of the welfare checks to be conducted by CDCR custody staff hourly in administrative segregation. The principal argument for half-hour welfare checks, especially when conducted on an irregular schedule, is that they reduce by at least half the temporal window of time within

which suicidal inmates might effect a successful hanging, the method elected in 90 percent of completed CDCR suicides, whether in administrative segregation or elsewhere. That argument, among other issues, rendered moot the need for waking every inmate during each check. In any event, the defendants' October 2, 2006 plan rejected the experts' recommendation for 30-minute welfare checks, citing the strain on thin custody resources it would entail, but promising to continue studying the issue.

In the their December 1, 2006 response to the plaintiffs' objections to the October plan, the defendants agreed to provide 30-minute welfare checks by July 1, 2007 of all newly arriving inmates in an administrative segregation unit for the first three weeks of their stay in the unit. While not fully responsive to the experts' recommendation or the American Correctional Association Standard, the concession does address partially the experts' recommendation for more intensive observation of arriving inmates during the first two or three weeks of their presence in administrative segregation.

3. Property for non-disciplinary inmates in administrative segregation: A significant percentage of inmates in administrative segregation are placed there not for disciplinary infractions but for their own safety. During the July 14th meeting, plaintiffs' counsel and the experts urged the department to consider either establishing separate housing or creating some personal property allowance (i.e., permission to retain in their administrative segregation cell some personal property, e.g., radio, television, etc.) for non-disciplinary inmates in administrative segregation for safety reasons. The defendants initially rejected the recommendation, citing the lack of any available independent space in the vastly overcrowded CDCR and arguing that such privileges would mark the

inmates receiving them as needing protection and increasing thereby physical threats and psychological torment directed at them in the administrative segregation environment. Plaintiffs' counsel and the experts countered that other correctional systems around the country allow different levels of privileges within the administrative segregation context; indeed, CDCR itself was currently conducting such an experiment in Pelican Bay State Prison under the auspices of the Madrid litigation.

In their December 1, 2006 filing, the defendants reversed their earlier outright rejection of some form of property privilege for non-disciplinary inmates in administrative segregation and indicated they are exploring some such a privilege and anticipated articulating a revised policy on the issue for executive review by December 29, 2006.

Other Issues:

The defendants' plan for curtailing suicide in administrative segregation included a list of 14 additional discrete initiatives, most of them identified and articulated initially by CDCR. Some of those have prompted protests from the plaintiffs primarily related to the speed with which the defendants plan to implement them. Included among the 14, the most troublesome are:

- Compliance with Title 15 requirements: Defendants' plan to meet Title 15 requirements for administrative segregation inmates for out-of-cell time focused almost exclusively on exercise. The department has directed institutions with "small management yards" to offer new administrative segregation inmates "walk alone" access to outside exercise as quickly as possible after their arrival. Defendants admit that the number of available small management yards is insufficient, but report a plan to construct

and/or fund 921 such yards in fiscal year 2006/2007. Even this effort, however, will leave a confessed shortfall of 441 small management yards, which will require future funding and construction, the details for which are not contained in the defendants' plan.

Pre- and post-placement screenings: The defendants propose to administer to all inmates entering administrative segregation a short pre-placement screening that seeks self-reported suicide history or current suicidal ideation. Any positive responses or a refusal to cooperate with the screening supposedly requires a mental health referral before placement in administrative segregation. The department has already developed a pre-placement chrono for the screening, which was scheduled to be implemented in June 2007. In their December 1, 2006 filing, the defendants indicated they would implement the pre-placement screening no later than January 1, 2007.

The post-placement screening includes the department's standard 31-item mental health questionnaire and is already required to be administered to all inmates in administrative segregation within 72 hours of their arrival. The defendants reportedly have already undertaken measures to ensure that an inmate's suicidal history recorded in the Mental Health Tracking System will be available to psych techs for all caseload inmates newly placed in administrative segregation, including inmates who may have been recently transferred from elsewhere in CDCR.

The defendants' plan also reports that, effective October 2, 2006, mental health staff will be conducting screening interviews in private settings, which afford confidentiality of sight and sound from other inmates and confidentiality of sound from custody staff. In addition, screening interviews are to be announced by custody staff as a "health appointment" to avoid stigmatization and possible retribution by other inmates.

Defendants assert they can prioritize space in administrative segregation units for confidential mental health interviews at each institution. If additional plant and/or staffing resources are needed to provide confidential interview space, the defendants promise to assess the need and submit an appropriate proposal through the annual budget process.

Reduction in length of stays in administrative segregation: Defendants' proposal optimistically cites the expected opening of a Sensitive Needs Yard for Level IV inmates (the highest level of CDCR security classification system) in January 2007 as a possible outlet for numerous eligible inmates in administrative segregation units around the system, and enumerates a quartet of management audits and utilization reviews that may serve as potential cures for extended stays in administrative segregation. Given the long and failed history of policy mandates, tracking systems, practice improvements and multi-discipline projects that have struggled with this issue, one can be forgiven for harboring some skepticism about the eventual efficacy of this latest round of proposed administrative remedies. To be successful, they must be closely managed by defendants and monitored.

Other elements of the defendants' suicide prevention plan for administrative segregation units are unremarkable in the sense that everyone agrees with their utility and appropriateness. All of them, including regular recording of "bad news" on inmates' return from court appearances; daily coordination among custody and mental health staff in administrative segregation units; audits of weekly rounds, screening refusals and suicide prevention practices; increased use of double-celling whenever appropriate; and faster implementation of cardio-pulmonary resuscitation and other

emergency measures, require extraordinary training, supervisory and monitoring efforts if they are to have much of an impact on the incidence of suicide in administrative segregation.

Having said all of that, the defendants have come a long way in recognizing and endorsing the elements essential to effective suicide prevention in administrative segregation. Beginning with a collaborative approach in mid-2006, parties, counsel, special master and all of their experts have teased much agreement out of apparent discord. The best course seems to be more of the same.

Recommendation:

The court should approve the defendants' October 2, 2006 plan, as amended in their December 1, 2006 filing, and require the defendants to implement the plan. At the same time the special master should be required to meet with defendants and plaintiffs' counsel monthly in person or by teleconference to follow up, refine and monitor implementation of each element of the defendants' plan and report back to the court in 90 days on the status of the defendants' compliance with the plan and any further recommendations that may be necessary.

Respectfully submitted,

/s/

J. Michael Keating, Jr.
Special Master

December 18, 2006