

	DISTRICT OF COLUMBIA DEPARTMENT OF CORRECTIONS		EFFECTIVE DATE:	August 9, 2017	Page 1 of 31
	POLICY AND PROCEDURE		SUPERSEDES:	6080.2F March 10, 2010	
			OPI:	HEALTH SERVICES	
			REVIEW DATE:	August 9, 2018	
			Approving Authority	Quincy L. Booth Director	
SUBJECT:		SUICIDE PREVENTION AND INTERVENTION			
NUMBER:		6080.2G			
Attachments:		Attachment A-Suicide Precautions Observations Report Attachment B-Multi-level Mortality Review			

SUMMARY OF CHANGES:

Section	Change
Revisions	<i>Major Revisions contained throughout policy</i>
§ 23	Section 23 has been revised in its entirety.
	<i>Verbiage to include the Inmate Reception Center has been added.</i>
	<i>Verbiage emphasizing the "no razors allowed in DOC facilities" has been added.</i>

APPROVED:



Quincy L. Booth Director

8/9/2017

Date Signed

DISTRICT OF COLUMBIA DEPARTMENT OF CORRECTIONS		EFFECTIVE DATE:	August 9, 2017	Page 2 of 31
POLICY AND PROCEDURE		SUPERSEDES:	6080.2F March 10, 2010	
		REVIEW DATE:	August 9, 2018	
SUBJECT:	SUICIDE PREVENTION AND INTERVENTION			
NUMBER:	6080.2G			
Attachments:	Attachment A- Suicide Precautions Observations Report Attachment B- Multi-level Mortality Review			

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 Correctional Treatment Facility (CTF) and contracted Community Correctional Centers (CCC); DOC employees, contractors, and volunteers who provide custodial, medical and mental health services to DOC inmates. Suicide prevention and intervention procedures for arrestees processed at Central Cell Block (CCB) are addressed in OM 5009.1, DOC Central Cell Block Manual, Chapter 10.
4. **PROGRAM OBJECTIVES.** The suicide prevention program shall include but not be limited to:
 - a. **Training.** DOC employees, contractors, and volunteers who work with inmates shall prior to a work assignment within DOC, complete Pre-Service orientation and annual training 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.

DISTRICT OF COLUMBIA DEPARTMENT OF CORRECTIONS		EFFECTIVE DATE:	August 9, 2017	Page 3 of 31
POLICY AND PROCEDURE		SUPERSEDES:	6080.2F March 10, 2010	
		REVIEW DATE:	August 9, 2018	
		SUBJECT:	SUICIDE PREVENTION AND INTERVENTION	
NUMBER:	6080.2G			
Attachments:	Attachment A- Suicide Precautions Observations Report Attachment B- Multi-level Mortality Review			

- 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.

DISTRICT OF COLUMBIA DEPARTMENT OF CORRECTIONS		EFFECTIVE DATE:	August 9, 2017	Page 4 of 31
POLICY AND PROCEDURE		SUPERSEDES:	6080.2F March 10, 2010	
		REVIEW DATE:	August 9, 2018	
SUBJECT:	SUICIDE PREVENTION AND INTERVENTION			
NUMBER:	6080.2G			
Attachments:	Attachment A- Suicide Precautions Observations Report Attachment B- Multi-level Mortality Review			

- 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 by or contracted by the Responsible Health Care Contractor 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.** Housing 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 patients to recover from surgeries or medical procedures, or to watch the general behavior of inmate’s whose mental stability appears questionable.
- i. **Potentially Suicidal.** Inmates who 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.

DISTRICT OF COLUMBIA DEPARTMENT OF CORRECTIONS		EFFECTIVE DATE:	August 9, 2017	Page 5 of 31
POLICY AND PROCEDURE		SUPERSEDES:	6080.2F March 10, 2010	
		REVIEW DATE:	August 9, 2018	
SUBJECT:	SUICIDE PREVENTION AND INTERVENTION			
NUMBER:	6080.2G			
Attachments:	Attachment A- Suicide Precautions Observations Report Attachment B- Multi-level Mortality Review			

- 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. **Safe Cell.** A housing cell on the Acute Care Mental Health Unit (SOUTH 3), on the CDF, on the 3rd floor Medical Unit, on the Special Management Unit (South One), or in the CTF Infirmary, or on the Acute Female Mental Health Unit (E4A) that provides visibility of inmates and is designed to be suicide resistant by being free of physical structures that could be used in a suicide attempt (e.g. electrical switches or outlets, bunks with open bottoms, towel racks on desks and sinks, radiator vents, or any other fixtures which could be used as anchoring devices for hanging or areas used to jump off of).

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

- n. **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 fifteen (15) minutes.

- o. **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.

- p. **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 oneself. Such items include, paper jumpsuits, safety blankets, and safety mattresses that have been approved by the Mental Health Director. Documentation of these items/privileges will be indicated outside cell door and placed in inmate's EMR.

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

DISTRICT OF COLUMBIA DEPARTMENT OF CORRECTIONS		EFFECTIVE DATE:	August 9, 2017	Page 6 of 31
POLICY AND PROCEDURE		SUPERSEDES:	6080.2F March 10, 2010	
		REVIEW DATE:	August 9, 2018	
SUBJECT:	SUICIDE PREVENTION AND INTERVENTION			
NUMBER:	6080.2G			
Attachments:	Attachment A- Suicide Precautions Observations Report Attachment B- Multi-level Mortality Review			

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, status as a victim of an intrafamily offense, 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.

7. DIRECTIVES AFFECTED

a. Directives Rescinded

PS 6080.2 Suicide Prevention and Intervention (3/10/2010)

b. Directive Referenced

- 1) PP 1280.2 Reporting and Notification Procedures for Significant Incidents and Extraordinary Occurrences
- 2) PP 1300.1 Freedom of Information Act
- 3) PM 1300.3 Health Information Privacy (HIPAA)
- 4) SOP 1311.9-16 After Action Review and Reports
- 5) PP 4352.1 Inmate/Arrestee/Resident Deaths
- 6) OM 5006.1 Inmate Reception Center (IRC) Manual
- 7) PP 5010.9 Use of Force and Application of Restraints
- 8) PM 6000.1 Medical Management

8. AUTHORITY

- a. D.C. Code § 24-211.02. Powers: Promulgation of Rules
- b. D.C. Code § 7-1231.09 Freedom from seclusion and restraint.
- c. D.C. Code § 24-306 Psychiatric Services

DISTRICT OF COLUMBIA DEPARTMENT OF CORRECTIONS		EFFECTIVE DATE:	August 9, 2017	Page 7 of 31
POLICY AND PROCEDURE		SUPERSEDES:	6080.2F March 10, 2010	
		REVIEW DATE:	August 9, 2018	
SUBJECT:	SUICIDE PREVENTION AND INTERVENTION			
NUMBER:	6080.2G			
Attachments:	Attachment A- Suicide Precautions Observations Report Attachment B- Multi-level Mortality Review			

- d. D.C. Code § 24-502 Commitment while serving sentence
- e. D.C. Code § 24-503 Restoration to sanity
- f. D.C. Code § 5-1405 Deaths—determinations and investigations; cremations
- g. D.C. Code § 7-1203.05 (Disclosures for research, auditing and program evaluation)

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.

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 national standard of care, 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.

DISTRICT OF COLUMBIA DEPARTMENT OF CORRECTIONS		EFFECTIVE DATE:	August 9, 2017	Page 8 of 31
POLICY AND PROCEDURE		SUPERSEDES:	6080.2F March 10, 2010	
		REVIEW DATE:	August 9, 2018	
SUBJECT:	SUICIDE PREVENTION AND INTERVENTION			
NUMBER:	6080.2G			
Attachments:	Attachment A- Suicide Precautions Observations Report Attachment B- Multi-level Mortality Review			

- 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 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, ensure that employees receive suicide prevention training.

- a. Employees, contractors, and volunteers 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 four (4) hour 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

DISTRICT OF COLUMBIA DEPARTMENT OF CORRECTIONS		EFFECTIVE DATE:	August 9, 2017	Page 9 of 31
POLICY AND PROCEDURE		SUPERSEDES:	6080.2F March 10, 2010	
		REVIEW DATE:	August 9, 2018	
SUBJECT:	SUICIDE PREVENTION AND INTERVENTION			
NUMBER:	6080.2G			
Attachments:	Attachment A- Suicide Precautions Observations Report Attachment B- Multi-level Mortality Review			

define procedures for Suicide Watches and Suicide Precautions; and to help monitor inmates who have made a suicide attempt.

- c. 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.
- d. The Warden, 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.

The Warden, DOC Health Services Administrator, DOC Risk Management and the Contractor Mental Health Director shall ensure a joint mock exercise simulating a suicide emergency is conducted once per shift annually. Each mock exercise will be documented and evaluated by the Office of Accreditation and Compliance (OAC) and the medical/mental health contractor for any necessary recommendations for policy and operational improvements.

12. CONFIDENTIALTY

- 1) All correctional employees and health care providers are instructed that health records and medical and mental health information are 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 policies to include but not be limited to PM 6000.1, Medical Management; PS 1300.3 Information Privacy (HIPAA); PP 1300.1, Freedom of Information Act (FOIA).

13. QUALITY ASSURANCE

- a. Suicide Prevention and Intervention Improvement Team. DOC shall chair the Suicide Prevention and Improvement Team.
 - 1) This team shall consist of but may not be limited to representatives from DOC Health Services Administration, security, Office of Investigative Services (OIS), risk management and Contractors Managers for administration, mental health and medical services.

DISTRICT OF COLUMBIA DEPARTMENT OF CORRECTIONS		EFFECTIVE DATE:	August 9, 2017	Page 10 of 31
POLICY AND PROCEDURE		SUPERSEDES:	6080.2F March 10, 2010	
		REVIEW DATE:	August 9, 2018	
SUBJECT:	SUICIDE PREVENTION AND INTERVENTION			
NUMBER:	6080.2G			
Attachments:	Attachment A- Suicide Precautions Observations Report Attachment B- Multi-level Mortality Review			

- 2) The Suicide Prevention and Intervention Team shall meet at least annually to identify opportunities for continued improvement; design quality improvement monitoring activities, discuss the results, implement corrective action to include policy and operational changes.
- 3) When deemed appropriate after a suicide or attempted suicide that required emergency medical or emergency correctional response, DOC shall convene the Suicide Prevention and Intervention 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 DOC shall receive an initial medical and mental health screening as part of the admissions process in the Inmate Reception Center (IRC). Inmates who have positive mental health screens will have a more comprehensive mental health assessment in the IRC.
- 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 processed within an hour in the IRC 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,

DISTRICT OF COLUMBIA DEPARTMENT OF CORRECTIONS		EFFECTIVE DATE:	August 9, 2017	Page 11 of 31
POLICY AND PROCEDURE		SUPERSEDES:	6080.2F March 10, 2010	
		REVIEW DATE:	August 9, 2018	
SUBJECT:	SUICIDE PREVENTION AND INTERVENTION			
NUMBER:	6080.2G			
Attachments:	Attachment A- Suicide Precautions Observations Report Attachment B- Multi-level Mortality Review			

- 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 returns from court after sentencing, receives difficult news from legal team, family, friends, and
- 5) 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 §16 of this directive.
- c. Mental Health Screening shall include the following inquiries:
 - 1) Is there an alert from the Court, MPD, US Marshal Services or Transportation Officers about a mental health problem or risk of suicide Is there a suicide alert indicated in the electronic medical record?
 - 2) Is there a suicide alert indicated in the electronic medical/record?
 - 3) Is the inmate currently been receiving MH services in the community?
 - 4) Have they received MH services in the past?
 - a. Has a history of inpatient psychiatric treatment?
 - b. Has a history of outpatient psychiatric treatment?
 - 5) Are they coming in from St. Elizabeth's or a psychiatric facility?
 - 6) Have they received treatment for alcohol or substance abuse?

DISTRICT OF COLUMBIA DEPARTMENT OF CORRECTIONS		EFFECTIVE DATE:	August 9, 2017	Page 12 of 31
POLICY AND PROCEDURE		SUPERSEDES:	6080.2F March 10, 2010	
		REVIEW DATE:	August 9, 2018	
SUBJECT:	SUICIDE PREVENTION AND INTERVENTION			
NUMBER:	6080.2G			
Attachments:	Attachment A- Suicide Precautions Observations Report Attachment B- Multi-level Mortality Review			

- 7) Do they have any mental health issues that they would like to talk to the mental health staff about?
 - 8) Do they hold a position of respect in the community and/or charged with a crime of notoriety?
 - 9) Are they now or have they been accused of committing a violent crime and/or sexual offense?
 - 10) Have they ever been a victim of a physical or sexual act of abuse?
 - 11) Is this their first DC incarceration?
 - 12) Do they feel they will have difficulty adjusting to jail?
 - 13) Do they feel there is nothing to look forward to in the immediate future?
 - 14) Have they ever attempted or considered suicide?
 - 15) Are they thinking of hurting or killing themselves?
 - 16) Do they have a family member, close friend, or significant other that has attempted or committed suicide?
 - 17) Are they a juvenile?
 - 18) Have they recently experienced a significant loss (relationship, death of a family member/close friend, job, etc...)?
 - 19) Have they ever received special education services?
- d. Suicide risk assessment- includes the following:
- 1) Reason for referral
 - 2) Suicide risk indicators
 - 3) Type of threat/attempt
 - 4) Protective factors
 - 5) Psychiatric history

DISTRICT OF COLUMBIA DEPARTMENT OF CORRECTIONS		EFFECTIVE DATE:	August 9, 2017	Page 13 of 31
POLICY AND PROCEDURE		SUPERSEDES:	6080.2F March 10, 2010	
		REVIEW DATE:	August 9, 2018	
SUBJECT:	SUICIDE PREVENTION AND INTERVENTION			
NUMBER:	6080.2G			
Attachments:	Attachment A- Suicide Precautions Observations Report Attachment B- Multi-level Mortality Review			

- 6) Suicide history
- 7) Current medications
- 8) Assessment
- 9) Treatment plan
- 10) Housing
- 11) Other referrals/recommendations

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. For every inmate who has a history of suicide attempt or gesture or if an inmate reports that an immediate family member had committed suicide, a suicide alert will be entered into the EMR.
- c. A licensed mental health professional shall evaluate any inmate referred for the more comprehensive assessment.
 - 1) The inmate shall not be moved from the Intake area, IRC or 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. 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) Clear the inmate for general population placement with appropriate referral to mental health care services for on-going counseling and treatment;

DISTRICT OF COLUMBIA DEPARTMENT OF CORRECTIONS		EFFECTIVE DATE:	August 9, 2017	Page 14 of 31
POLICY AND PROCEDURE		SUPERSEDES:	6080.2F March 10, 2010	
		REVIEW DATE:	August 9, 2018	
SUBJECT:	SUICIDE PREVENTION AND INTERVENTION			
NUMBER:	6080.2G			
Attachments:	Attachment A- Suicide Precautions Observations Report Attachment B- Multi-level Mortality Review			

- 3) Order the inmate's placement in the mental health unit or in an observation/safe cell for a continuum of mental health care;
 - 4) Order the inmate's placement on Suicide Precautions or Suicide Watch;
or
 - 5) Refer the inmate to appropriate mental health care for emergency treatment.
- e. 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 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 all.

DISTRICT OF COLUMBIA DEPARTMENT OF CORRECTIONS		EFFECTIVE DATE:	August 9, 2017	Page 15 of 31
POLICY AND PROCEDURE		SUPERSEDES:	6080.2F March 10, 2010	
		REVIEW DATE:	August 9, 2018	
SUBJECT:	SUICIDE PREVENTION AND INTERVENTION			
NUMBER:	6080.2G			
Attachments:	Attachment A- Suicide Precautions Observations Report Attachment B- Multi-level Mortality Review			

- 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 is often the first to identify signs of potential suicidal behavior because of their more frequent observations of inmates.
- d. All attempts will be made to double cell inmates when possible. Single-celled inmates will be rounded on every 15 minutes regardless of housing unit.
- e. 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 (e.g. 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 (e.g. 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.

DISTRICT OF COLUMBIA DEPARTMENT OF CORRECTIONS		EFFECTIVE DATE:	August 9, 2017	Page 16 of 31
POLICY AND PROCEDURE		SUPERSEDES:	6080.2F March 10, 2010	
		REVIEW DATE:	August 9, 2018	
SUBJECT:	SUICIDE PREVENTION AND INTERVENTION			
NUMBER:	6080.2G			
Attachments:	Attachment A- Suicide Precautions Observations Report Attachment B- Multi-level Mortality Review			

- f. Correctional staff shall complete scheduled and unscheduled rounds in accordance with DOC policy but not less than every 30 minutes in all general population housing units. On Restrictive Housing Units, in the acute Mental Health Unit (South 3) and on the Juvenile Housing Unit, rounds are made every 15 minutes. 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.
- g. 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.
- h. 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.
- i. Correctional staff shall maintain a constant watch, to ensure the inmate's safety until medical/mental health staff arrives.
- j. 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. If a medical or mental health professional is unable to respond to the housing unit, a or a correctional officer shall expeditiously escort the inmate to the CDF Medical Unit or CTF Medical 68.
- 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.
- k. 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.

DISTRICT OF COLUMBIA DEPARTMENT OF CORRECTIONS		EFFECTIVE DATE:	August 9, 2017	Page 17 of 31
POLICY AND PROCEDURE		SUPERSEDES:	6080.2F March 10, 2010	
		REVIEW DATE:	August 9, 2018	
SUBJECT:	SUICIDE PREVENTION AND INTERVENTION			
NUMBER:	6080.2G			
Attachments:	Attachment A- Suicide Precautions Observations Report Attachment B- Multi-level Mortality Review			

- I. 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 – RESTRICTIVE HOUSING

- a. All status inmates shall receive a medical clearance and a mental health screening prior to placement in segregated housing.
- 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

DISTRICT OF COLUMBIA DEPARTMENT OF CORRECTIONS		EFFECTIVE DATE:	August 9, 2017	Page 18 of 31
POLICY AND PROCEDURE		SUPERSEDES:	6080.2F March 10, 2010	
		REVIEW DATE:	August 9, 2018	
SUBJECT:	SUICIDE PREVENTION AND INTERVENTION			
NUMBER:	6080.2G			
Attachments:	Attachment A- Suicide Precautions Observations Report Attachment B- Multi-level Mortality Review			

respond to the housing unit within four (4) minutes, or a correctional officer shall expeditiously escort the inmate to the CDF Medical Unit or CTF Medical 68.

- 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 on Restrictive Housing units 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 PP 5010.9, *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.

DISTRICT OF COLUMBIA DEPARTMENT OF CORRECTIONS		EFFECTIVE DATE:	August 9, 2017	Page 19 of 31
POLICY AND PROCEDURE		SUPERSEDES:	6080.2F March 10, 2010	
		REVIEW DATE:	August 9, 2018	
SUBJECT:	SUICIDE PREVENTION AND INTERVENTION			
NUMBER:	6080.2G			
Attachments:	Attachment A- Suicide Precautions Observations Report Attachment B- Multi-level Mortality Review			

- 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.

DISTRICT OF COLUMBIA DEPARTMENT OF CORRECTIONS		EFFECTIVE DATE:	August 9, 2017	Page 20 of 31
POLICY AND PROCEDURE		SUPERSEDES:	6080.2F March 10, 2010	
		REVIEW DATE:	August 9, 2018	
SUBJECT:	SUICIDE PREVENTION AND INTERVENTION			
NUMBER:	6080.2G			
Attachments:	Attachment A- Suicide Precautions Observations Report Attachment B- Multi-level Mortality Review			

- 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. Initiating suicide watch or precautions: A licensed mental health professional conducts a suicide risk assessment of a patient's mental status whenever the patient has been identified as potentially suicidal.
- 1) If a psychiatrist conducts the assessment and initiates the watch, she/he then completes
 - a) A suicide risk assessment, indicating the inmate's current mental status, diagnosis, medications, and other pertinent information; and
 - b) Provider's order, indicating the initiation of the suicide watch, placing inmate in a safety smock or safety clothing, the level and location of the Watch, the medications ordered, and any other necessary orders.
 - 2) If a licensed provider other than a psychiatrist initiates the suicide watch, they can order the level and location of the watch; place inmate in a paper jumpsuit, and any other special instructions to staff. The following must be completed:
 - a) Provider's order
 - b) On call psychiatrist is notified within one hour if after hours
 - c) A licensed mental health professional will see the inmate and complete a suicide risk assessment.

DISTRICT OF COLUMBIA DEPARTMENT OF CORRECTIONS		EFFECTIVE DATE:	August 9, 2017	Page 21 of 31
POLICY AND PROCEDURE		SUPERSEDES:	6080.2F March 10, 2010	
		REVIEW DATE:	August 9, 2018	
SUBJECT:	SUICIDE PREVENTION AND INTERVENTION			
NUMBER:	6080.2G			
Attachments:	Attachment A- Suicide Precautions Observations Report Attachment B- Multi-level Mortality Review			

- d) A psychiatrist will flow up within 24 hours to assess if inmate needs to continue on watch or precautions, be downgraded, or released back to their housing unit.
- 3) Inmates placed on suicide precautions or watch are strip-searched by correctional staff prior to being placed in a safety smock or safety clothing and placed in the designed safe cell.
 - 4) The designated cell is inspected for cleanliness and contraband by the officer-in-charge (OIC) of the unit prior to placement of the inmate in the cell. The OIC is responsible for ensuring that inmates placed on suicide precautions or watch, are housed in the designated safe cells. The inmate must stay on watch for at least 24 hours.
 - 5) Inmates on suicide watch are to be scratched from court appearances. Inmates on suicide precautions may attend court if cleared by a mental health professional who completes the suicide risk assessment and notification is made the transportation officers and court.
 - 6) Except for exigent circumstances or legitimate penological reasons, while suicidal inmates are housed in safe cells where the inmates are monitored for their safety and security, there will be an individualized determination on what restrictions will be in place while an inmate is on suicide watch and suicide precaution, based on the acuity of risk, as determined by the judgment of a mental health clinician, and documented in the medical record and on a form posted on the cell door. If consistent with the safety of the inmate, he or she may have:
 - a. **Out of Cell Time:** Inmates placed in a safe cell will be allowed 30 minutes out of cell time daily.
 - b. **Telephone Calls:** Inmates not under disciplinary restrictions may have phone calls on a daily basis while in a safe cell.
 - c. **Video Visitation:** Inmates not under disciplinary restrictions may have previously scheduled video visitation appointments.
 - d. **Family Visits:** Inmates not under disciplinary restrictions may have previously scheduled family visits.

DISTRICT OF COLUMBIA DEPARTMENT OF CORRECTIONS		EFFECTIVE DATE:	August 9, 2017	Page 22 of 31
POLICY AND PROCEDURE		SUPERSEDES:	6080.2F March 10, 2010	
		REVIEW DATE:	August 9, 2018	
SUBJECT:	SUICIDE PREVENTION AND INTERVENTION			
NUMBER:	6080.2G			
Attachments:	Attachment A- Suicide Precautions Observations Report Attachment B- Multi-level Mortality Review			

- e. **Access to Running Water:** Inmates shall have access to running water. Restrictions may be imposed if an inmate has made previous attempts to flood his/her cell or attempted to inflict self-harm by drowning.
 - f. **Access to Safe Mattresses and Blankets:** DOC will provide inmates with a safety mattress and a safety blanket.
 - g. **Access to Safe Eating Utensils:** In order to increase the variety of an inmate's diet and food items offered, safe eating utensils will be provided in safe cells.
 - h. **Unrestricted View from the Cell:** Inmates placed in safe cells will have an unrestricted view from the cell door unless they have a history of sexual exposure. Detachable curtains are placed on the lower half of the outside of the safe cell window and are drawn when there is a history of sexual exposure.
 - i. **Personal Hygiene:** Inmates may have access to a shower.
 - j. **Clothing:** Inmates may be provided a safety smock, socks and shoes.
 - k. **Access to Personal Property:** Inmates may have access to personal property such as: books, paper, pens, pencils, magazines, etc.
 - l. **Lighting:** Safe cells will be equipped with dimmer switches. Lights will be dimmed no less than 40% for at least eight (8) hours per night absent an individualized determination documented by medical personnel that they cannot be dimmed for the safety of the inmate.
- c. Reassessment
- 1) A psychiatrist or psychiatric nurse practitioner reassesses an inmate on suicide precautions or watch at least every 24 hours.

DISTRICT OF COLUMBIA DEPARTMENT OF CORRECTIONS		EFFECTIVE DATE:	August 9, 2017	Page 23 of 31
POLICY AND PROCEDURE		SUPERSEDES:	6080.2F March 10, 2010	
		REVIEW DATE:	August 9, 2018	
SUBJECT:	SUICIDE PREVENTION AND INTERVENTION			
NUMBER:	6080.2G			
Attachments:	Attachment A- Suicide Precautions Observations Report Attachment B- Multi-level Mortality Review			

d. Changing watch level or terminating a suicide watch:

- 1) Discontinuation of a suicide precaution status or downgrading from suicide watch to precaution status is determined by a psychiatrist or psychiatric nurse practitioner and documented in the EMR following a face-to-face evaluation of the inmate and completion of the suicide risk assessment or through a documented verbal order to the on-duty urgent care provider. The orders should include recommendations for appropriate housing and follow up care.
- 2) All inmates whose suicide watch/precaution status is discontinued will be given a treatment plan prior to leaving the safe cell by the psychiatrist or psychiatric nurse practitioner to further assess safety and offer continued support. An assessment for ongoing mental health services will be determined at that time.
- 3) Upgrading from precautions to suicide watch may be initiated by a license mental health professional or medical provider. Notification should be given within one hour to the on-call psychiatrist if after hours, or the Mental Health Director during regular business hours. This will be reviewed by a psychiatrist or psychiatric nurse practitioner within 24 hours.
- 4) Assessment for hospitalization: procedures regarding patients who are assessed by the psychiatrist to be in need of inpatient psychiatric hospitalization follow the usual external hospitalization procedures.

e. Monitoring

- 1) Suicide precautions (not acutely suicidal inmates):
 - a) Suicide precautions may occur on either the acute care mental health unit (South 3), the special management unit (South 1), in a safe cell area on medical unit or IRC when an inmate is required to be observed at staggered intervals that do not exceed 15 minutes.
 - b) If suicide precautions occur on the acute care mental health unit:
 1. The Charge Nurse assigns nursing staff to complete an interim nursing care plan.

DISTRICT OF COLUMBIA DEPARTMENT OF CORRECTIONS		EFFECTIVE DATE:	August 9, 2017	Page 24 of 31
POLICY AND PROCEDURE		SUPERSEDES:	6080.2F March 10, 2010	
		REVIEW DATE:	August 9, 2018	
SUBJECT:	SUICIDE PREVENTION AND INTERVENTION			
NUMBER:	6080.2G			
Attachments:	Attachment A- Suicide Precautions Observations Report Attachment B- Multi-level Mortality Review			

2. The OIC assigns an officer to conduct and document the checks at staggered intervals that do not exceed 15 minutes.

- c) If the suicide precaution occurs in the medical unit safe cells the charge nurse assigns nursing staff to conduct and document observations on the Seclusion and Restraint Form at staggered intervals not to exceed 15 minutes.
- d) If the suicide precaution occurs on the Special Management Unit (South 1), the Officer-In-Charge (OIC) assigns an officer to conduct and document the checks at staggered intervals not to exceed every 15 minutes.
- e) If the suicide precaution occurs in the IRC, the OIC assigns an officer to conduct and document the checks at staggered intervals that do not exceed 15 minutes.
- f) On South 3 and South 1 "pipe" logs are utilized to document security checks.
- g) When an inmate remains on suicide precautions or watch for more than one shift, the shift commander and charge nurse ensure that the incoming supervisors are informed , so that the suicide precautions or watch are continued without interruption.
- h) All inmates who have been released from suicide precautions or watch will be followed up by the mental health clinician within 24 hours, again within 72 hours, again within 1 week, and then periodically until release from custody.

2) Suicide Watch (actively suicidal inmates)

- a) On the CDF medical unit the charge nurse or his/her designee is responsible for ensuring that the staff member assigned to an inmate on constant watch has no other duties during the period of observation.
- b) In the IRC, the OIC or his/her designee is responsible for ensuring that the officer assigned to an inmate on constant observation has no other duties during the period of observation.

DISTRICT OF COLUMBIA DEPARTMENT OF CORRECTIONS		EFFECTIVE DATE:	August 9, 2017	Page 25 of 31
POLICY AND PROCEDURE		SUPERSEDES:	6080.2F March 10, 2010	
		REVIEW DATE:	August 9, 2018	
		SUBJECT:	SUICIDE PREVENTION AND INTERVENTION	
NUMBER:	6080.2G			
Attachments:	Attachment A- Suicide Precautions Observations Report Attachment B- Multi-level Mortality Review			

- c) Inmates will not be on suicide watch on the male Acute Mental Health Unit (South 3).
- d) Inmates who remain on suicide watch for more than 8 hours receive an evaluation by a psychiatrist or psychiatric nurse practitioner who will complete the suicide risk assessment at least every 24 hours.
- e) Inmates who remain on constant observation in a safe cell for 72 hours become the subject of a case review which will be arranged by the Mental Health Director and include the Mental Health Director, Medical Director, Psychiatric Director, the treating psychiatrist (s) and others as assigned. The review will address the inmates' progress and treatment plan, and to determine the inmate's need for emergency psychiatric hospitalization.
- f) All inmates who have been released from suicide watch will be downgraded to suicide precaution and followed up and re-evaluated by the psychiatrist or psychiatric nurse practitioner within 24 hours.

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. If CPR is needed, the employee is to tell another employee nearby to contact the Command Center to contact 911 immediately.
- 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.

DISTRICT OF COLUMBIA DEPARTMENT OF CORRECTIONS		EFFECTIVE DATE:	August 9, 2017	Page 26 of 31
POLICY AND PROCEDURE		SUPERSEDES:	6080.2F March 10, 2010	
		REVIEW DATE:	August 9, 2018	
SUBJECT:	SUICIDE PREVENTION AND INTERVENTION			
NUMBER:	6080.2G			
Attachments:	Attachment A- Suicide Precautions Observations Report Attachment B- Multi-level Mortality Review			

- 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 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. Immediately survey 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 ligature to take the inmate down. The employees 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.* Any employee beginning CPR must direct another staff member to have the Command Center call 911.
- 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 awaiting DCFEMS team.
- 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.

DISTRICT OF COLUMBIA DEPARTMENT OF CORRECTIONS		EFFECTIVE DATE:	August 9, 2017	Page 27 of 31
POLICY AND PROCEDURE		SUPERSEDES:	6080.2F March 10, 2010	
		REVIEW DATE:	August 9, 2018	
SUBJECT:	SUICIDE PREVENTION AND INTERVENTION			
NUMBER:	6080.2G			
Attachments:	Attachment A- Suicide Precautions Observations Report Attachment B- Multi-level Mortality Review			

- c. DOC correctional staff shall facilitate security according to PS 4910.1, 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 §28 of this policy.

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 Metropolitan Police Department (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.

- a. Verbal Notification
 - 1) When an inmate suicide or suicide attempt occurs, the senior supervisor on duty shall ensure that notification is made in accordance with PP

DISTRICT OF COLUMBIA DEPARTMENT OF CORRECTIONS		EFFECTIVE DATE:	August 9, 2017	Page 28 of 31
POLICY AND PROCEDURE		SUPERSEDES:	6080.2F March 10, 2010	
		REVIEW DATE:	August 9, 2018	
SUBJECT:	SUICIDE PREVENTION AND INTERVENTION			
NUMBER:	6080.2G			
Attachments:	Attachment A- Suicide Precautions Observations Report Attachment B- Multi-level Mortality Review			

1280.2 Reporting and Notification Procedures for Significant Incidents and Extraordinary Occurrences.

- 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 or personal matters relating to an inmate suicide/suicide attempt shall be required to submit a written report on a DCDC Notification Form 1.
 - 2) 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 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 Investigative Service

DISTRICT OF COLUMBIA DEPARTMENT OF CORRECTIONS		EFFECTIVE DATE:	August 9, 2017	Page 29 of 31
POLICY AND PROCEDURE		SUPERSEDES:	6080.2F March 10, 2010	
		REVIEW DATE:	August 9, 2018	
		SUBJECT:	SUICIDE PREVENTION AND INTERVENTION	
NUMBER:	6080.2G			
Attachments:	Attachment A- Suicide Precautions Observations Report Attachment B- Multi-level Mortality Review			

(OIS). The report shall include employee incident reports, the preliminary medical evaluation report and other pertinent facts relative to the suicide/suicide attempt.

- 8) OIS 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 will meet within 72 hours of the event and provide a report within 7 days of the event. The team shall be comprised of the following:

DOC Representatives:

- a. Medical Officer
- b. Warden
- c. Chief OIS
- d. Risk Manager

Medical Contractor Representatives:

- a. Health Services Administrator
- b. Mental Health Director
- c. 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 OIS 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.

DISTRICT OF COLUMBIA DEPARTMENT OF CORRECTIONS		EFFECTIVE DATE:	August 9, 2017	Page 30 of 31
POLICY AND PROCEDURE		SUPERSEDES:	6080.2F March 10, 2010	
		REVIEW DATE:	August 9, 2018	
SUBJECT:	SUICIDE PREVENTION AND INTERVENTION			
NUMBER:	6080.2G			
Attachments:	Attachment A- Suicide Precautions Observations Report Attachment B- Multi-level Mortality Review			

A report of the Team's findings based on the criteria listed above shall be submitted to the DOC Director no later than one week 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 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 30 days of the event to the DOC Director and DOC General Counsel.
- d. The DOC Director shall ensure the Office of Investigative Services (OIS) conducts an investigation and presents findings of whether policy and procedures were adhered to.

DISTRICT OF COLUMBIA DEPARTMENT OF CORRECTIONS		EFFECTIVE DATE:	August 9, 2017	Page 31 of 31
POLICY AND PROCEDURE		SUPERSEDES:	6080.2F March 10, 2010	
		REVIEW DATE:	August 9, 2018	
SUBJECT:	SUICIDE PREVENTION AND INTERVENTION			
NUMBER:	6080.2G			
Attachments:	Attachment A- Suicide Precautions Observations Report Attachment B- Multi-level Mortality Review			

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

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

DOC/PP6080.2G/8/9/2017



Department of Corrections to Seclusion / Restraint

NAME: _____ DCDC _____ TODAY'S DATE _____
(Last) (First) (MI)
ORDER DATE: _____ Initiated _____ CELL LOCATION _____
ORDERING PROVIDER _____

CLOSE (Physical check at staggered intervals and to be recorded every 15 minutes) _____
CONSTANT (Continuous uninterrupted observation) _____

MEDICAL RESTRAINTS Yes () No () PAPER JUMPSUIT Yes () No ()
SECLUSION

ITEMS ALLOWED Clothing () Undergarment () Safety Blanket () Mattress Pillow ()
Reading Materials () Toiletries () Other () Out

Form must include
Out of Cell Time,
Telephone Calls,
Video Visitation,
Family Visits,
Access to Running
Water, Access to
Safe Mattresses
and Blankets,
Access to Safe
Eating Utensils,
Unrestricted View
from the Cell,
Shower, Access to
Personal Property,
Lighting dimmed
no less than 40%
for at least eight
(8) hours per night

SAFE CELL CHECKED FOR HAZARDS: Yes () No () DATE _____ TIME _____

CODE FOR RESIDENT BEHAVIOR AND STAFF INTERVENTIONS

- | | | | |
|----------------------------|----------------------------|------------------|----------------------|
| A. Self Injurious Behavior | F. Quiet/Seclusive | K. Sleeping | P. Yelling/Screaming |
| B. Assaultive Behavior | G. Self-Contained Activity | L. Medical | Q. Telephone Call |
| C. Destructive Behavior | H. Social Activity/Program | M. Mental Health | R. Visit |
| D. Hyperactive | I. Medication | N. Eating | S. Incoherent |
| E. Active | J. Toilet/Shower | O. Crying | T. Vital Signs |



TIME	CODES	VITAL SIGNS	INITIALS	TIME	CODE	VITAL SIGNS	INITIALS



CODE FOR RESIDENT BEHAVIOR AND STAFF INTERVENTIONS

A. Self Injurious Behavior	F. Quiet/Seclusive	K. Sleeping	P. Yelling/Screaming
B. Assaultive Behavior	G. Self-Contained Activity	L. Medical	Q. Telephone Call
C. Destructive Behavior	H. Social Activity/Program	M. Mental Health	R. Visit
D. Hyperactive	I. Medication	N. Eating	S. Incoherent
E. Active	J. Toilet/Shower	O. Crying	T. Vital Signs

TIME	CODES	VITAL SIGNS	INITIALS	TIME	CODE	VITAL SIGNS	INITIALS

TOTAL TIME ON WATCH _____

CHARGE NURSE NAME: _____

CHARGE NURSE SIGNATURE _____

DATE OUT: _____

TIME OUT: _____





Multi-Level Morbidity and Mortality Review Form

Date:	_____ (MM/DD/YYYY)
To:	Department of Corrections Director and General Counsel
From:	_____
Cc:	_____

Inmate Details

Date of Recent Intake:	_____ (MM/DD/YYYY)						
Last Name:	_____	First Name:	_____	Prefix:	_____	Suffix:	_____
DCDC Number:	_____						
Date Of Death:	_____ (MM/DD/YYYY)	Date Of Birth:	_____ (MM/DD/YYYY)				

Date of CTF Admission/ Hospitalization:	_____ (MM/DD/YYYY)
Place of Death:	_____
Name of Community Hospital:	_____
Nature of Death:	_____
If inmate was a transfer, specify where he/ she was transferred from:	_____
If 'OTHER' above, please specify:	_____

Cause (s) of Death: Office of Chief Medical Examiner (OCME)

Narrative Summary
(Should include components below)

Diagnosis:

Current Medications:

Mental Health History:

Description of course of illness (past and present) and cause of death

Please provide in sufficient detail to indicate circumstances of death, including treatment, medications, diagnostic testing, etc.	
Is Intake Screening History and Physical present?	_____
Date of most recent History and Physical:	_____ (MM/DD/YYYY)
Timeliness of Diagnostic and Treatment regimes	_____



Multi-Level Morbidity and Mortality Review Form

Discharge summary from any prior hospitalizations on chart:	
Institution:	
Community Hospital:	
Autopsy:	
Toxicology:	
Death Certificate Available:	

DOC Medical Care Review

Severity of illness at time of diagnosis/ treatment at health services unit or admission to the CTF Infirmary.	
Prognosis during treatment at the health services unit or admission to the CTF Infirmary.	_____
Were diagnostic procedures appropriate and timely?	_____
Was treatment appropriate to diagnosis and instituted timely?	_____
Prognosis with treatment:	_____
Any Complications adversely affecting outcome	
<i>If 'Yes' above, please describe complications in brief:</i>	

Was treatment appropriate to complication	
Were Surgical procedures used ?	
<i>If 'Yes' to above, then list surgical procedures below:</i>	

Appropriate pre-operative evaluation completed, including lab, physical exam, and updated history	
Were there complications related to surgical procedures?	
<i>If 'Yes' to above, please describe the complications below:</i>	

Prognosis following surgical procedure	
Patient complaint with treatment / medications	
Discussion with patient or patient's family regarding prognosis	
Select DNR order; <i>If 'Yes' enter date</i>	Date (MM/DD/YYYY): _____
Advance Directive / Living Will	



Multi-Level Morbidity and Mortality Review Form

Local Community Hospitalization Only

Type of Admission:			
Method of transportation appropriate to patient condition:			
Severity of condition at time of admission to local hospital:			
Prognosis on admission to local hospital			
Were diagnostic procedures appropriate and timely			
Was treatment appropriate to diagnosis and instituted timely			
Prognosis with treatment:			
Do any complications adversely affect outcome			
<i>If 'Yes' to above, then describe the complications below</i>			

Is treatment appropriate to complication?			
Were Surgical procedures used ?			
<i>If 'Yes' to above, then list surgical procedures below:</i>			

Appropriate pre-operative evaluation completed, including lab, physical exam, and updated history			
Were there complications related to surgical procedures?			
<i>If 'Yes' to above, please describe the complications below:</i>			

Prognosis following surgical procedure			
Patient complaint with treatment / medications			
Discussion with patient or patient's family regarding prognosis			
Select DNR order; <i>If 'Yes' enter date</i>	Date (MM/DD/YYYY):	_____	
Advance Directive / Living Will; <i>If 'Yes' enter date</i>	Date (MM/DD/YYYY):	_____	

Review of Emergency Medical Care

Select DNR order; <i>If 'Yes' enter date</i>	Date (MM/DD/YYYY):	_____	
Advance Directive / Living Will; <i>If 'Yes' enter date and provide a copy of the order for review.</i>	Date (MM/DD/YYYY):	_____	
Was death related to a medical emergency?			



Multi-Level Morbidity and Mortality Review Form

Was response to medical emergency notification timely?	
Physician:	
Physician Assistant:	
Nurse Practitioner:	
Nurse (s):	
Emergency Medical Technicians:	
Others:	
<i>If 'Others', please specify below:</i>	
1. _____	
2. _____	
3. _____	
<i>Cardiopulmonary resuscitation (CPR)</i>	
ACLS List protocols(s) used (if appropriate)	
Problems encountered during medical emergency, e.g., equipment, communications, transportation.	
<i>Describe below the problems encountered:</i>	

Providers responding maintain current certification / credentials in BCLS, ACLS (if required)	
SUMMARY REVIEW:	

Documentation in medical record reviewed by Morbidity and Mortality Review Committee and found to be within acceptable limits.	
<i>If 'No', please describe below:</i>	

Did patient receive appropriate and adequate health care, consistent with community standards, during his/ her incarceration at the Central Detention Facility?	
<i>If 'No' to above, then please explain below:</i>	



Multi-Level Morbidity and Mortality Review Form

State any strengths and weaknesses that existed:	

Recommendation (s) if any:	

Attachments:	
<i>If selected 'OTHER documents', please list the documents below:</i>	

ALL INFORMATION CONTAINED IN THIS REPORT IS EXEMPT AND IS TO BE CONSIDERED FOR REVIEW/ VIEWING ON A NEED TO KNOW BASIS ONLY.

REVIEW COMMITTEE

List of Morbidity and Mortality Review Committee Members:

<u>Contractors</u>	
_____	, Medical Director
_____	, Deputy Medical Director
_____	, Health Services Administrator
_____	, Director of Nursing
_____	, Mental Health Director
_____	, Quality Assurance Director

<u>DOC</u>	
_____	, Health Services Administrator
_____	, Medical Director

OFFICE OF THE HEALTH SERVICES ADMINISTRATOR

Comments:

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Recommendations or Action taken:



Multi-Level Morbidity and Mortality Review Form

_____	_____
Health Services Administrator	Date

OFFICE OF HEALTH SERVICES, DOC

Comments:

Signature of Review Committee Members:

_____	_____	_____
Signature	Print Name Above	Date
_____	_____	_____
Signature	Print Name Above	Date