OVERVIEW OF RECOMMENDATIONS OF SUICIDE PREVENTION EXPERT, LINDSAY HAYES, REGARDING SUICIDE PREVENTION PRACTICES WITHIN THE SANTA CLARA COUNTY DEPARTMENT OF CORRECTION

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Introduction

On December 15, 2016, the Board of Supervisors approved an agreement with Sabot Consulting to administer a comprehensive gap analysis to assess and evaluate the provision of health care within the Santa Clara County Department of Correction (DOC). I retained five consultants to conduct the gap analysis and that work is still in progress. In an effort to keep the County updated on the progress of the gap analysis as the information becomes available, I am providing the following information about the recommendations of the Suicide Prevention Consultant, Lindsay M. Hayes, who has completed his assessment. As of December 2015, the DOC had experienced a relatively steady high number of inmate suicides and suicide rate within the past several years. Although these deaths have been reviewed by both the Santa Clara County Sheriff's Office and its mental health provider (the Santa Clara Valley Health and Hospital System, Adult Custody Health Services), the County agreed with a Sabot Consulting recommendation to independently assess current suicide prevention practices, as well as offer any appropriate recommendations to revise existing suicide prevention policies and procedures, as part of a larger gap analysis of the DOC.

Qualifications of Lindsay Hayes

Mr. Hayes is nationally recognized as an expert in the field of suicide prevention within jails, prisons and juvenile facilities, and has been appointed as a Federal Court Monitor (and expert to special masters/monitors) in the monitoring of suicide prevention practices in several adult and juvenile correctional systems under court jurisdiction. Mr. Hayes has also served as a suicide prevention consultant to the U.S. Justice Department's Civil Rights Division (Special Litigation Section) and selectively for the Office of Civil Rights and Civil Liberties of the U.S. Department of Homeland Security (Immigration and Customs Enforcement) in their investigations of conditions of confinement in both adult and juvenile correctional facilities throughout the country. Mr. Hayes also serves as an expert witness/consultant in inmate suicide litigation cases, as well as serving as a technical assistance consultant/expert by conducting training seminars and assessing inmate and juvenile suicide prevention practices in various state and local jurisdictions throughout the country.

Mr. Hayes has conducted the only five national studies of jail, prison, and juvenile suicide. Mr. Hayes has authored numerous publications on suicide prevention in custodial settings.

Background

As of December 31, 2015, the DOC had an average daily population of 3,641 inmates, with 30,328 admissions in the jail facility each year, making it the fifth largest county jail system in California and among the 20 largest county jail systems in the United States. On January 7, 2016, the total jail population was 3,485 inmates.

The DOC experienced nine inmate suicides during the five-year period of 2011 through 2015. Based upon the average daily population during this same period, the suicide rate in the DOC was 47.4 deaths per 100,000 inmates – a rate that is slightly higher than that of county jails of varying sizes throughout the United States.

The average daily population, yearly admissions, suicide totals, and suicide rate within the DOC from 2011 through 2015 are as follows:

Year	ADP	Yearly Admissions	Suicides	Suicide Rate[1]
2011	3,568	29,993	3	84.1
2012	3,658	29,167	3	82.0
2013	4,006	30,657	0	0
2014	4,124	32,465	1	24.2
2015	3,641	30,328	2	55.0
2011-2015	18,997	151,985	9	47.4

Assessment Methodology

Mr. Hayes conducted an on-site assessment of the County's jails from January 4 through January 8, 2016. In conducting the assessment, Mr. Hayes met with and/or interviewed numerous correctional, medical, and mental health officials and staff from the DOC and the Santa Clara Valley Health and Hospital System (SCVHHS); reviewed numerous policies and procedures related to suicide prevention, screening/assessment protocols, and training materials; reviewed various health care charts and investigative reviews of nine inmate suicides between 2011 and 2015; and toured four jail facilities that comprise most of the DOC. These facilities were the Main Jail North and Main Jail South located in downtown San Jose, and the Elmwood Men's Medium Correctional Facility and Elmwood Women's Correctional Facility, both located in Milpitas.

Mr. Hayes conducted his assessment of DOC and SCVHHS using an eight-part protocol that examines the critical components of suicide prevention: (1) staff training; (2) identification/screening; (3) communication; (4) housing; (5) levels of supervision/management; (6) intervention; (7) reporting; and (8) follow-up/morbidity-mortality review. Mr. Hayes previously developed the protocol, which is consistent with national correctional standards, including those of the American Correctional Association's Performance-Based Standards for Adult Local Detention Facilities (2004); Standard J-G-05 of the National Commission on Correctional Health Care's Standards for Health Services in Jails (2014); and the "Suicide Prevention and Intervention Standard" of the U.S. Department of Homeland Security's

[1]The jail suicide rate is calculated by dividing the number of suicides by the ADP and then multiplying that number by 100,000.

Operations Manual ICE Performance-Based National Detention Standards (2011), as well as the California Board of State and Community Corrections' Minimum Standards for Local Detention Facilities as outlined in Titles 15 and 24, California Code of Regulations.

Mr. Hayes's Review of Eight Critical Components of Suicide Protocol and Recommendations for Improvement

1. Staff Training

Mr. Hayes explained the significance of training as follows:

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

Mr. Hayes accordingly advocates for the following training standard:

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

After completing an assessment of current practices at DOC, Mr. Hayes made the following five recommendations to strengthen the length and content, as well as commitment to, suicide prevention training offered to both correctional and healthcare personnel who work within the DOC:

A. All custody personnel (correctional officers and deputies) and providers (including medical physicians and psychiatrists) should complete suicide prevention training on an annual basis.

B. DOC and SCVHHS should only utilize classroom-instructed suicide prevention training.

C. DOC and SCVHHS should collaborate on the development of a new four to eight hour pre-service suicide prevention curriculum for new employees (including custody, medical and mental health staff).

D. DOC and SCVHHS should collaborate on the development of a two-hour annual suicide prevention curriculum for all custody, medical and mental health staff.

E. SCVHHS mental health personnel (including psychiatrists) should receive additional training on comprehensive suicide risk assessments and how to develop a reasonable treatment plan that contains specific strategies for reducing future suicidal ideation.

2. Intake Screening/Assessment:

Mr. Hayes emphasized the importance of intake screening/assessment:

> Intake screening/assessment is also critical to a correctional system's suicide prevention efforts. An inmate can attempt suicide at any point during incarceration - beginning immediately following reception and continuing through a stressful aspect of confinement. Although there is disagreement within the psychiatric and medical communities as to which factors are most predictive of suicide in general, research in the area of jail and prison suicides has identified a number of characteristics that are strongly related to suicide, including: intoxication, emotional state, family history of suicide, recent significant loss, limited prior incarceration, lack of social support system, psychiatric history, and various "stressors of confinement." Most importantly, prior research has consistently reported that at least two thirds of all suicide victims communicate their intent some time prior to death, and that any individual with a history of one or more suicide attempts is at a much greater risk for suicide than those who have never made an attempt. In addition, according to the most recent research on inmate suicide, at least one-third of all inmate suicide victims had prior histories of both mental illness and suicidal behavior. The key to identifying potentially suicidal behavior in inmates is through inquiry during both the intake screening/assessment phase, as well as other high-risk periods of incarceration.
>
> Finally, given the strong association between inmate suicide and special management (i.e., disciplinary and/or administrative segregation) housing unit placement, any inmate assigned to such a special housing unit should receive a brief assessment for suicide risk by health care staff upon admission to such placement.

Mr. Hayes advocates for the following suicide prevention practices during intake and assessment in correction facilities:

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

Mr. Hayes offered the following recommendations for improving the intake screening/assessment process within the DOC:

A. SCVHHS should revise the current suicide risk inquiry contained on the current "Medical Clearance" form embedded in the Electronic Medical Record to include the following questions about the inmates' suicide risk:

1) Have you ever attempted suicide?
2) Have you ever considered suicide?
3) Are you now or have you ever been treated for mental health or emotional problems?
4) Have you recently experienced a significant loss (relationship, death of family member/close friend, job, etc.)?
5) Has a family member/close friend ever attempted or committed suicide?
6) Do you feel there is nothing to look forward to in the immediate future (inmate expressing helplessness and/or hopelessness)?
7) Are you thinking of hurting and/or killing yourself?

B. SCVHHS officials should initiate a continuous quality assurance plan to periodically audit the intake screening process to ensure that nursing staff are asking all questions to newly admitted detainees as required.

C. DOC officials should look at options for better ensuring reasonable sound privacy at the booking counter when multiple nurses are conducting intake screening.

D. DOC and SCVHHS should always initiate a mental health referral if there is documentation reflecting possible mental illness and/or suicidal

behavior during an inmate's prior confinement within the DOC.

E. SCVHHS officials should develop a triage system for mental health referrals based upon acuity of behavior, including emergent, urgent, and routine. Any inmate expressing current suicidal ideation and/or current suicidal/self-injurious behavior should result in an emergent mental health referral.

F. SCVHHS should conduct a continuous quality improvement audit to determine whether the 12 current criminal offenses that automatically result in a "charge-based mental health referral" are effective in preventing suicides.

G. SCVHHS mental health staff should conduct screening and/or crisis assessments in an area that provides reasonable privacy and confidentiality.

3. Communication:

Mr. Hayes identified three levels of communication needed to prevent inmate suicides:

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

As such, Mr. Hayes advocates for procedures that ensure adequate communication in correction facilities:

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

In his assessment of DOC, Mr. Hayes concluded that correctional, medical, and mental health personnel had a good working relationship. He had no recommendations in the area of communication as it relates to suicide prevention.

4. Housing:

Mr. Hayes addressed the appropriate housing of inmates as follows:

> In determining the most appropriate location to house a suicidal inmate, there is often the tendency for correctional officials in general to physically isolate the individual. This response may be more convenient for staff, but it is detrimental to the inmate. The use of isolation not only escalates the inmate's sense of alienation, but also further serves to remove the individual from proper staff supervision. National correctional standards stress that, to every extent possible, suicidal inmates should be housed in the general population, mental health unit, or medical infirmary, located in close proximity to staff.
>
> Of course, housing a suicidal inmate in a general population unit when their security level prohibits such assignment raises a difficult issue. The result, of course, will be the assignment of the suicidal inmate to a housing unit commensurate with their security level. Within a correctional system, this assignment might be a "special housing" unit, e.g., restrictive housing, disciplinary confinement, administrative segregation, etc. However, the most important consideration is that suicidal inmates must be housed in suicide-resistant, protrusion-free cells. Further, cancellation of routine privileges (showers, visits, telephone calls, recreation, etc.), removal of clothing (excluding belts and shoelaces), as well as the use of physical restraints (e.g., restraint chairs/boards, straitjackets, leather straps, etc.) should be avoided whenever possible, and only utilized as a last resort for periods in which the inmate is physically engaging in self-destructive behavior. Housing assignments should not be based on decisions that heighten depersonalizing aspects of incarceration, but on the ability to maximize staff interaction with inmates.

Mr. Hayes advocates for the following suicide prevention practices for housing suicidal inmates in correction facilities:

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

Mr. Hayes offered the following recommendations for improving the housing and management of inmates on suicide precautions within the DOC:

A. Santa Clara County Sheriff's Office (SCCSO) officials should designate specific cells within the DOC that will be utilized to house suicidal inmates, and then embark upon an inspection program to ensure that inmates on suicide precautions are housed in "suicide-resistant" cells. Specific recommendations regarding the removal of obvious protrusions in cells can be found in the "Checklist for the 'Suicide-Resistant' Design of Correctional Facilities." (See Appendix A to this Overview of Recommendations.)

B. SCVHHS safety smocks should be implemented only by medical and/or mental health staff and only when a clinician believes that the inmate is at high risk for suicide by hanging, and not as a default or behavior management plan.

C. SCVHHS should develop suicide prevention policies to address procedures for deciding which possessions and privileges are provided to inmates on suicide precautions.

5. Levels of Supervision/Management

Here, Mr. Hayes noted as follows:

> Experience has shown that prompt, effective emergency medical service can save lives. Research indicates that the overwhelming majority of suicide attempts in custody is by hanging. Medical experts warn that brain damage from asphyxiation can occur within four minutes, with death often resulting within five to six minutes. In inmate suicide attempts, the promptness of the response is often driven by the level of supervision afforded the inmate.

Mr. Hayes advocates for the following suicide prevention practices for supervision and management of suicidal inmates in correction facilities:

> **Two levels of supervision are generally recommended for suicidal inmates -- *close observation* and *constant observation. Close Observation* is reserved for the inmate who is not actively suicidal, but expresses suicidal ideation and/or has a recent prior history of self-destructive behavior. In addition, an inmate who denies suicidal ideation or does not threaten suicide, but demonstrates other concerning behavior (through actions, current circumstances, or recent history) indicating the potential for self-injury, should be placed under close observation. This inmate should be observed by staff at staggered intervals not to exceed every 10 minutes. *Constant Observation* is reserved for the inmate who is actively suicidal,**

either by threatening or engaging in self-injury. This inmate should be observed by a staff member on a continuous, uninterrupted basis. Other supervision aids (e.g., closed circuit television, inmate companions/watchers, etc.) can be utilized as a supplement to, but never as a substitute for, these observation levels. Inmates on suicide precautions should be reassessed on a daily basis.

Mr. Hayes offered the following recommendations for strengthening the observation and management of inmates identified as suicidal and/or exhibiting self-injurious behavior within the DOC:

A. SCCSO and SCVHHS suicide prevention policies should include two levels of observation (close observation and constant observation) that

describe with specificity the behavior warranting each level of observation.

B. SCVHHS should eliminate the minimum and maximum length of stay on suicide precautions for inmates identified as suicidal and instead use clinical judgment on a case-by-case basis to determine the length of stay.

C. SCVHHS should revise any suicide prevention policy to permit both custody and medical staff to initiate suicide precautions and require that only mental health staff can discontinue suicide precautions after a comprehensive suicide risk assessment.

D. SCVHHS's *draft* Suicide Risk Assessment form should be finalized and implemented as soon as possible. The current draft should be revised to include a disposition section (e.g., initiate, continue, or discharge suicide precautions; specified level of observation; etc.), as well as a treatment or safety plan section that requires the clinician to specify strategies to reduce future suicidal ideation.

E. All SCVHHS clinicians (including psychiatrists and other qualified mental health professionals) should complete the Suicide Risk Assessment form whenever an inmate is identified and referred for possible suicidal behavior. The Suicide Risk Assessment form should be utilized at least twice, i.e., for initiation of suicide precautions, as well as justification for discharging the inmate from suicide precautions.

F. The Suicide Risk Assessment form should be completed in a private setting and not cell-side unless the inmate-patient refuses a private interview. Refusal of a private interview should be documented in the electronic medical record (EMR).

G. SCVHHS mental health clinicians should develop treatment plans for inmates discharged from suicide precautions. Those plans should describe

signs, symptoms, and the circumstances in which the risk for suicide is likely to recur; how recurrence of suicidal thoughts can be avoided; and actions the patient or staff can take if suicidal thoughts occur.

H. All SCVHHS mental health personnel (including psychiatrists) should receive additional training on: 1) how to complete the Suicide Risk Assessment form, which should include examples of adequate and inadequate assessments; and 2) how to complete a reasonable treatment plan that contains specific strategies for reducing future suicidal ideation, which should include examples of adequate and inadequate treatment plans.

I. SCVHHS should ensure that all inmates discharged from suicide precautions remain on mental health caseloads and receive regularly scheduled follow-up assessments by mental health staff until their release from custody, in order to safeguard the continuity of care for suicidal inmates.

J. SCVHHS should extend the current "psych hold or "K-Hold" to include those inmates on suicide precautions at the time of their scheduled release from custody. DOC staff should also inform mental health personnel of the scheduled release of inmates on suicide precautions so mental health staff can conduct a brief mental health assessment to ensure the inmate's stabilization for release.

6. Intervention:

Mr. Hayes stated that following a suicide attempt, the degree and promptness of intervention provided by staff often foretells whether the victim will survive.

Mr. Hayes advocates for the following suicide prevention standard for suicide intervention in correction facilities:

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

> **ensure an efficient emergency response to suicide attempts, "mock drills" should be incorporated into both initial and refresher training for all staff.**

Mr. Hayes offered the following recommendation for strengthening the degree and promptness of intervention following a suicide attempt within the DOC:

A. DOC should ensure that the compliance rate of CPR/AED training for custody personnel (excluding those who might be out on disability or other leave) be maintained at a minimum of 90 percent

7. Reporting:

Mr. Hayes advocates for the following suicide reporting practices for suicide intervention in correction facilities:

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

Mr. Hayes made no recommendations for improving the DOC's current practices for reporting a suicide to the appropriate correctional officials in the chain of command, outside authorities, and family.

8. Follow-Up/Morbidity-Mortality Review:

In this regard, Mr. Hayes commented:

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

Mr. Hayes thus advocates for the following follow-up/morbidity-mortality review practices in correction facilities:

> **Every completed suicide, as well as serious suicide attempt (i.e., requiring hospitalization), should be examined by a morbidity-**

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

Mr. Hayes offered the following recommendations to improve the mortality review process for inmate suicides:

A. DOC should disband its Death Review Committee and instead utilize and attend the SCVHHS-run Death Review Committee. SCVHHS should revise an existing policy or create a new policy that sets forth appropriate procedures for conducting the Death Review Committee.

B. DOC representatives to the Death Review Committee should become active participants and partners on the SCVHHS-run Death Review Committee.

C. The multidisciplinary Suicide Prevention Committee should act as the continuous quality improvement arm within DOC for suicide prevention and should be charged with developing a corrective action plan to implement the recommendations made by Mr. Hayes, as well as monitoring implementation of any recommendations made by the Death Review Committee. DOC and SCVHHS executive leadership should attend at least the first meeting.

D. The multidisciplinary Suicide Prevention Committee should be reconstituted with a different operational mission. Instead of reviewing demographic data on suicide attempts and completed suicides, the Committee should act as the continuous quality improvement arm within the DOC for suicide prevention.

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APPENDIX A

CHECKLIST FOR THE "SUICIDE-RESISTANT" DESIGN OF CORRECTIONAL FACILITIES

Lindsay M. Hayes

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

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

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

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

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

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

3) If cells have floor drains, they should also have holes that are ideally 1/8 inches wide, and no more than 3/16 inches wide or 16-mesh per square inch (inmates have been known to weave one end of a ligature through the floor drain with the other end tied around their neck, then lay on the floor and spin in a circular motion as the ligature tightens);

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

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

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

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

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

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

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

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

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

10) CCTV monitoring does not prevent a suicide, it only identifies a suicide attempt in progress. If utilized, CCTV monitoring should only supplement the physical observation by staff. The camera should obviously be enclosed in a box that is tamper-proof and does not contain anchoring points. It should be placed in a high corner location of the cell and all edges around the housing should be caulked or grouted.

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

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

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

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

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

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

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

15) Some inmates hang themselves under desks, benches, tables or stools/pull-out seats. Potential suicide-resistant remedies are: (a) Extending the bed slab for use as a seat; (b) Cylinder-shaped concrete seat anchored to floor, with rounded edges; (c) Triangular corner desk

top anchored to the two walls; and (d) Rectangular desk top, with triangular end plates, anchored to the wall. Towel racks should also be removed from any desk area;

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

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

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

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

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

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

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

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

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

NOTE: A portion of this checklist was originally derived from R. Atlas (1989), “Reducing the Opportunity for Inmate Suicide: A Design Guide,” Psychiatric Quarterly, 60 (2): 161-171. Additions and modifications were made by Lindsay M. Hayes, and updated by Randall Atlas, Ph.D., a registered architect. See also Hayes, L.M. (2003), “Suicide Prevention and “Protrusion-Free Design of Correctional Facilities,” Jail Suicide/Mental Health Update, 12 (3): 1-5. Last revised Mr. Hayes in February 2016.