DISTRICT OF COLUMBIA
DEPARTMENT OF CORRECTIONS

Program Statement

OPI:	**MEDICAL**
Number:	**6080.2F**
Date:	**March 10, 2010**
Supersedes:	**6080.2F (9/23/09)**
Subject:	**Suicide Prevention and Intervention**

1. **PURPOSE AND SCOPE.** To provide policy and procedures for suicide prevention and management of inmates in the custody of the DC Department of Corrections (DOC) and who are potentially at risk for suicide or self-harm.

2. **POLICY.** It is the policy of DOC to provide a safe and secure environment, to preserve life, to prevent injury and to respond appropriately to special management needs of inmates.

3. **APPLICABILITY.** This directive applies to all inmates committed to DOC and housed in the Central Detention Facility (CDF) and contract facilities to include the Correctional Treatment Facility (CTF) and Community Correctional Centers (CCC); DOC employees and contractors who provide custodial, medical and mental health services to DOC inmates.

4. **PROGRAM OBJECTIVES.** The suicide prevention program shall include but not be limited to:

   a. **Training.** DOC employees and contractors who work with inmates shall prior to a work assignment within CDF, receive Pre-Service orientation to recognize verbal and behavioral clues that indicate a potentially suicidal inmate and how to respond appropriately.

   b. **Identification.** The medical contractor shall administer a mental health screening for each newly admitted inmate to include an interview, medical record review and observation related to the inmate's potential suicide risk. If any staff person identifies someone who is potentially suicidal or self-harming, authorized medical staff shall place the inmate on an appropriate observation status and ensure the inmate receives further mental health intervention as set forth in this directive.

   c. **Monitoring.** Procedures specify monitoring when an inmate is identified as having increased risk for suicidal or self-harming behaviors.

d. **Referral.** Staff shall refer potentially suicidal inmates and inmates who have attempted suicide to mental health care providers in the time frame set forth in this directive.

e. **Evaluation.** Qualified mental health professionals shall evaluate the inmate to determine the inmate's level of suicide risk and the appropriate response.

f. **Housing.** Procedures that address placing an inmate in the mental health unit, Medical Unit or off-site hospitalization.

g. **Communications.** Procedures prescribe the communications process between medical, mental health and correctional staff for implementation of the suicide prevention program.

h. **Intervention.** Procedures are prescribed for handling a suicide attempt or self-harming behavior that is in progress, including appropriate first-aid measures.

i. **Notification.** Procedures are prescribed for notifying DOC administrators, outside authorities and family members regarding potential, attempted and completed suicides.

j. **Reporting.** Procedures require specific documentation upon identification of a potential or attempted suicide, for subsequent monitoring and for reporting a completed suicide.

k. **Review.** Procedures require a clinical and administrative quality management review following a serious suicide attempt, self-injurious behavior or completed suicide.

l. **Critical Incident Debriefing.** Procedures require critical incident debriefing to affected employees and inmates.

5. **Definitions**

a. **Actively Suicidal.** An inmate determined by a medical or mental health professional to be in imminent danger of committing suicide because of a recent suicide attempt, a verbalized threat to commit suicide, or other suicide risk indicator.

b. **Critical Suicide Attempt.** Any incident in which an inmate's suicide attempt results in an emergency medical hospitalization or psychiatric hospitalization.

c. **Clinical Restraints.** A therapeutic intervention initiated by medical or mental health staff to use devices designed to safely limit a patient's mobility in a crisis due to physical or mental illness.

d. **Critical Incident Briefing.** A process whereby individuals are provided an opportunity to express their thoughts and feelings about a critical incident (e.g. suicide, serious injury or death of an inmate or employee), develop an understanding of critical stress symptoms and develop ways of dealing with those symptoms.

e. **Lethality.** The relative probability of an inmate committing suicide, measured in severity on a “low-risk” to “high-risk” continuum.

f. **Medical Staff.** Licensed health professionals who are employed in or contracted by the Department’s Health Services Division and are responsible for providing medical services to inmates (e.g. physicians, physician assistants, nurses).

g. **Mental Health Staff.** Individuals whose primary duty is to provide mental health services to inmates in keeping with their respective levels of education, experience, credentials, and training.

h. **Observation Bed/Cell.** Are designed for medical or mental health observation for specific purposes, such as watching the patient’s response to a change in medication regimen. Patient’s also can be placed in observation beds to prevent them from eating or drinking before a medical test that requires such restriction, to allow patient’s to recover from day surgeries or medical procedures, or to watch the general behavior of inmate’s whose mental stability appears questionable.

i. **Potentially Suicidal.** Inmates are not actively suicidal but express suicidal ideation and/or have a recent history of self-destructive behavior.

j. **Psychological Autopsy (Psychological Reconstruction).** Usually conducted by a psychologist or other qualified mental health professional, is a written reconstruction of an individual’s life with an emphasis on factors that may have contributed to the death.

k. **Qualified Health Care Professional.** Include physicians, physician assistants, nurses, nurse practitioners, dentists, mental health professionals, and others who by virtue of their education, credentials and experience are permitted by law to evaluate and care for patients.

l. **Suicide Attempt.** A non-fatal self-inflicted destructive act with explicit or deferred intent to die.

m. **Suicide Precaution.** A measure utilized for the inmate who, though suicidal, is not thought to require continuous observation. Inmates on close observation may be housed in an observation bed/cell and are observed at staggered intervals that do not exceed (15) minutes.

n. **Suicide Watch.** A measure utilized for the inmate who is actively suicidal. Inmates on constant observation are housed in an observation bed/cell that allows continuous observation without interruption with documentation every (15) minutes.

o. **Suicide Watch Paraphernalia.** Items which may be issued to inmates on suicide watch that are especially designed so as to be relatively indestructible and less likely to be used to harm self. Such items include, paper jumpsuits, safety blankets, and safety mattresses that have been approved by the Mental Health Director.

p. **Suicidal Ideation.** "Thoughts of harming or killing oneself". The severity of a suicidal ideation can be determined by assessing the frequency, intensity, and duration of these thoughts**.**

6. NOTICE OF NON-DISCRIMINATION

a. Staff In accordance with the D.C. Human Rights Act of 1977, as amended, D.C. Official Code § 2.1401.01 et seq., (Act) the District of Columbia does not discriminate on the basis of race, color, religion, national origin, sex, age, marital status, personal appearance, sexual orientation, gender identity or expression, familial status, family responsibilities, matriculation, political affiliation, genetic information, disability, source of income, or place of residence or business. Sexual harassment is a form of sex discrimination that is also prohibited by the Act. Discrimination in violation of the Act will not be tolerated. Violators will be subject to disciplinary action.

b. DOC prohibits discrimination against inmates based on race, religion, national origin, gender, sexual orientation or disability when making administrative decisions in providing access to programs. Discrimination on the basis of disability is prohibited in the provision of services, programs and activities.

7. DIRECTIVES AFFECTED

a. Directives Rescinded

None

b. Directive Referenced

1) PS 1280.2 Reporting and Notification Procedures for Significant Incidents and Extraordinary Occurrences

2) PS 1300.3 Health Information Privacy (HIPAA)

3) PS 1311.9 After Action Review and Reports

4) PS 4352.1 Inmate Death

5) PS 5010.9 Use of Force and Application of Restraints

6) PM 6000.1 Medical Management

7) PS 6014.6 Psychiatric Evaluation and Hospitalization of DC Department of Corrections Inmates and Detainees

8. **AUTHORITY**

a. D.C. Code § 24-211.02. Powers: Promulgation of Rules

b. DC Code § 7-1231.09 Human Health Care and Safety. Subtitle C. Mental Health. Chapter 12A. Consumer Rights. Freedom from seclusion and restraint.

c. DC Code § 24-306 Psychiatric Services

d. DC Code § 24-502 Insane Defendants – Commitment while serving sentence

e. DC Code § 24-503 Restoration to sanity

f. DC Code 5-1405 Deaths—determinations and investigations; cremations

9. **STANDARDS REFERENCED**

a. American Correctional Association (ACA) 4th Edition Standards for Adult Local Detention Facilities: 4-ALDF-4C-07, 4-ALDF-4C-08, 4-ALDF-4C-22, 4-ALDF-4C-27, 4-ALDF-4C-28, 4-ALDF-4C-29, 4-ALDF-4C-30, 4-ALDF-4C-31, 4-ALDF-4C-32, 4-ALDF-4C-33, 4-ALDF-4C-34, 4-ALDF-4D-02, 4-ALDF-4D-08, 4-ALDF-4D-21, 4-ALDF-7B-08, 4-ALDF-7B-09, 4-ALDF-7B-10, 4-ALDF-7B-12.

b. National Commission on Correctional Health Care (NCCHC) Standards for Health Services in Jails, 2003: J-C-04, J-E-02, J-G-05, Appendix C.

10. **RESPONSIBILITIES**

a. **Health Services Contractor**

1) The Contractor's Mental Health Director shall ensure that all mental health services are provided in accordance with the contract, protocol, and ACA/NCCHC Standards.

2) The Contractor's mental health professionals, Physicians, nurses, and designated clinical staff are responsible for the management, care and supervision of inmates on Suicide Watch.

3) The Contractor's mental health professionals, Physicians, nurses and designated clinical staff shall have experience or specialized training in correctional practices to include risks specifically presented in a correctional environment.

4) Clinical decisions are the sole province of the responsible clinicians and shall not be countermanded by non-clinicians.

5) The Quality Management Performance Indicators shall be developed and implemented on a continuous basis by the Contractor's mental health provider, in concert with DOC approval.

b. **DOC**

1) DOC Health Services Administration shall provide oversight for the suicide prevention program through monitoring compliance with local regulations and procedures as set forth in the contractual agreement.

2) DOC and CCA/CTF Wardens shall provide correctional security, custody and other support services as set forth in this directive.

3) Correctional Supervision

a) To facilitate institution security and discourage suicide attempts, inmates shall be prohibited from obstructing the view of their cells or living quarters. Each inmate shall be visible during routine security checks.

b) Housing unit correctional staff and health care providers shall be advised of the location of the first aid kit, mouth shield(s), rescue tool (wonder knife), Ambu bag and Automated Electronic Defibrillator.

11. **TRAINING.** The Contractor's Mental Health Director shall in conjunction with the Training Administrators at DOC/CDF and CCA/CTF, ensure that employees receive suicide prevention training.

a. Employees, volunteers, and interns shall receive an orientation of the potential for emergencies that may arise, the proper response to life-threatening situations and the role they play in the early detection of illness and prevention of injury. Training shall include suicide prevention training as a module of the forty (40) hour Pre-service training and annual In-service training program.

b. Staff who regularly work with inmates shall be trained to identify the warning signs and symptoms of potentially suicidal behavior; to appropriately respond to inmates who exhibit suicidal behavior; to

effectively coordinate security and treatment procedures between correctional and health care personnel; to define procedures for Suicide Watches and Suicide Precautions; and to monitor inmates who have made a suicide attempt.

c. Correctional employees shall be trained in the application of medical restraints. Medical restraints are made of soft leather or polyurethane and are deliberately applied on an emergency basis to immobilize the limbs of persons who are engaged in injurious behavior.

d. DOC correctional employees and contract employees who have regular contact with inmates shall receive standard First Aid and CPR training during Pre-service and annual In-service instruction.

e. Prior to assignment to a mental health unit or to the female housing unit (noting females with mental illness may also be housed there), each correctional officer shall receive forty (40) hours training in correctional management of inmates who have mental illness. Eight (8) hours of the training shall be dedicated to the suicide prevention program. Each correctional officer assigned to the mental health unit and/or a female mental health tier/cells shall be provided an annual forty (40) hours training session which includes eight (8) hours dedicated to the suicide prevention program.

f. The Wardens, Deputy Wardens, Major and Shift Commanders at each facility shall include and document discussions of the suicide prevention program at staff meetings and roll call.

g. The CDF and CTF Wardens, DOC Health Services Administrator and the Contractor Mental Health Director shall ensure a joint mock exercise simulating a suicide emergency is conducted once per shift every six (6) months. Each mock exercise will be documented and evaluated by the designated HSA for any necessary recommendations for policy and operational improvements.

h. The CDF and CTF Wardens shall ensure that information about recognizing potentially suicidal inmates and procedures to follow shall be included in all Housing Unit Post Orders.

12. **CONFIDENTIALTY**

All correctional employees and health care providers are instructed that health records and medical and mental health information is confidential. Health care providers and employees shall share information regarding an inmate's health status only to the extent for ensuring preservation of the health and safety of the inmate, other inmates and employees. Privacy of health records and information

are addressed in other DOC policy to include but not be limited to Medical Management, FOIA and HIPAA.

13. **QUALITY ASSURANCE**

a. Suicide Prevention and Intervention Improvement Team. DOC shall chair the Suicide Prevention and Intervention Improvement Team.

1) This team shall consist of but may not be limited to representatives from DOC health services administration, security, internal affairs, risk management and the Contractor's managers for administration, mental health and medical services.

2) The Suicide Prevention and Intervention Improvement Team shall meet at least every quarter to identify opportunities for continued improvement; design quality improvement monitoring activities, discuss the results, implement corrective action to include policy and operational changes.

3) DOC shall when deemed appropriate after a suicide or attempted suicide that required emergency medical or emergency correctional response, convene the Suicide Prevention and Intervention Improvement Team to conduct After action Reviews as outlined in Section (30) of this directive.

b. The Contractor for health care services shall in conjunction with the DOC Health Services Administrator and no less than annually, evaluate and document program performance and compliance with this directive, local regulations and established performance based standards.

c. The Contractor for health care services and the DOC Health Services Administrator shall, at least annually, review and make appropriate enhancements to the suicide prevention program and to this directive.

d. The medical contractor shall conduct Morbidity and Mortality Reviews on a monthly basis, which will include review of self-injurious behaviors, suicide attempts, and completed suicides. The reviews will be conducted as part of the peer review committee of the Contractor's medical staff.

14. **HEALTH SCREENING**

a. *Intake*. All inmates committed to the CDF regardless of the date of any prior incarceration, shall receive an initial medical and mental health screening as part of the admissions process.

b. *Intrasystem Transfer*. All inmates when transferred from the CDF to the CTF or the CTF to the CDF or returned from an outside mental health care

facility shall receive a health screening by a qualified health care professional.

c. Priority Screening. Newly committed inmates shall be expeditiously processed through Intake at Receiving and Discharge and taken to the medical unit for a *Mental Health Assessment* as set forth in §15 of this directive when:

1) Court ordered mental health alerts,

2) The inmate is exhibiting obvious signs of potentially self harming behavior during admissions,

3) The inmate has a recorded alert in JACCS or who is known to have a history of suicide or self harming behavior, or

4) The inmate is under the age of eighteen (18).

15. INTAKE MENTAL HEALTH SCREENING

a. A Nurse Practitioner, Physician's Assistant, and/or Physician shall during the health screening, review the inmate's medical record and interview the inmate to determine if the inmate has a history of suicide behavior(s), suicidal gestures or self-destructive activities, the inmate's emotional response to incarceration and intellectual functioning (i.e., mental retardation, developmental disability, learning disability).

b. When an inmate responds affirmatively to any question in the mental health screening, the inmate shall receive further mental health assessment as set forth in §15 of this directive.

c. Mental Health Screening shall include the following inquiries:

1) Currently receiving MH services in the community? (Emergency);

2) Received MH services in the past? If yes, (Urgent)

a. Has a history of inpatient psychiatric treatment?

b. Has a history of outpatient psychiatric treatment?

3) Experiences a significant loss within 6 months (Urgent);

4) Very worried about "major" problems other than legal?(Urgent);

5) Family or significant other attempted suicide? (Urgent);

6) Holds position of respect in the community and/or charged with a crime of notoriety? (Emergency);

7) Thinking about killing him/herself? (Emergency);

8) History of suicide attempt(s), self-injury, or suicidal ideation? If yes, was the previous attempt within the past 6 months? (Emergency if yes, Urgent if no);

9) Lacks close family or friends in the community? (Urgent);

10) First DC Incarceration?(Urgent);

11) Returning from JHP (Emergency);

12) Referred fro court-ordered forensic evaluation? (Urgent);

13) Have you ever been a victim of physical or sexual assault? (Urgent);

14) History of special education placement? (Urgent);

15) History of sex offenses?(Urgent);

16) Apparently under the influence of drugs or alcohol? (Emergency);

17) Is inmate a juvenile (Emergency).

16. **MENTAL HEALTH ASSESSMENT**

a. When the inmate answers “yes” to any of the above screening queries, medical staff shall refer the inmate for further mental health assessment as set forth in ¶ c. of this section.

b. A licensed mental health professional shall evaluate any inmate referred for the more comprehensive assessment.

c. *Emergency Referral*

1) Within four (4) hours of referral, a qualified mental health professional shall retrieve the EMR referral form and conduct the mental health assessment when the inmate has answered “yes” to any question in §14. ¶c. that is designated (Emergency).

2) The inmate shall not be moved from the Medical Unit to any housing unit or intake cell until a qualified mental health professional has completed the mental health assessment and made a housing placement determination as described in ¶e. of this section.

d. *Urgent Referral*. Within twenty-four (24) hours of referral, a qualified mental health professional shall retrieve the EMR referral form and conduct the mental health assessment when the inmate has answered yes to any question in §14. ¶c. that is not designated (Urgent).

e. Based upon the results of the comprehensive mental health assessment, licensed mental health clinicians may take one of the following listed actions. Licensed clinicians shall include a Licensed Independent Clinical Social Worker (LICSW), Licensed Graduate Social Worker (LGSW), Licensed Professional Counselor (LPC), Psychiatric Nurse-Certified, Nurse Practitioner (NP), Physician Assistant (PA), Psychiatrist and Physician (MD).

1) Clear the inmate for general population placement;

2) Notify the DOC Compliance Office in writing to remove a mental health alert from JACCS when the inmate was referred based upon a previous JACCS data entry;

3) Clear the inmate for general population placement with appropriate referral to mental health care services for on-going counseling and treatment;

4) Order the inmate's placement in the mental health unit or in an observation/safe cell for a continuum of mental health care;

5) Order the inmate's placement on Suicide Precautions or Suicide Watch; or

6) Refer the inmate to appropriate mental health care for emergency treatment.

f. Notification to Psychiatrist

1) Suicide Precautions or Suicide Watch

a) The clinician shall consult with the attendant or on-call Psychiatrist within one hour of ordering Suicide Precautions or Suicide Watch.

b) The Psychiatrist shall conduct a face-to-face interview with the affected inmate within twenty-four (24) hours.

2) Mental Health Unit Placement

a) When an inmate is placed in a mental health unit/cell for the clinician shall notify the Psychiatrist or Nurse Practitioner within one hour of placement.

b) The Psychiatrist shall conduct a face-to-face interview with the inmate within twenty-four (24) hours.

3) Psychotropic Medication

Physicians, Nurse Practitioners and Physician Assistants may order psychotropic medications for up to seven (7) days with referral to a Psychiatrist for evaluation within those seven (7) days.

17. **OBSERVED BEHAVIOR - GENERAL POPULATION**

a. There are varying degrees of increased risk potential for suicidal and other deliberate self-injurious behavior. As appropriate, licensed mental health clinicians may recommend a variety of clinical interventions which may include but not be limited to placing the inmate on Suicide Precautions or Suicide Watch to a cell change, increased observation or interaction with the inmate, or referral for psychotropic medication evaluation or both.

b. *Newly Incarcerated Inmates* may be at increased risk of committing suicide and the first few hours and days after admission can be critical.

c. However, a serious suicidal crisis may occur at any time. Housing unit staff are often the first to identify signs of potential suicidal behavior because of their more frequent observations of inmates.

d. Staff shall refer inmates to the Contractor's Mental Health Director, mental health nurse or Medical Unit when observing signs of potential suicide or other unusual behavior such as:

1) Talk of suicide;

2) Leaving suicidal notes;

3) Giving away possessions;

4) The inmate is acting and/or talking in a strange manner (cannot focus attention; hearing or seeing things that are not there);

5) The inmate appears overly anxious, panicked, or afraid;

6) The inmate show signs of depression (crying, emotional flatness);

7) There are sudden changes in behavior to obtain needed attention;

8) The inmate appears unusually calm after a period of agitation (having a flat affect and/or refusing to communicate, often the decision to attempt suicide has now been made);

9) The inmate is expressing unrealistic talk of release or talking about plans to escape;

10) The inmate is engaging in unusual behavior as a cry for help or to obtain needed attention;

11) There are other signs of distress, deterioration in hygiene or sudden changes in behavior.

e. Correctional staff shall complete scheduled and unscheduled rounds in accordance with DOC policy but not less than every 30 minutes in all housing units. Staff shall log accurate information of observations made while making rounds. This is important information to help determine changes in an inmate's behavior. Staff shall also prepare an Unusual Incident Report when observing significant changes or behaviors/ statements reflected in ¶d. above.

f. Employees shall take seriously all threats, self-injury, attempts to self injure and suicide attempts or information from other inmates about an inmate exhibiting potentially suicidal behavior.

g. Correctional staff shall immediately notify a medical or mental health professional and the shift commander if an inmate is observed displaying signs of potential suicidal behavior.

h. Correctional staff shall maintain a constant watch, to ensure the inmate's safety until medical/mental health staff arrive.

i. Upon notification, the medical or mental health professional depending upon the severity of the observation shall respond within four (4) minutes if deemed emergency or (1) hour, if deemed a non-emergency as defined by clinician, to evaluate the inmate.

1) CDF – The medical or mental health professional shall respond by interviewing and assessing the inmate on the housing unit or in CDF Medical Unit.

2) CTF – The medical or mental health professional shall respond by interviewing and assessing the inmate on Medical 68 or on the housing unit.

j. The medical or mental health professional may take appropriate clinical interventions as outlined in §15. ¶f. when determining that the inmate is at risk of harm to self or others, or in need of more intense or acute mental health intervention.

k. The Licensed mental health clinician or designated mental health nurse (RN), who completes the suicide risk assessment (SRA) shall document

prior to the end of his/her shift, the results of the suicide assessment and actions taken. The suicide risk assessment shall document the diagnosis and findings relative to the inmate's suicide risk as high, moderate or low; actions taken to address the suicide concern and safety of the inmate; demographic information and any other relevant information including referrals for care and management.

18. **OBSERVED BEHAVIOR – SEGREGATION HOUSING**

a. All status inmates shall receive a medical clearance prior to placement in segregated housing, and a mental health screening prior to or within 24 hours of segregation placement.

b. Status inmates may be at higher risk for potential suicidal behavior. Any status inmate presenting observed behavior defined in §16. ¶d. of this directive or presenting suicidal gestures or threats may be at increased risk for potential suicide attempts.

c. *Protective Custody (PC)*

1) Inmates, who request PC without a documented reason especially during the first seventy-two (72) hours of admission, may be at increased risk for suicide.

2) Inmates housed in PC for extended periods, including those with long sentences, may also be at increased risk for suicide.

3) Inmates taking psychotropic medication may be at increased risk for suicide depending on their mental illness and their risk factors and may refuse, hoard or not take their medications.

d. If staff observes the inmate displaying signs of distress, deterioration in hygiene, sudden changes in behavior or potential suicidal behavior, the employee shall continuously observe the inmate to ensure the inmate's safety and shall immediately notify a medical or mental health professional and the shift commander. Staff shall document the behavior observed and action taken to include notification made in an Unusual Incident Report.

e. Upon receiving notification of an inmate displaying signs of potential suicidal behavior, the Contractor's medical or mental health professional shall respond to the housing unit within four (4) minutes.

f. The Contractor's medical or mental health professional shall take appropriate clinical interventions as outlined in §15. ¶f., when determining that the inmate is at risk of harm to himself or others, or in need of more intensive or acute mental health intervention.

g. The licensed mental health clinician, or designated mental health nurse (RN), who completes the suicide risk assessment shall document prior to the end of their shift the results of the suicide risk assessment and actions taken as described in §16. ¶k. of this directive.

h. Rounds by mental health staff shall be conducted three times per week to identify inmates expressing or reporting increased risk of harm to self or deterioration in mental status.

19. **USE OF FORCE.** Correctional staff may in accordance with PS 5010.9C *Use of Force and Application of Restraints* physically restrain an inmate to prevent the inmate from self-injury, injury to others, damage or destruction of property and to control violent behavior.

20. **MEDICAL RESTRAINTS.** In compliance with DC Code § 7-1231.09, medical restraints shall only be used in the following manner.

a. Only a Psychiatrist or Physician shall assess and, after determination that less restrictive interventions are ineffective, issue a written order to use restraints necessary to prevent serious injury to the inmate or others.

b. Medical restraints shall never be ordered or otherwise applied as a means of coercion, discipline, convenience, or retaliation.

c. The Psychiatrist's or Physician's order may only be in effect for up to four (4) hours duration for adult inmates and up to two (2) hours for inmates ages seventeen (17) years or younger.

d. Within one (1) hour of the application of restraints, a Physician shall conduct a face-to-face observation of the inmate to evaluate the need for continued restraint.

e. As clinically deemed necessary, the Physician may contact the Psychiatrist who gave the initial order for restraints to request the Psychiatrist to renew the original order for up to another four (4) hours for an adult or up to two (2) hours for a person who is seventeen (17) or younger.

f. Inmates placed in medical restraints shall be placed in designated cells within the Medical Unit. The restraints shall be applied in the less restrictive manner that is possible based upon the Physician's evaluation and order.

g. Inmates placed in medical restraints shall only be placed in a face-up position.

h. The Mental Health Nurse Manager, or designee, shall assign nursing staff to provide constant observation of an inmate in medical restraints.

21. **TERMINATION OF MEDICAL RESTRAINTS.** Except in the event of a medical emergency for the inmate, *only* a Psychiatrist or other Physician shall determine when an inmate shall be released from medical restraints.

22. **NON EMERGENCY TRANSPORT**

a. Health care staff shall coordinate with the Shift Commander and transportation staff about appropriate security precautions to observe when transporting a suicidal inmate to a medical facility outside of CDF or CTF. Health care staff shall advise the Shift Commander and transportation staff about such concerns as:

1) Adding an extra officer to the transport detail to manage security concerns;

2) Using correctional officers with special training in working with mentally ill inmates;

3) Using appropriate restraints; and

4) Identifying medical precautions for staff and the inmate (for example: facemask, gloves, etc.).

b. Transportation staff shall provide custodial security and supervision of a suicidal inmate during transport to a facility outside of the CDF or CTF and while the inmate undergoes treatment.

c. An inmate returning from emergency psychiatric hospitalization and/or emergency medical treatment due to suicidal behavior(s) shall be evaluated by a licensed mental health provider. Mental health staff shall, within one (1) hour of the inmates' arrival, conduct a comprehensive mental health assessment to determine housing.

23. **SUICIDE WATCH AND SUICIDE PRECAUTIONS**

a. A Physician, licensed mental health professional or other clinician may place an inmate on Suicide Watch or Suicide Precautions. The referring provider shall consult with the on-call or attending Psychiatrist within one (1) hour of taking this action, and the Psychiatrist shall conduct a face-to-face interview with the inmate within twenty-four (24) hours.

b. *Observation Beds/Cells*

1) Observation beds/cells are located on the Inpatient Mental Health Unit and in the Medical Unit safe cells.

2) An observation bed/cell shall not contain electrical switches or outlets, bunks with open bottoms, towel racks, desks and sinks, radiator vents or any other fixtures that could be used as an anchoring device for hanging.

3) The bed/cell shall allow a full and clear line of sight and sound of the inmate.

4) The observer and the suicidal inmate shall not be in the same cell and shall have a locked door separating them.

5) The observer shall have a means to summon help immediately if emergency intervention becomes necessary.

c. *Suicide Precautions*

1) The assigned nursing staff shall physically observe each inmate on Suicide Precautions at staggered intervals of no more than every (15) fifteen minutes. The actual physical observation shall be staggered within the (15) fifteen-minute intervals (e.g., 5, 12, 10 minutes).

2) Designated nursing staff shall document each physical observation and the inmate's activities as they occur on the Seclusion and Restraint Form (Attachment A). Nursing staff shall also input documentation notes into the DOC Electronic Medical Record.

3) The Clinical Nurse Manager for Mental Health, or designee, shall ensure that nursing staff assigned to an inmate on suicide precaution has no other duties during the period of observation.

d. *Suicide Watch* is a precautionary measure used when the inmate presents a higher risk of suicide than determined for those placed on Suicide Precautions.

1) The Clinical Nurse Manager for Mental Health, or designee, shall assign designated nursing staff to conduct and document their observation of the inmate and his/her activities.

2) The Clinical Nurse Manager for Mental Health, or designee, shall ensure that nursing staff assigned to an inmate on suicide watch has no other duties during the period of observation.

3) Nursing staff assigned to the suicide watch shall follow required protocol and complete the Seclusion and Restraint Form.

e. *Security Requirements for Suicide Watch and Suicide Precautions*

1) The Shift Commander shall ensure that the inmate is strip-searched and all restricted items are confiscated.

2) The inmate shall be placed in a paper jumpsuit.

3) The clinician may order other precautions such as safety blankets and safety mattresses.

4) The housing unit OIC (or the Shift Commander if a Medical Unit cell is used) shall inspect the designated observation bed/cell to remove any unauthorized items before placing the inmate in the observation bed/cell.

5) The inmate may keep only those items prescribed as deemed safe.

6) In addition to the clinical observations Contractor's clinicians provide, DOC correctional staff shall conduct and document regular security checks every 30 minutes.

f. *Termination of Suicide Watch or Suicide Precautions*

1) Only a Psychiatrist or Psychiatric Nurse Practitioner shall authorize a downgrade from Suicide Watch to Suicide Precautions for a reasonable period prior to the termination of the Suicide Watch. A Psychiatrist or Nurse Practitioner's approval to terminate Suicide Watch shall be provided in person or through a documented verbal order.

2) Only a Psychiatrist shall approve termination of Suicide Watch status for an inmate. A Psychiatrist's approval to terminate Suicide Watch shall be provided in person or through a documented verbal order. The Psychiatrist's order shall include clinical recommendations for appropriate housing as well as an order for follow up care within seventy-two (72) hours.

3) The Clinical Nurse Manager for Mental Health, or designee, shall ensure that the termination of an inmate's Suicide Watch status is documented in the inmate's medical record and/or in the inmate's electronic medical record. Documentation shall also include name, date, time, and specific instructional remarks.

24. **SUICIDE ATTEMPTS**

a. The DOC health services contractor shall respond to all medical emergencies, including those involving inmates, DOC and contract staff.

b. Any employee, who discovers a possible suicide attempt, an individual who is unresponsive or an inmate who appears ready to inflict self harm, shall immediately sound the alarm for emergency medical and correctional response.

c. Staff shall also take reasonable care as the inmate may act unpredictably and may become violent. The employee shall take necessary and appropriate action to preserve the affected inmate's life including emergency CPR when needed.

d. As practical, correctional staff shall lock down all inmates or ensure they are moved away from the area and are well supervised before attempting intervention.

e. Contractor's health services staff and additional correctional staff are expected to respond to the emergency within four (4) minutes or less.

f. Upon arrival, medical staff shall assess the inmate's condition to determine if the inmate requires emergency transportation to an outside hospital

g. If medical staff determines the inmate requires urgent transportation, the nurse shall notify Command Center to call 911.

h. If the inmate is already in the Medical Unit, medical staff shall directly notify 911 when the inmate-patient requires emergency medical care and transport.

25. **HANGING.** An employee who discovers an inmate hanging shall:

a. After surveying the scene and calling for help and for medical assistance, the employee who discovers the hanging inmate shall attempt to reduce tension on the inmate's neck by supporting the inmate by the legs while the inmate is facing the employee.

b. Upon arrival of additional staff, the first employee on the scene shall continue to support the inmate's body while a second officer shall use the rescue tool (wonder knife) to cut the inmate down. The employee shall immediately remove the noose from around the inmate's neck.

c. DOC correctional employees are trained in Cardiopulmonary Resuscitation (CPR)/First Aid. As such, a correctional employee shall immediately initiate CPR and/or First Aid, as appropriate, until medical staff relieves the

employee. An *employee shall immediately start CPR/First Aid and never wait for medical staff to arrive before initiating life saving measures*.

d. Upon arrival, the Contractor's health services providers shall assume medical care and decisions, and shall continue CPR and other life saving measures while instructing that the 911 DCFEMS team be called.

e. The Contractor's Physician, Nurse Practitioner or Physician Assistant remains the authorized medical authority as it relates to any patient emergency care or decisions until DCFEMS arrives.

26. **EMERGENCY MEDICAL TRANSPORT**

a. DCFEMS shall always be escorted to the site of the suicide attempt to administer emergency measures and confer with the Contractor's Physician.

b. The DCFEMS responders will transport the inmate to the nearest emergency facility for continued assessment and treatment, if CPR is still in progress.

c. DOC correctional staff shall facilitate security according to PS 4910.1F Escorted Trips.

27. **INMATE DEATH**

a. If the Contractor's Physician determines through assessment of the victim that all of the clinically accepted signs and symptoms of death are present and that the victim is clinically dead and beyond being revived, the Contractor's Physician may order that CPR be ceased and may pronounce death.

b. Upon pronouncement of death, the site shall then be treated as a crime scene and evidence preserved pursuant to §26. below.

28. **EVIDENCE PRESERVATION.** Sites where an inmate has attempted or successfully committed suicide shall be treated as a crime scene in the following manner.

a. The initial response pursuant to guidelines set forth in the directive in order shall be to preserve life and control witnesses.

b. Integrity of Physical Site. A DOC correctional supervisor shall ensure:

1) The area is partitioned with a barrier in order to control access and to avoid contamination of evidence;

2) Staff and other inmates do not touch or move items;

3) Staff and other inmates do not touch or move the deceased inmate; and

4) Correctional staff shall wait for MPD crime scene technicians to process the crime scene.

29. **NOTIFICATION FOLLOWING A SUICIDE OR SUICIDE ATTEMPT.** The Shift Commander shall ensure that notification is made in accordance with PS 1280.2 *Reporting and Notification Procedures for Significant Incidents and Extraordinary Occurrences*.

a. Verbal Notification

1) When an inmate suicide or suicide attempt occurs, the senior supervisor on duty shall ensure that notification is made, through the chain-of-command to the Deputy Warden of Operations, Warden, Contractor's Director of Mental Health, DOC Health Services Administrator and the DOC Director's Office.

2) The Deputy Warden of Operations or designee shall notify the Employee Assistance Program following a suicide or suicide attempt. DOC shall offer employee assistance services to staff that witnessed or were involved in handling the suicide/suicide attempt.

b. Written Notification

1) The Shift Commander shall ensure that each employee who has relevant knowledge of the circumstances relating to an inmate suicide/suicide attempt or personal matters affecting a suicide victim, shall be required to submit a written report on DCDC Notification

2) Form 1. The Shift Commander shall obtain and secure the employee's written reports related to a suicide/suicide attempt.

3) Each Contractor's health services employee who is aware of facts pertinent to a suicide/suicide attempt shall submit a written incident report to their supervisor prior to completion of his/her shift and prior to leaving the facility. A copy of each written incident report shall be submitted to the shift commander.

4) The Contractor's Physician shall within twenty-four (24) hours of the incident, submit to the Shift Commander or designee, a preliminary medical evaluation report of relevant details concerning the inmate suicide/suicide attempt.

5) The Shift Commander, or designee, shall interview inmates who have knowledge of the suicide/suicide attempt and collect inmate witness accounts of this incident.

6) The Shift Commander shall forward the significant incident report package through the chain-of-command to the Warden. The incident report package shall include written reports from staff, inmate witness accounts of the incident, the inmate's official institutional record, and the medical evaluation report from the Contractor's Medical Director.

7) The CDF or CTF Warden, or designee, shall complete a preliminary report within three (3) business days. The Warden shall forward the report to the DOC Director, Health Services Administrator and Office of Internal Affairs. The report shall include employee incident reports, the preliminary medical evaluation report and other pertinent facts relative to the suicide/suicide attempt.

8) OIA shall conduct its investigation and submit its findings to the DOC Director.

30. **AFTER ACTION REVIEW.** Following a suicide or suicide attempt that resulted in an emergency medical/correctional response, the Suicide Prevention and Intervention Improvement Team (SPITT) shall meet within seven (7) days. The team shall be comprised of the following:

DOC Representatives:

1. Health Services Administrator

2. Medical Director

3. Warden

4. Chief OIA

5. Risk Manager

CTF Representatives:

1. Warden

2. Quality Assurance Manager

Medical Contractor Representatives:

1. Health Services Administrator

2. Mental Health Director

3. Medical Director

The Team shall meet and prepare a written report to the DOC Director that shall include but not be limited to:

a. A summary of significant information resulting from the team review and OIA investigation findings;

b. A report of events as they occurred;

c. The team's analysis and conclusions of the events; and

d. Recommendations for policy and operational improvements.

A preliminary report of the Team's findings based on the criteria listed above shall be submitted to the DOC Director no later than seventy-two (72) hours after the initial SPITT meeting.

31. **MORBIDITY & MORTALITY AND PSYCHOLOGICAL POSTMORTEM REVIEW**. A review committee shall conduct and prepare the Morbidity & Mortality and Psychological Postmortem Review within thirty (30) days after an event in which a death occurs by suicide.

    a. The Morbidity and Mortality Review Committee shall include the DOC Health Services Administrator and Medical Director, the Contractor's Medical Director, Deputy Medical Director, Health Services Administrator, Director of Nursing, Mental Health Director, and Quality Assurance Director.

    b. The review shall include:

        1) A clinical mortality review which is an assessment of the clinical care provided and the circumstances leading up to death;

        2) A psychologist or other qualified mental health professional's report of psychological autopsy (sometimes called a psychological reconstruction). The purpose is to provide written reconstruction of an individual's life with emphasis on factors that may have contributed to the individual's death; and

3) An evaluation that ascertains whether policy, procedures or practices are appropriate or require revision and identifies trends that require further study. The DOC Multi-level Mortality Review Form shall be utilized to conduct the review (Attachment B).

c. A summary report, including a copy of the completed DOC Multi-level Mortality Form shall be prepared and presented with in three (3) days of the review committee meeting to the DOC Director and DOC General Counsel.

d. The DOC Director shall ensure the Office of Internal Affairs (OIA) conducts an investigation and presents findings of whether policy and procedures were adhered to.

e. In addition to the M&M Review and the OIA investigation, the Health Services Administrator designated DOC executive staff along with the Contractor's Chief Executive Officer and senior medical staff shall within one (1) week conduct a comprehensive administrative assessment that DOC and related contractor policy and procedures in place at the time of the suicide met regulations, standards and best practices.

32. **CRITICAL INCIDENT DEBRIEFING**

a. Following a suicide or suicide attempt, trained Contractor's mental health staff as authorized by the Contractor's Director of Mental Health shall conduct critical stress debriefing and crisis intervention for staff and inmates who witnessed or were involved in a suicide incident.

b. Each inmate or employee who witnessed or was involved in a suicide incident shall be provided access to mental health counseling via the mental health clinician. The Deputy Warden for Operations shall ensure that employees and inmates are aware of the availability of this service.

c. DOC Employee Assistance Program staff shall also assist DOC employees who need additional counseling beyond the sessions provided by the critical stress debriefing team

Devon Brown
Director

Attachment A Suicide Precautions Observations Report
Attachment B Multi-level Mortality Review