REPORT ON JAIL SUICIDE PREVENTION PRACTICES WITHIN THE BRISTOL COUNTY SHERIFF'S OFFICE

Dartmouth, Massachusetts

by

Lindsay M. Hayes

e-mail: Lhayesta@msn.com

April 4, 2023

TABLE OF CONTENTS

A. Introduction....3-4

B. Qualifications....5-7

C. Findings and Recommendations....7-8

1) Staff Training....9-13
2) Intake Screening/Assessment....13-24
3) Communication....24-25
4) Housing....26-35
5) Levels of Supervision/Management....36-44
6) Intervention....45-46
7) Reporting....46
8) Follow-up/Mortality-Morbidity Review....47-51

D. Summary of Recommendations....52-56

E. Conclusion....57-58

Appendices

REPORT ON JAIL SUICIDE PREVENTION PRACTICES WITHIN THE BRISTOL COUNTY SHERIFF'S OFFICE
Dartmouth, Massachusetts

A. INTRODUCTION

The following is a summary of the observations, findings, and recommendations of Lindsay M. Hayes following an assessment of jail suicide prevention practices within the Bristol County Sheriff's Office in Dartmouth, Massachusetts. During the most recent seven-year period from 2017 through March 2023, the Bristol County Sheriff's Office experienced 10 inmate suicides, the most recent of which occurred a few days after Paul Heroux became the new Bristol County Sheriff in January 2023. Seven of these deaths occurred at the Bristol House of Correction and Jail in Dartmouth. Notwithstanding previous attempts to curb inmate suicides, the Bristol County Sheriff's Office once again recently began to review various policy and procedural directives, as well as practices, relating to suicide prevention. In order to more independently assess current practices, as well as offer any appropriate recommendations for improving suicide prevention policies and practices, Sheriff Heroux decided to seek the assistance of this writer.

It should be noted that the determination for the need of this writer's assessment was not prompted by litigation or critical investigation of any inmate suicide. Rather, these actions were taken through the pro-active initiative of Sheriff Heroux who was committed to determining what steps, if any, were necessary to improve suicide prevention practices within the department, with the overall goal to reduce the number and rate of suicides.

In conducting this assessment, this writer was on-site from March 6 through March 8, 2023, and toured the Bristol House of Correction and Jail and the Ash Street Jail and Regional Lock-Up;

met with various correctional, medical, and mental health officials and staff from each facility; reviewed numerous documents related to suicide prevention, including policies and procedures, screening protocols, and suicide prevention lesson plans/training curricula/training data; and reviewed pertinent documentation of all 10 inmate suicides that occurred between 2017 and January 2023. A debriefing of this writer's preliminary findings occurred with Sheriff Heroux and his management team during the late afternoon of March 8.

The Bristol County Sheriff's Office comprises three jail facilities: Bristol House of Correction and Jail, Women's Center, and the Ash Street Jail and /Regional Lock-Up. Opened in 1990, the Bristol House of Correction and Jail, located in Dartmouth, houses both sentenced (up to 30 months) inmates and pre-trial detainees. The facility, housing both male and female individuals, has a rated capacity for 1,100 inmates, and held approximately 680 inmates during the onsite assessment. The Women's Center, also located in Dartmouth, has a rated capacity for 106 medium security female inmates. Built in 1888, the Ash Street Jail and Regional Lock-Up in New Bedford has a capacity for over 200 inmates, but housed approximately only 85 inmates during the onsite assessment, the vast majority of whom were pre-trial detainees and inmate workers. The Regional Lock-Up temporarily houses arrestees prior to their initial court appearances.

As noted above, the Bristol County Sheriff's Office has experienced 10 inmate suicides in its jail facilities between 2017 and January 2023, resulting in this writer's calculation of an inmate suicide rate of 165.1 deaths per 100,000 inmates.[1] According to the most recent national data, the

[1]The calculation assumes an average daily population (ADP) of 865 inmates in the Bristol County jail system each year during the past seven years. The suicide rate is calculated by adding up the ADP for the seven years (6,055 inmates), dividing the 10 suicides by 6,055 inmates, and multiplying that number by 100,000 inmates.

suicide rate in local jails throughout the country during 2019 was 49 deaths per 100,000 inmates.[2] As such, the inmate suicide rate within the Bristol County jail system was more than three times higher than the national average.

During the last several years, there has been a great deal of speculation and discussion in the media and elsewhere regarding the suicide rate within the Bristol County jail system, and how it relates to other county jails within the Commonwealth of Massachusetts, including the theory that the county has a more significant opioid crisis then other jurisdictions of comparable size. It would be this writer's opinion that, although suicide rates may appear interesting, and individual suicides can point to indicators of deficiencies, inmate suicides and the corresponding suicide rate should not be the sole barometer by which the adequacy of suicide prevention practices are measured. As detailed in the following pages, the adequacy of a suicide prevention program can only be measured by a thorough review of suicide prevention practices (principally in the areas of training, identification/assessment, management, and emergency response), as well as review of inmate suicides on a case-by-case basis.

B. QUALIFICATIONS

This writer 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. This writer has also served as a suicide prevention consultant to the U.S. Justice Department's Civil Rights Division (Special Litigation

---

[2] E. Carson (2021), *Mortality in Local Jails, 2000–2019 – Statistical Tables*, Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.

Section) and to 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. This writer 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.

This writer has conducted the only five national studies of jail, prison, and juvenile suicide (*And Darkness Closes In...National Study of Jail Suicides* in 1981, *National Study of Jail Suicides: Seven Years Later* in 1988, *Prison Suicide: An Overview and Guide to Prevention* in 1995, *Juvenile Suicide in Confinement: A National Survey* in 2004, and *National Study of Jail Suicide: 20 Years Later* in 2010). The jail and prison suicide studies were conducted through contracts with the National Institute of Corrections (NIC), U.S. Justice Department; whereas the first national study of juvenile suicide in confinement was conducted through a contract with the Office of Juvenile Justice and Delinquency Prevention, U.S. Justice Department.

This writer served as editor/project director of the *Jail Suicide/Mental Health Update*, a quarterly newsletter devoted to research, training, prevention, and litigation that was funded by NIC from 1986 thru 2008; and was a consulting editor and editorial board member of *Suicide and Life-Threatening Behavior*, the official scientific journal of the American Association of Suicidology, as well as current editorial board member of *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, the official scientific journal of the International Association of Suicide Prevention. This writer has authored over 100 publications in the area of suicide

prevention within jail, prison and juvenile facilities, including model training curricula on both adult inmate and juvenile suicide prevention. This writer's *Training Curriculum and Program Guide on Suicide Detection and Prevention in Juvenile Detention/Correctional Facilities and Residential Programs: Instructor's Manual* was released in April 2013; whereas the *Training Curriculum and Program Guide on Suicide Detection and Prevention in Jail and Prison Facilities: Instructor's Manual* was released in March 2016.

As a result of research, technical assistance, and expert witness consultant work in the area of suicide prevention in correctional facilities, this writer has reviewed and/or examined over 3,800 cases of suicide in jail, prison, and juvenile facilities throughout the country during the past 42 years. This writer was a past recipient of the National Commission on Correctional Health Care's Award of Excellence for outstanding contribution in the field of suicide prevention in correctional facilities. This writer's work has been cited in the suicide prevention sections of various state and national correctional health care standards, as well as numerous suicide prevention training curricula.

C. FINDINGS AND RECOMMENDATIONS

Detailed below is this writer's assessment of jail suicide prevention practices within the Bristol County Sheriff's Office. It is formatted according to this writer's eight (8) critical components of a suicide prevention policy: staff training, identification/screening, communication, housing, levels of supervision/management, intervention, reporting, and follow-up/mortality-morbidity review. This protocol was previously developed by this writer and 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-B-05 of the

National Commission on Correctional Health Care's *Standards for Health Services in Jails* (2018); and "Suicide Prevention and Intervention Standard" of the U.S. Department of Homeland Security's *Operations Manual ICE Performance-Based National Detention Standards* (2011).[3] Where indicated, recommendations are also provided.

Finally, this writer reviewed various Bristol County Sheriff's Office and Correctional Psychiatric Services[4] policies and procedures related to suicide prevention, including:

- Correctional Psychiatric Services, Policy J-B-05/O-G-01, "Inmate Suicide Prevention and Intervention," revised March 2022;
- Bristol County Sheriff's Office, Policy No. 12.13.00, "Inmate Suicide Prevention and Intervention," revised August 2019;
- Bristol County Sheriff's Office, Policy No. 25.01.00, "Bristol County Regional Lockup," revised February 2021; and
- Bristol County Sheriff's Office, Policy No. 12.06.00, "Inmate Mental Health Services," revised February 2021.

[3]American Correctional Association (2004), *Performance-Based Standards for Adult Local Detention Facilities*, 4th Edition, Lanham, MD: Author; National Commission on Correctional Health Care (2018), *Standards for Health Services in Jails*, Chicago, IL: Author; and U.S. Department of Homeland Security (2011), Immigration and Customs Enforcement, *Operations Manual ICE Performance-Based National Detention Standards*, Washington, DC: Author.

[4]Correctional Psychiatric Services provides both medical and mental health services to Bristol County House of Correction (HOC) and Jail and Ash Street Jail inmates, but no services to Regional Lock-Up inmates. Services to HOC and Ash Street Jail inmates are available 24 hours a day, seven days a week, including after-hours, on-call mental health services.

1) **<u>Staff Training</u>**

> ***All*** **correctional, medical, and mental health staff should receive four to eight (8) hours of initial suicide prevention training, followed by two (2) hours of annual training. At a minimum, training should include guiding principles to suicide prevention, 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.**

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.

Both the American Correctional Association (ACA) and National Commission on Correctional Health Care (NCCHC) standards stress the importance of training as a critical component to any suicide prevention program. ACA Standard 4-ALDF-7B-10 requires that all correctional staff receive both initial and annual training in the "signs of suicide risk" and "suicide precautions;" while Standard 4-ALDF-4C-32 requires that staff be trained in the implementation of the suicide prevention program. As stressed in NCCHC Standard J-B-05 -- "All staff members who work with inmates are trained to recognize verbal and behavioral cues that indicate potential

suicide and how to respond appropriately. Initial and at least annual training is provided." Finally, the U.S. Department of Homeland Security's *Operations Manual ICE Performance-Based National Detention Standards* require that all staff receive both pre-service and annual training in the following areas: recognizing verbal and behavioral cues that indicate potential suicide; demographic, cultural, and precipitating factors of suicidal behavior; responding to suicidal and depressed detainees; effective communication between correctional and health care personnel; necessary referral procedures; constant observation and suicide-watch procedures; follow-up monitoring of detainees who have already attempted suicide; and reporting and written documentation procedures."

Finally, although the standard of care in correctional facilities does not set a minimum requirement for the number of hours devoted to either pre-service or annual suicide prevention training, it has been this writer's experience that a commitment to 4- to 8-hour initial suicide prevention workshop for new employees, as well as a 2-hour annual suicide prevention workshop for all employees, is necessary.

FINDINGS: Both the Correctional Psychiatric Services, Policy J-B-05/O-G-01, "Inmate Suicide Prevention and Intervention," revised March 2022, and Bristol County Sheriff's Office, Policy No. 12.13.00, "Inmate Suicide Prevention and Intervention," revised August 2019, provide adequate descriptions of the policy requirements for suicide prevention training. The Bristol County Sheriff's Office's "Inmate Suicide Prevention and Intervention" policy (No. 12.13.00) addresses the requirements for pre-service suicide prevention training by requiring that the curriculum include instruction on:

- effective methods for identifying the warning signs, symptoms and verbal/behavioral cues of impending suicidal behavior/ideation by inmates;

- demographic and cultural parameters of inmate's suicidal behavior, including incidents and variations in precipitating factors;
- responding to suicidal and depressed inmates;
- suicidal precautions, housing observations, mental health watches;
- mental health disorders;
- effective communication between correctional and health personnel;
- high risk periods of incarceration;
- necessary referral procedures;
- avoiding negative attitudes in suicide prevention;
- follow-up monitoring procedures for inmates who make suicide attempts;
- applicable medical and mental health policies and procedures;
- reporting and written documentation procedures; and
- any other subject matter approved by the superintendent and contracted medical provider.

BSCO policy requirements for annual in-service training included the following:

- a review of materials discussed during orientation training;
- recent changes of Sheriff Office suicide prevention policies and procedures, if applicable; and
- general discussions on inmate suicide attempts which have occurred during the past year, if applicable. Privacy rights shall be respected.

Review of the training material provided by both the Bristol County Sheriff's Office (BCSO) and Correctional Psychiatric Services (CPS) found that many, but not all, of the above listed topics were adequately covered during suicide prevention workshops. For example, a 69-slide PowerPoint presentation entitled "Suicide Prevention and Intervention," developed by CPS and most recently revised in 2023, was said to be utilized in both the new employee pre-service training at the BCSO Training Academy, as well as during annual in-service training. Both trainings are provided by a CPS mental health clinician, generally the mental health director. The presentation typically lasts between 2 and 2.5 hours. Review of the PowerPoint slides found that they covered such areas as: facts and myths about suicide, suicide risk factors, inmate suicide research, profile of inmate suicides within the BCSO, BCSO/CPS suicide prevention policies, and suicide in law enforcement. Although the reviewed information was accurate and helpful, it is

insufficient for pre-service, new employee training, as well as not covering all of the required topics listed in the BCSO suicide prevention policy.

In addition, this writer was informed that CPS medical and mental health personnel were required to complete annual suicide prevention training from an e-learning format.

Finally, training data provided by both BCSO and CPS indicated that only 77 percent of custody personnel and 56 percent of healthcare (medical/mental health) personnel received suicide prevention training during 2022, a concerning finding. Most of non-compliance in healthcare training was with medical staff.

RECOMMENDATIONS: A few recommendations are offered to strengthen both the content and deliverability of suicide prevention training offered to both custody and healthcare personnel working within the Bristol County jail system. *First*, as noted above, although the standard of care in correctional facilities does not set a minimum requirement for the number of hours devoted to both pre-service and annual suicide prevention training, it is strongly recommended that the pre-service suicide prevention training requirement be expanded to include at least four (4) hours of instruction. Additional topics for inclusion into the curriculum should include: 1) guiding principles to suicide prevention, 2) avoiding negative attitudes to suicide prevention, 3) identifying suicidal inmates despite the denial of risk, 4) presentation of case studies, and 5) liability issues associated with inmate suicide. There are a number of resources available to supplement and revise such a training curriculum.[5]

[5]This writer's *Training Curriculum and Program Guide on Suicide Detection and Prevention in Jail and Prison Facilities*, published in March 2016, will be provided to BCSP/CPS upon request. See also the NCCHC's *Suicide*

Second, it is strongly recommended that the BCSO and CPS ensure that its correctional, medical, and mental health personnel regularly achieve at least 90 percent compliance with annual suicide prevention training.

2) <u>Intake Screening/Assessment</u>

> **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; and transporting officer(s) information regarding inmate's suicide risk. The intake screening process should include procedures for referral to mental health and/or medical personnel. Reasonable efforts should be made to ensure privacy and confidentiality (from both other inmates and non-health care personnel) during the intake screening process. Any inmate assigned to a segregation unit should be screened to ensure that there are no medical and/or mental health contraindications for such placement.**

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

---

Prevention Resource Guide, published in November 2019 and available at: https://project2025.afsp.org/wp-content/uploads/2020/01/NCCHC-AFSP_Suicide_Prevention_Resource_Guide.pdf

support system, psychiatric history, and various stressors of confinement.[6] 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.[7] In addition, according to the most recent national research on inmate suicide, at least one-third of all inmate suicide victims had prior histories of both mental illness and suicidal behavior.[8] 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.

Further, it would not be unusual for an otherwise suicidal inmate to deny suicidal ideation when questioned in a physical environment that lacks both privacy and confidentiality. The booking area of any jail is traditionally both chaotic and noisy; an environment where staff feel pressure to process a high number of arrestees in a short period of time. Two key ingredients for identifying suicidal behavior - time and privacy - are at a minimum. The ability to carefully assess the potential for suicide by asking the inmate a series of questions, interpreting their response (including gauging the truthfulness of their denial of suicide risk), and observing their behavior is grossly compromised by an impersonal environment that lends itself to something quite the opposite. As a result, the clearly suicidal behavior of many arrestees, as well as circumstances that may lend themselves to potential self-injury, are lost. As such, reasonable efforts should be made

---

[6]American Psychiatric Association (2016), *Psychiatric Services in Correctional Facilities*, Third Edition, Arlington, VA, American Psychiatric Association.
[7]Pompili, M., Murri, B., Patti, S. et al. (2016), "The Communication of Suicidal Intentions: A Meta-Analysis," *Psychological Medicine*, 46 (11): 2239-2253.
[8]Hayes, L.M. (2012), "National Study of Jail Suicides: 20 Years Later," *Journal of Correctional Health Care*, 18 (3).

to ensure privacy and confidentiality (from both other inmates and non-health care personnel) during the intake screening process.[9]

Finally, given the strong association between inmate suicide and special management (e.g., disciplinary and/or administrative segregation, etc.) housing unit placement, any inmate assigned to segregation should receive a brief assessment for suicide risk by health care staff upon admission to such placement. For example, both the ACA and NCCHC standards address the issue of assessing inmates assigned to segregation. According to ACA Standard 4-ALDF-2A-45: "When an inmate is transferred to segregation, health care personnel are informed immediately and provide assessment and review as indicated by the protocol as established by the health authority." NCCHC Standard J-G-02 states that "Upon notification that an inmate is placed in segregation: a) a qualified health care professional reviews the inmate's health record, b) if existing medical, dental, or mental health needs require accommodation, custody staff are notified, c) the review and documentation, if applicable, are documented in the health record."

FINDINGS: Both the Correctional Psychiatric Services, Policy J-B-05/O-G-01, "Inmate Suicide Prevention and Intervention," revised March 2022, and Bristol County Sheriff's Office, Policy No. 12.13.00, "Inmate Suicide Prevention and Intervention," revised August 2019, provide very limited descriptions of the policy requirements for intake screening to identify suicidal inmates. In addition, there were problematic practices found in both the intake screening process itself, as well as the screening forms utilized to identify suicide risk.

---

[9]See Hayes, L.M. (2013), "Suicide Prevention in Correctional Facilities: Reflections and Next Steps," *International Journal of Law and Psychiatry* 36: 188-194.

Bristol County House of Correction and Jail

In practice, all detainees admitted into the Bristol County House of Correction and Jail in Dartmouth (hereafter referred to as the HOC), are remanded from court, returned to jail as probation/parole violators, or from another placement (such as Bridgewater State Hospital). Intake screening is conducted by both custody booking officers and nursing staff. As part of the booking process, BCSO classification staff conduct an "Q-5" inquiry (now referred to as "SUI1" and "SUI2") through the Massachusetts Department of Criminal Justice Information Services (DCJIS) to determine whether the individual had previously threatened or attempted suicide while in the custody of a correctional and/or law enforcement agency within the Commonwealth. An affirmative response from the DCJIS inquiry results in an immediate mental health referral. In addition, any inmate who had a positive Q-5 recorded within the last several days would automatically be placed on suicide precautions[10] until they can be assessed by mental health staff. These are all good practices.

With regard to the intake screening process completed by nursing staff, this writer observed that the process occurs in the nurse's office in booking, with the door open, and officers milling about in the busy hallway, as well as entering/leaving the room. Such a practice is very problematic because there is no reasonable privacy and confidentiality afforded to the inmate during the screening process. A second nurse's office was available for use during busy booking hours and had the same privacy and confidentiality limitations. When available, the nurse practitioner conducts intake screening (up to four days per week) in the nurse's office at booking, an excellent practice.

[10]Within the Bristol County jail system, inmates identified as suicidal are placed on "mental health watch," a term that will be utilized throughout this report.

A "Medical History and Screening" form, embedded in the electronic health record-correctional (EHR-C), is completed by the intake nurse and contains the following inquiry regarding suicide risk:

- Have you ever been treated for a psychiatric illness?
- Have you ever attempted suicide?
- Do you have thoughts or plans to hurt yourself or someone else?
- Are you hearing voices?
- What are they saying?
- Does the inmate appear tearful?
- Is the inmate's communication incoherent?
- Is the inmate demonstrating bizarre/unusual behavior?

The screening form is problematic for several reasons, including the fact that it contains a compound question ("Do you have thoughts or plans to hurt yourself or someone else?"). In addition, several areas of critical inquiry are omitted, including prior suicidal ideation, experiencing a recent significant loss (relationship, death of family member/close friend, job, etc.), family member/close friend ever attempted or committed suicide, feeling there is nothing to look forward to in the immediate future (inmate expressing helplessness and/or hopelessness), and inmate's placement on mental health watch during a prior confinement.

With regard to inquiry about an inmate's placed on mental health watch during a prior confinement, this writer was informed that the Mental Health tab within the EHR-C contains a listing of an inmate's previous placement on the mental health watch. This is an excellent feature of the EHR-C and, although said to be accessed by mental health staff on a regular basis, it is not routinely accessed by nursing staff at intake.

In addition, a "Mental Health Screening" form is utilized for all inmates housed in the HOC for more than 14 days, as well as for initial mental health referrals. Ironically, although the form has a section entitled "Suicide" inquiry and lists "suicide attempts, suicide acts, family history of suicide, and mental status evaluation," there is no inquiry on the form regarding *current* risk for suicide. A "Comprehensive Mental Health Evaluation and Treatment Plan" form is completed on any inmate placed on the mental health caseload for a serious mental illness.

Further, due to COVID-19, all incoming detainees to the HOC are placed in restrictive housing status and, as such, are seen by a mental health clinician staff following the medical intake process. Clinicians complete a Data, Assessment, and Plan (DAP) formatted progress note following the interaction. It was unclear if, post COVID-19, mental health staff would continue to see every incoming detainee to the HOC or revert to the prior practice of seeing inmates at intake upon referral by the intake nurse.

Finally, with regard to restrictive housing, nursing staff complete an "Initial Segregation Assessment" whenever an inmate is placed in restrictive housing. The form contains inquiry regarding prior suicide attempts and current suicidal ideation, as well as requires the nurse to review the EHR-C. Affirmative responses to these questions result in mental health referrals. This is an excellent practice.

Ash Street Jail and Regional Lock-Up

Finally, as will be noted throughout this report, there were various problematic practices found at the Ash Street Jail and Regional Lock-Up, starting with the intake screening process.

Although medical staff were available 24 hours a day, very limited medical services (i.e., nursing staff response to medical emergencies), and no mental health services, were available at Regional Lock-Up arrestees. Routine medical services were provided to pre-trial and sentenced "inmates" at the Ash Street Jail,[11] and mental health clinicians provided coverage for these inmates up to four hours per week. This coverage included rounds of the restrictive housing unit, monthly contacts with caseload inmates, and responding to mental health referrals. But these healthcare services *exclude* Regional Lock-Up arrestees. If Regional Lock-Up arrestees needed either medical or mental health emergency, they were either not accepted into BCSO custody from local law enforcement agencies, or transported to outside facilities/agencies if the emergency occurred following acceptance of BCSO custody.

The Ash Street Jail and Regional Lock-Up has a starkly different process for intake screening for newly admitted detainees arrested by either local municipalities within Bristol County or the Massachusetts State Police. Because nursing staff are not involved with the intake screening process, a BCSO booking officer is exclusively responsible for intake screening by completing a 33-item "Receiving Screening Form" and an 18-item "Suicide Prevention Screening Guidelines" form. This writer found problems with both forms.

First, the Receiving Screening Form was originally designed to automatically provide a weighted scale for certain questions answered in the affirmative that would guide the officer in determining whether a referral to a custody supervisor was appropriate. During the on-site assessment, when this writer asked a booking officer why all of the affirmative responses on a

[11]Of note, nursing staff at the Ash Street Jail did not have access to EHR-C nor the BCSO's Offender Management System (OMS). Only manual, hardcopy charts were kept at the facility.

recently completed Receiving Screening Form provided to this writer were marked with a weighted scale of "0," the officer replied that the automated scale was broken and the BCSO's information technology (IT) department had been previously notified of the problem a few months earlier.

Second, this writer is very familiar with the 18-item Suicide Prevention Screening Guidelines form. The form, originally developed by the New York State Office of Mental Health and Commission on Correction during the 1980s, is widely utilized throughout the country, principally by either police departments and/or small county jails that do not have access to on-site mental health services.[12] There are two significant defects in the BCSO version of this Suicide Prevention Screening Guidelines form: 1) it inexplicably does not contain the critical question of – "Detainee is thinking about killing self," and 2) it does not contain all of the automatic referrals to a shift supervisor and placement on suicide precautions when a detainee answers in the affirmative to certain questions specific to current suicide risk.

During the onsite assessment, a booking officer also summarized an example of a recent booking and intake screening that had occurred earlier that morning (March 7, 2023). The individual (Case No. 1) had been found to be wandering in the woods of a neighboring Bristol County town, and possibly in possession of a firearm. A friend of this individual had called the local police department and expressed concern that the individual was possibly suicidal and asked that they locate his friend and perform a welfare check. Police officers were able to utilize GPS and locate the individual in the woods. Based upon the belief that individual was suicidal, police

---

[12]See https://scoc.ny.gov/pdfdocs/fillable_adm330_instructions_2018.pdf

officers transported the individual to a local hospital for assessment. The individual was subsequently cleared and, based upon the fact that he had several outstanding warrants, was transported to the Ash Street Jail as a "regional lockup." The BCSO booking officer completed the intake screening process at approximately 4:00am on March 7, and the individual answered "no" to all questions related to suicide risk. Based upon these negative responses, and despite the fact that there had been concern just a few hours earlier that this individual was suicidal and wandering in the woods, possibly with a firearm, he was not referred to a shift supervisor and not placed on a mental health watch. The individual attended his initial court hearing a few hours earlier and (fortunately for the Bristol County Sheriff's Office) was released on his own recognizance. *This case example should be of great concern to the BCSO because it exemplifies that all decisions regarding whether or not Regional Lock-Up arrestees are deemed to be suicidal is exclusively determined by booking officers and/or their shift supervisors who are not qualified to make such decisions.*

In conclusion, it would be this writer's opinion that the management of Regional Lock-Up arrestees housed at the Ash Street Jail is very precarious. While maintaining physical custody of these individuals, the BCSO currently allows for virtually no healthcare services while relying exclusively on its custody personnel to identify and manage suicidal individuals.

RECOMMENDATIONS: Several recommendations are offered to improve the intake screening process within the Bristol County jail system. *First*, it is strongly recommended that both the Correctional Psychiatric Services, Policy J-B-05/O-G-01, "Inmate Suicide Prevention and Intervention" and Bristol County Sheriff's Office, Policy No. 12.13.00, "Inmate Suicide

Prevention and Intervention" provide a better description of intake screening requirements, particularly at the Ash Steet Jail and Regional Lock-Up.

Second, it is strongly recommended that the following suicide risk questions be added to the "Medical History and Screening" form currently contained in the EHR-C and utilized at the HOC:

- Have you ever considered suicide?
- Have you recently experienced a significant loss (relationship, death of family member/close friend, job, etc.)?
- Has a family member/close friend ever attempted or committed suicide?
- Do you feel there is nothing to look forward to in the immediate future (inmate expressing helplessness and/or hopelessness)?

Third, it is strongly recommended that intake nurses (including the nurse practitioner) be required to verify whether an in-coming detainee had previous been placed on mental health in the Bristol County jail system by accessing the Mental Health tab within the EHR-C.

Fourth, it is strongly recommended that the "Mental Health Screening" form utilized for all inmates housed in the HOC for more than 14 days, as well as for initial mental health referrals, be revised to correct a defect by including the following suicide risk inquiry: "Do you have any current thoughts or plans to hurt yourself?"

Fifth, it is strongly recommended that measures be taken to ensure better privacy and confidentiality during the intake screening process conducted by nursing staff at the HOC. As such, doors to the nurse's offices currently utilized for medical screening should be replaced with doors containing a glass enclosure to ensure full visibility into the room by custody staff in the

corridor. During the intake screening process, the door to the offices should be closed with officers posted outside each office. Should nursing staff feel uncomfortable with the door closed, the detainee should be handcuffed.

Sixth, it is strongly recommended that, if the Bristol County Sheriff's Office continues to utilize the Ash Street Jail for the housing of Regional Lock-Up arrestees, such utilization should include the basic provision of both medical and mental health services.[13] At a minimum, nursing staff should review all intake screening forms that are completed by booking officers at the facility. A better practice would be that, because they are onsite at the facility 24 hours a day, nursing staff should complete the intake screening process. In addition, mental health clinicians should assess all Regional Lock-Up arrestees placed on mental health watch in the facility (and not exclusively rely on decisions from a local hospital or community crisis center that the individual is "cleared").[14]

Seventh, it is strongly recommended that, if booking officers at the Ash Street Jail continue to be exclusively responsible for the intake screening process, the defective weighted scale mechanism on the Receiving Screening Form be repaired immediately by the BCSO's IT department.

Eighth, it is strongly recommended that, if booking officers at the Ash Street Jail continue to be exclusively responsible for the intake screening process, the original version of the Suicide

[13]Although there might be a belief that because arrestees only remain in the Regional Lock-up for a few hours prior to their initial court hearing, negating the importance of health care involvement, there are instances every weekend where arrestees are housed in the facility for up to 72 hours (or more during a holiday weekend).
[14]It has been this writer's experience that outside medical hospitals, as well community crisis centers, more often than not assess and "clear" law enforcement-involved individuals because they either do not have the capacity to treat such individuals or simply choose not to treat them. Unfortunately, decisions to "clear" an individual and return them to law enforcement custody are made despite their continued risk for suicide.

Prevention Screening Guidelines form be utilized, including insertion of the critical question of – "Detainee is thinking about killing self," as well as all of the automatic referrals to a shift supervisor and placement on mental health watch until assessed by a mental health clinician.

3) Communication

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.

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.

FINDINGS: Effective communication between correctional, medical, and mental health staff is not an issue that can be easily written as a policy directive, and is often dealt with more effectively through examples of multi-disciplinary problem-solving. There were several examples of effective communication within the Bristol County jail system. First, Correctional Psychiatric Services has an EHR-C that, with the exception of Ash Street Jail, provides the opportunity for effective communication between medical and mental health personnel in the identification and

management of suicidal inmates. In addition, mental health staff have access to BCSO's Offender Management System, an excellent practice.

Second, there are several multidisciplinary meetings that regularly occur between custody, medical, and mental health staff within the Bristol County jail system, including, but are not limited to, a restrictive housing unit meeting between mental health and classification staff held three times per week; a case coordination meeting between mental health clinicians, the health services administrator, and providers held every other week; a Dartmouth Behavioral Unit (DBU)[15] meeting between mental health and custody staff held monthly; a mental health triage meeting between mental health clinicians and the health services administrator held monthly; and a mental health triage meeting amongst mental health clinicians held daily. In addition, a multidisciplinary mortality review committee, that generally meets within 30 days following an inmate suicide, will be discussed later in this report. Finally, although on-site for only a few days, this writer sensed that custody and healthcare personnel within the Bristol County jail system had a good working relationship.

<u>RECOMMENDATIONS</u>: None

[15]The Dartmouth Behavioral Unit, located in ED and EA Units of the HOC, was not part of this suicide prevention assessment because it only has a capacity for two inmates in each unit and there were no inmates in the program during the on-site assessment.

4) Housing

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

In determining the most appropriate location to house a suicidal inmate, there is often the tendency for correctional officials in general to physically isolate 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. Yet, housing assignments should not be based on decisions that heighten depersonalizing aspects of incarceration, rather they should be based on the ability to maximize staff interaction with inmates. With that said, *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, wrap, 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. Finally, unless exigent circumstances exist, court hearings should not be postponed for inmates on suicide precautions.

FINDINGS: Neither the Correctional Psychiatric Services, Policy J-B-05/O-G-01, "Inmate Suicide Prevention and Intervention," revised March 2022, or Bristol County Sheriff's Office, Policy No. 12.13.00, "Inmate Suicide Prevention and Intervention," revised August 2019, provide adequate descriptions of the policy requirements for the housing of suicidal inmates. The BCSO policy does not address "suicide-resistant" housing, and the CPS policy inaccurately states: "Inmates who are determined to require a constant observation watch normally shall be housed in a room in the Health Services Unit (HSU) or a designated room in the ED Unit that has been made as suicide-resistant as possible." In addition, neither policy adequately addresses procedures regarding possessions and privileges afforded to suicidal inmates.

In practice, all inmates identified as suicidal in the Bristol County House of Correction and Jail are placed in either: 1) the eight (8) cell ED Unit for male inmates, with the EE and EC Units also available for suicidal male inmates who also have additional behavioral/security issues; 2) the eight (8) cell EA Unit for female inmates; and 3) four (4) cells within the Health Services Unit (HSU) that can accommodate both male and female inmates, and are utilized as either overflow from the ED and EA Units, or for suicidal inmates who also have medical issues. All Regional

Lock-Up arrestees identified as suicidal are housed in 1-Alley of the Ash Street Jail and Regional Lock-Up.

This writer investigated all of the designated housing areas for suicidal inmates and, *with the exception of the Health Services Unit (HSU) cells, all other cells contained numerous hazards and protrusions that were conducive to suicide by hanging*. As such, none of these cells were suicide-resistant. Whereas the HSU cells contained ceiling and wall ventilation grates that were consistent with the industry standard size of 3/16 inch in diameter, as well as contained Lexan sheeting over the exterior vertical window bars, cells in other designated areas were very dangerous. For example, in the ED (and EE and EC) Units, each of the cells had double bunks with metal frames (including some with ventilation holes in the bunk), vertical window bars, ceiling and/or wall ventilation grates that were in excess of the industry standard size of 3/16 inch in diameter, and a clothing hook on the right side of the sink. Each cell in the EA Unit had similar hazards, including double bunks with metal frames (including some with ventilation holes in the bunk), vertical window bars, ceiling and/or wall ventilation grates that were in excess of the industry standard size of 3/16 inch in diameter, and a desk stool with a support bracket attached to the wall. Of note, *all of the seven (7) suicides at the HOC between 2017 and January 2023 involved use of the metal bunk beds whereby inmates utilized the metal railing or ventilation holes as an anchoring point in their suicides by hanging.* Although none of the suicide victims were on a mental health watch, three of the deaths occurred in the EA Unit.

Based upon the antiquated nature of the Ash Street Jail and Regional Lock-Up, three designated cells in 1-Alley contained numerous hazards, including vertical and horizontal cell bars, ventilation holes in the bunk, and exposed conduit piping on the walls.

All inmates on mental health watch in the Bristol County jail system are treated as "restrictive housing" inmates and, as such, remain locked down in their cell up to 24 hours a day. On rare occasions when suicidal inmates are permitted out of the cell, they always in restraints. Although mental health clinicians make decisions regarding possessions (e.g., clothing, book, and tablet), and inmates of mental health watch are generally permitted showers and a few were said to be allowed telephone calls, theses inmates generally were locked down all day and prohibited from utilizing the dayroom, yard, or (non-legal) visitation.

In addition, despite the BCSO suicide prevention policy stating that a mental health clinician "may decide" to cloth an inmate in a safety smock," and the CPS suicide prevention policy stating that "When standard-issue clothing presents a security or medical risk, the inmate is to be provided an alternative garment," it was this writer's observation that *safety smocks were utilized as the default for all inmates on mental health watch.*[16] In fact, with an average of six inmates on mental health watch each day of the three-day assessment, this writer observed that only one inmate was issued their regular jail clothing. In addition, several inmates in safety smocks were observed to be on mental health watch not because they were assessed as suicidal, but because they were either "off their baseline" or thought to be seriously mentally ill.

---

[16]Commonly referred to as a "turtle suit" or "pickle suit," a safety smock is a heavy quilted and tear-resistant sleeveless garment designed for the limited purpose of preventing suicide attempts by hanging.

One case exemplified the overly harsh and restrictive conditions of mental health watch within the Bristol County jail system. The inmate (Case No. 2) was placed on mental health watch in a safety smock during the evening of March 6, 2023 after corresponding with his wife via a tablet and expressing vague suicidal ideation about wanting to die following a diagnosis of colon cancer. He was housed in the HSU because of an upcoming scheduled surgery related to his diagnosis. When this writer observed the clinician's interaction with the inmate on March 7, he expressed being "okay" with wanting to die while at the same time vacillating between optimism and anxiety about the upcoming surgery. He remained in the safety smock. When assessed the following day (March 8), the inmate emphatically denied that he was suicidal, began crying and implored the clinician to return of his clothing. There was a foul smell in the room due to not receiving a shower for three days. The clinician subsequently authorized the return of the inmate's clothing, as well as return of his tablet. This writer spoke with an officer assigned to the HSU and requested that the inmate be provided with a shower. This case was significant in that it would be challenging for a clinician to determine if this inmate's denial of suicide risk was based upon his genuine lack of wanting to die or simply wanting to avoid the continued harsh conditions of mental health watch (i.e., clothed in a smock, no property, and no access to out-of-cell activities, including a shower).

Not surprisingly, this writer's calculation of the length of stay on mental health watch in the Bristol County jail system during January 2023 found that the majority (51 percent) were held between 1 and 3 days. Only 12 percent of the inmates on mental health watch had a length of stay of five days or more.

Conclusion

In many ways, the conditions for suicidal inmates housed on mental health watch were harsher than for those on restrictive housing status in the Bristol County jail system. It would be this writer's opinion that current management of these inmates was overly restrictive and seemingly punitive. Confining a suicidal inmate to their cell 24 hours a day only enhances isolation and is anti-therapeutic. Under these conditions, it is also difficult, if not impossible, to accurately gauge the source of an inmate's suicidal ideation. Take, for example, the scenario of a clinician assessing an inmate on suicide precautions. The inmate has been confined in their cell for a day or two, clothed only in a safety smock. The clinician approaches the inmate cell front, within easy hearing distance of both other inmates and jail staff, and asks through the closed door: "Are you suicidal?" Given the circumstances he or she finds themselves in, the likelihood of a suicidal inmate answering affirmatively to that question, the result of which will be their continued placement under these conditions, is highly questionable. As such, *mental health clinicians should be very concerned about external factors (such as the overly restrictive conditions of mental health watch) negatively impacting their ability to assess the suicidality of their patients.*

Available research suggests that suicidal inmates are often reluctant to discuss their suicidal thoughts because of the likelihood of being exposed to the harsh conditions of suicide precautions, with almost 75 percent of inmates reporting that they did not want to be transferred to an observation cell. According to the authors:

> "Possible reasons inmates dislike observation cells are numerous. For GP patients they can suffer taunting from other inmates with the identification of being in a mental health crisis after they return from the OB (observation). Further, an inmate-patient is removed from his more familiar surroundings of a single cell with his books, writing material, and own clothes, and his normal routine of recreation and work assignment. In the OB he often can no longer wear his clothes, and books and

> recreation are limited. In an OB cell a patient often is dressed in a special gown and the room may only contain a special mattress. Privacy is limited, since often all four sides of the OB are available for observation whereas in his own cell only one side is open for observation. Finally, admission in an OB can create anxiety and fear for the patient as it may be an unknown environment, and because the OB is the place the psychiatrists decide if patient is to be involuntarily transferred to the distant inpatient unit."[17]

This writer was informed by various BCSO and CPS personnel that the conditions of mental health watch were not intentionally punitive, but driven by concern for the safety of the inmate. The BCSO and CPS commitment to safety is not being challenged here. Safety of the inmate is, of course, of utmost concern when developing a suicide prevention policy. But the number and types of restrictions (e.g., exclusive reliance on safety smocks, denying all out-of-cell activities such dayroom, yard, visitation, etc.) imposed in the name of safety must be reasonable and commensurate with the inmate's level of suicide risk.

Officials might also have argued (although they did not to this writer) that the rationale for these restrictions was that suicidal inmates were unpredictable and bad news received during a family visit, telephone call, or court hearing might trigger suicidal ideation and result in an increased risk for suicide. This rationale, however, ignores the obvious -- what better opportunity was there to observe an inmate's reaction to potentially negative news then when they were on suicide precautions, as well as the fact that interaction with the outside world can be therapeutic and reduce isolation -- a leading cause of suicidal behavior. Staff might also have argued (although they did not to this writer) that most inmates who were mentally ill and on suicide precautions were so debilitated by their illness that "they did not care" how they were treated (i.e.,

[17]See Way, B., Kaufman, A., Knoll, J., and Chlebowski, S. (2013), "Suicidal Ideation Among Inmate-Patients in State Prison: Prevalence, Reluctance to Report, and Treatment Preferences," *Behavioral Sciences and the Law*, 30: 230-238.

the withholding of basic privileges). Of course, this assumption was not only unsupported but ignored the real possibility that these measures were contributing to an inmate's debilitating mental illness.

Further, some might also argue that these highly restrictive measures were effective in managing those inmates suspected as being manipulative or malingering. Although distinguishable, manipulative behavior and suicidal behavior are not mutually exclusive. Both types of behavior could occur (or overlap) in the same individual and cause serious injury and death. Several studies of self-harm and suicide in the correctional environment have found "substantial co-existence of manipulative motive with both suicidal intent and potentially high lethality of self-harming behavior."[18] As one observer has stated, "There are no reliable bases upon which we can differentiate 'manipulative' suicide attempts posing no threat to the inmate's life from those 'true, non-manipulative' attempts which may end in death. The term 'manipulative' is simply useless in understanding, and destructive in attempting to manage, the suicidal behavior of inmates (or of anybody else).[19] Self-harm is often a complex, multifaceted behavior, rather than simply manipulative behavior motivated by secondary gain. At a minimum, any inmate who would go to the extreme of threatening suicide or engaging in self-harming behavior is suffering from at least an emotional imbalance that requires special attention. They may also be seriously mentally ill. Simply stated, inmates labeled as manipulative still commit suicide.

---

[18]Dear G, Thomson D, Hills A. (2000), "Self-Harm in Prison: Manipulators Can Also Be Suicide Attempters," *Criminal Justice and Behavior*, 27: 160-175.
[19]Haycock J. (1992), "Listening to 'Attention Seekers:' The Clinical Management of People Threatening Suicide," *Jail Suicide Update*, 4 (4): 8-11.

RECOMMENDATIONS: The following recommendations are offered to improve the housing and management of inmates on mental health watch within the Bristol County jail system. *First*, it is strongly recommended that BCSO officials inspect any cell designated to house suicidal inmates in both the House of Corrections and Ash Street Jail to ensure that they are suicide-resistant, including, but not limited to, the replacement or retrofitting of metal bunk frames, replacement of ventilation grates on walls and ceilings and holes with grates that are no more than 3/16 inches in diameter, covering of cell and window bars with Lexan sheeting (similar to what currently exists in the HSU), and covering of exposed conduit piping. This writer's "Checklist for the 'Suicide-Resistant' Design of Correctional Facilities," included as Appendix A of this report, can be utilized as a guideline for such an inspection.

Second, it is strongly recommended that, consistent with existing BCSO and CPS suicide prevention policies, safety smocks should not be utilized as a default, and decisions regarding issuance of clothing or safety smocks should be individualized and commensurate with the suicidal inmate's level of risk as determined by a mental health clinician following assessment. It is critically important for a clinician to realize that safety smocks are designed to have the limited purpose of thwarting suicide attempts by hanging and, as such, their use should be restricted for that purpose.

Third, it is strongly recommended that that decisions regarding issuance of clothing, possessions, and privileges should be individualized and commensurate with the suicidal inmate's

level of risk as determined by a mental health clinician following assessment. As such, current BCSO and CPS suicide prevention policies should be appropriately revised as follows:

- All decisions regarding the removal of an inmate's clothing, bedding, possessions (books, slippers/sandals, eyeglasses, tablet, etc.) and privileges shall be commensurate with the level of suicide risk as determined on a case-by-case basis by a clinician and documented in the EHR-C;
- If a clinician determines that an inmate's clothing needs to be removed for reasons of safety, the inmate shall always be issued a safety smock and safety blanket;
- A safety mattress shall be issued to all inmates on mental health watch unless the inmate utilizes the mattress in ways in which it was not intended (i.e., attempting to tamper with/destroy, utilize to obstruct visibility into the cell, etc.);
- All inmates on mental health watch shall be allowed all routine privileges (e.g., showers, family visits, telephone calls, etc.), unless the inmate has lost those privileges as a result of a disciplinary sanction, and
- All inmates on mental health watch shall not automatically be locked down. They should be allowed dayroom, yard, and/or out-of-cell access commensurate with their security level and clinical judgment of mental health clinicians.

5) <u>Levels of Supervision/Management</u>

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 (e.g., expressing a wish to die without a plan) 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 10-15 minutes. *Constant Observation* is reserved for the inmate who is actively suicidal, either by threatening (with a plan) 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. Reasonable efforts should be made, particularly when considering the discharge of an inmate from suicide precautions, to avoid a cell-side encounters; rather, such assessments should be made in a private and confidential setting.

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.[20] Medical experts warn that brain damage from asphyxiation can occur within four minutes, with death often resulting within five to six minutes. In inmate suicide attempts, the promptness of the response is often driven by the level of supervision afforded the inmate. Both the ACA and NCCHC standards address *levels of supervision*, although the degree of specificity varies. ACA Standard 4-ALDF-2A-52 vaguely requires that "suicidal inmates are under continuous observation," while NCCHC Standard J-B-05 requires physical observation ranging from constant supervision for acutely suicidal inmates to "irregular intervals no more than 15 minutes apart" for

---

[20]Hayes, L.M. (2010), "National Study of Jail Suicides: 20 Years Later," *Journal of Correctional Health Care*, 18 (3).

non-acutely suicidal inmates. According to the Suicide Prevention and Intervention Standard from the U.S. Department of Homeland Security's *Operations Manual ICE Performance-Based National Detention Standards*, "Suicidal detainees will be monitored by the assigned security officers who maintain constant one-on-one visual observation, 24 hours a day, until the detainee is released from suicide watch. The assigned security officer makes notations every 15 minutes on the behavioral observation checklist."

In addition, the component of "Levels of Supervision" encompasses the overall management of the inmate on suicide precautions and includes the appropriate level of observation, timely and comprehensive suicide risk assessments that include reasonable efforts to provide private and confidential settings, downgrading the level of observation following a period of stability, and providing periodic follow-up assessments following discharge from suicide precautions based upon an individualized treatment plan.

FINDINGS: Both the Correctional Psychiatric Services, Policy J-B-05/O-G-01, "Inmate Suicide Prevention and Intervention," revised March 2022, or Bristol County Sheriff's Office, Policy No. 12.13.00, "Inmate Suicide Prevention and Intervention," revised August 2019, provide varying degrees of adequacy regarding the observation and management of suicidal inmates. In practice, there are two levels of mental health watch within the Bristol County jail system: *constant observation*, which requires continuous, uninterrupted supervision and is generally reserved for inmates assessed at imminent risk for suicide; whereas *close observation*, which requires supervision at intervals that do not exceed 15-minutes and is generally reserved for inmates who may have expressed suicidal ideation or other concerning behavior, but are not

viewed as imminent risk for suicide. It should be noted that a previous option of placing "two inmates into two separate, but adjacent, cells" for constant observation was removed from the BCSO suicide prevention policy in December 2018 via the previous sheriff's signature page, but remains in the current CPS suicide prevention policy.

During the current assessment, this writer observed that, although "Mental Health Watch Forms" containing the level of observation, possessions, and privileges afforded to inmates on mental health watch were placed *outside* each inmate's cell door, documentation of the required observation was found in a spreadsheet contained in the OMS *inside* the officer's station. Although this writer did observe officers conducting rounds at 15-minute intervals, a better practice for ensuring the accuracy of rounds being completed as required would be the placement of observation sheets on the cell doors of each inmate.

In addition, mental health clinicians are required to assess suicidal inmates are on a daily basis, Monday through Saturday, with a clinician only available on Sundays to inmates on constant observation. With one exception, this writer observed that all interactions between mental health clinicians and inmates on mental health watch were conducted cell front, with the cell door closed, and an officer often shadowing the clinician. The exception was the inmate on a mental health watch in the HSU on March 6, 2023, where the door was left open and an officer provided security from the corridor. Similar to the intake screening process, the practice of not affording inmates the opportunity for reasonable privacy and confidentiality during a clinician's inquiry regarding suicide risk was very problematic.

It was noteworthy that this writer observed that a "strip cage room" was located in both the ED and EA Units that could be easily utilized for clinical contacts, with the inmate placed in the strip cage and the officer providing security from outside the room. In addition, the ED Unit (and perhaps the EA Unit), had a program room that included a television and three "restart chairs."[21] This room could also be utilized for individual contacts, with an inmate classified as a security risk placed in a restart chair and the officer providing security from outside the room.

All assessments of inmates, whether they are suicidal or being seen by mental health clinicians for other reasons, are documented as Data, Assessment, and Plan (DAP) formatted progress notes, not on a separate suicide risk assessment template. Such a practice is very problematic. Review of the CPS suicide prevention policy found that assessments of suicide risk should include a minimum of the following inquiry: "relevant history, environmental factors, lethality of suicide plan, psychological factors, a determination of level of suicide risk, level of supervision needed, referral/ transfer for inpatient care (if needed), instructions to medical staff or care, and reassessment time frames." This writer reviewed several medical charts of inmates recently discharged from mental health watch. Overall, inmates were consistent seen on daily basis (with the exception of Sundays when mental health clinicians had limited availability), and DAP-formatted progress notes were completed for each interaction. These DAP notes were generally comprehensive, however, progress notes that provided documentation allowing for an inmate's discharge from mental health watch did not contain a reasonably comprehensive assessment of an inmate's suicide risk and justification for discharge.

[21] A "restart" chair is a stationary chair with arm and leg restraints often utilized to allow high security inmates out of their cells for purposes of programming.

The standard of care requires that documentation of a comprehensive assessment of suicide risk includes sufficient description of the current behavior and justification for either placement on, or discharge from, suicide precautions. For example, the assessment should include a brief mental status examination (MSE), listing of chronic and acute risk factors (including prior history of suicidal behavior), listing of any protective factors, level of suicide risk (e.g., low, medium, or high), and a treatment plan.[22] The DAP progress notes for inmates discharged from mental health watch reviewed by this writer: 1) did not provide a sufficient description of the current behavior (other than the inmate's denial of suicidal ideation) and justification for discharge from suicide precautions; 2) did not provide any discussion as to why the inmate had become suicidal; 3) did not provide a listing of chronic and acute risk factors, nor a listing of any protective factors; 4) did not provide a viable treatment plan for reducing future suicidal ideation; and 5) did not provide a specific schedule for follow-up following discharge from mental health watch.

Despite not utilized a suicide risk assessment template for an inmate's placement on, and discharge from, mental health watch, this writer observed that clinicians had a very good practice of debriefing amongst themselves following daily rounds of inmates on mental health watch. This writer was able to observe this process each day during the three-day assessment and found that clinicians possessed a good understanding of each case and, apart from their over-reliance on safety smocks, generated very good discussion and decision-making.

Further, according to national correctional standards, a "treatment or risk management plan" for an inmate discharged from suicide precautions should "describe signs, symptoms, and

[22]See American Psychiatric Association (2003), "Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors," *American Journal of Psychiatry*, (160) 11: 1-60 (Supplement).

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 do occur" (see NCCHC, 2018, page 40). National correctional standards, including those of the NCCHC, also require "procedures for periodic follow-up assessment after the individual's discharge from suicide precautions." (see NCCHC, 2018, page 40). Although national standards are generally vague regarding the follow-up schedule, in order to avoid unbridled clinical discretion and simplify quality assurance requirements, an agency's procedures for follow-up should not be vague, but provide a specific schedule requirement.

Although the CPS suicide prevention policy narrative requiring treatment plans for suicidal inmates "will address the environmental, historical, and psychological factors that contribute to it suicidal ideation. The plan should include: strategies and interventions to be followed by staff if suicidal ideation reoccurs, strategies for improved functioning, and regular follow-up appointments based on level of acuity," review of DAP progress notes indicated that such treatment planning was not being documented as required. For example, the following case exemplifies the lack of reasonable treatment planning (as well scheduled follow-up) for inmates with mental health watch. The inmate (Case No. 3) was placed on mental health watch on February 28, 2023 upon admission to the HOC because he had a positive Q-5 based upon a provocative statement he made regarding suicide. He was seen by mental health clinicians on a daily basis, consistently denied suicidal ideation and stated that his previous statement was made out of frustration. He also denied a prior history of suicidal behavior, mental illness, and psychiatric hospitalization. For reasons that were unclear, the inmate remained on a mental health watch for seven (7) days until March 6 when he was discharged from the watch. The "plan" contained within

the DAP-formatted progress note stated the following: "Consulted with MHD. Discontinue 15'MHW. Do not house alone recommendation forwarded to security. Access to MH services was reviewed and acknowledged. MH to follow up as clinically indicated/PRN." In this case, there was no treatment plan and follow-up was simply listed as when "clinically indicated" or needed.

Finally, it was very noteworthy, that CPS previously instituted a position entitled a "risk assessment specialist" or clinician with the specific purpose of providing follow-up assessment to inmates discharged from mental health watch up to one month in duration. Although this position has been vacant for several months, this writer was informed it will be filled again in April 2023. This is an excellent practice.

RECOMMENDATIONS: This writer would offer several recommendations to correct deficient policies and practices regarding the observation and management of inmates identified as suicidal within the Bristol County jail system. *First*, it is strongly recommended that both the BCSO and CPS suicide prevention policies be revised to delete reference for the option of observing two inmates on constant observation by one officer.

Second, in order to better ensure that observation of suicidal inmates occurs as required, it is strongly recommended that observation sheets for each inmate be kept on cell doors and not documented in the OMS at the officer's station.

Third, it is strongly recommended that reasonable efforts should be made, especially when considering the discharge of an inmate from mental health watch, to avoid a cell front encounters.

Rather, suicide risk assessments should take place in a private and confidential setting. Should an inmate refuse a private interview, the reason(s) for the refusal should be documented in the EHR-C. As noted above, there are currently a few options (i.e., strip cage room and program room) in both the ED and EA Units of the HOC to accommodate a reasonable private and confidential setting.

Fourth, consistent with the standard of care, all inmates initially placed on, as well as discharged from, mental health watch should be assessed by a clinician utilizing a comprehensive suicide risk assessment form. As such, it is strongly recommended that a Suicide Risk Assessment form be created and embedded within EHR-C that allows for sufficient description of the current behavior and justification for either, placement on, or discharge from, suicide precautions, as well as a brief mental status examination, listing of chronic and acute risk factors, listing of any protective factors, level of suicide risk (e.g., low, medium, or high), changes in behavior since the last assessment to warrant change in observation, and a treatment plan. Sample narrative for a comprehensive suicide risk assessment is attached in Appendix B for consideration. Daily assessment of inmates that continue to need mental health watch should be documented with the current DAP progress note.

Fifth, it is strongly recommended that, regardless of their length of stay on mental health watch, any arrestee placed on mental health watch in the Regional Lock-Up should be assessed by a clinician on a daily basis (including Sundays and holidays).[23]

---

[23]As noted previously in this report, a clinician is already available on Sundays and holidays to assess suicidal inmates on constant observation.

Sixth, it is strongly recommended that, consistent with national correctional standards, all inmates held on mental health watch for more than 24 hours[24] and then subsequently discharged from mental health watch should have a treatment plan developed describes 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 do occur.

Seventh, it is strongly recommended that, in order to safeguard the continuity of care for suicidal inmates, all inmates held on mental health watch for more than 24 hours[25] and then subsequently discharged from that watch should remain on the mental health caseload and receive regularly scheduled follow-up assessments by clinicians until their release from custody. As such, unless an inmate's individual circumstances direct otherwise (e.g., an inmate inappropriately placed on suicide precautions by non-mental health staff and released less than 24 hours later following an assessment), the follow-up schedule should be: within 24 hours, again within 72 hours, again within 1 week, and then periodically as determined by the inmate's status on the CPS caseload.

---

[24]There are times in which an inmate might have been inappropriately placed on mental health watch by nursing or custody staff based upon their intoxication and/or other non-suicidal behavior. If they are initially assessed by a clinician and not found appropriate for continued mental health watch, a safety plan and/or follow-up assessment might not be necessary. However, if the clinician continues the mental health watch beyond 24 hours, it would be reasonable to develop a safety plan and conduct follow-up assessments of the inmate.
[25]Ibid.

6) Intervention

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

Following a suicide attempt, the degree and promptness of intervention provided by staff often foretells whether the victim will survive. Although both ACA and NCCHC standards address the issue of intervention, neither are elaborative in offering specific protocols. For example, ACA Standard 4-ALDF-4D-08 requires that -- "Correctional and health care personnel are trained to respond to health-related situations within a four-minute response time. The training program...includes the following: recognition of signs and symptoms, and knowledge of action required in potential emergency situations; administration of basic first aid and certification in cardiopulmonary resuscitation (CPR)..." NCCHC Standard J-B-05 states -- "Intervention: There are procedures addressing how to handle a suicide attempt in progress, including appropriate first-aid measures."

FINDINGS: The Bristol County Sheriff's Office, Policy No. 12.13.00, "Inmate Suicide Prevention and Intervention," revised August 2019, provides an adequate description regarding the emergency medical response to a suicide attempt; whereas the Correctional Psychiatric

Services, Policy J-B-05/O-G-01, "Inmate Suicide Prevention and Intervention," revised March 2022, references its emergency responses policies. During the onsite assessment, emergency medical equipment, including a cut-down tool and first-aid kit, were located in the control areas of all housing units of the HOC that were inspected by this writer. At the Ash Street Jail, an officer station near 1-Alley contained a medical bag, automated external defibrillator (AED), and cut-down tool. In this writer's review of the BCSO Special Investigations Unit's reports that were available on inmate suicides between 2017 and January 2023, proper emergency responses were found in each case. Finally, according to available training data provided to this writer, 100 percent of medical staff and 89 percent of custody personnel were currently certified in first aid and CPR training.

RECOMMENDATIONS: None

7) **Reporting**

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

FINDINGS: As described in the next section, although not all investigative reports on the 10 inmates between 2017 and 2023 were not available for review, those reports that were available indicated that all reporting requirements appeared to have been appropriately followed.

RECOMMENDATIONS: None

8) Follow-up/Mortality-Morbidity Review

Every completed suicide, as well as serious suicide attempt (i.e., requiring medical treatment outside the facility), 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.

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.

FINDINGS: Neither the Bristol County Sheriff's Office, Policy No. 12.13.00, "Inmate Suicide Prevention and Intervention," revised August 2019, or the Correctional Psychiatric Services, Policy J-B-05/O-G-01, "Inmate Suicide Prevention and Intervention," revised March

2022, provides adequate descriptions regarding the morbidity and mortality review process following a serious suicide attempt or suicide. The CPS policy simply states that: "In the event of an inmate death by suicide the CPS Health Services Administrator shall be responsible for scheduling administrative and clinical mortality reviews within the required time frames in accordance with CPS Policy J-A-10 'Procedure in the Event of an Inmate Death'," whereas the BCSO policy simply states that: "The Director of Mental Health shall also complete a psychological autopsy report within 30 days of the inmate death. The report shall be filed with the Health Services Administrator and the Director of Mental Health."

Although the BCSO and CPS suicide prevention polices are in need of revision to adequately describe both the investigative and mortality review processes, as well as initiate a morbidity review process for serious suicide attempts, this writer found that there were various layers of review following an inmate suicide in the Bristol County jail system. First, all inmate deaths, including suicides, are required to be investigated by both the BCSO's Special Investigations Unit and the Massachusetts State Police (MSP) conduct separate investigations of all inmate deaths. These investigations are conducted independently of each other. In addition, a CPS mental health clinician conducts a "psychological reconstruction" of each inmate suicide through a medical chart review.

Of the 10 inmate suicides that occurred in the Bristol County jail system between 2017 through January 2023, this writer was provided 7 of 10 BCSO Special Investigations Unit reports, 6 of 10 Massachusetts State Police reports, and 8 of 10 psychological reconstruction reports. With one exception, the reason why some of these reports were unavailable was unclear. The exception

was that BCSO/CPS officials previously decided not to complete psychological reconstruction reports for any suicide occurring within the Regional Lock-Up. It would be this writer's opinion that the decision not to conduct such reviews was both ill-advised and problematic.[26] Overall, the available BCSO and MSP investigative reports were adequately written, and the psychological reconstruction summaries became more comprehensive in later years.

Following completion of the above described reports, a multidisciplinary mortality review committee, comprised of representatives of the BCSO and CPS, generally meet within 30 days of the inmate suicide to discuss each case. Of note, there are occasions in which the BCSO and MSP investigative reports are not available for review within 30 days. The committee is co-chaired by the health services administrator, mental health director, and BCSO assistant deputy superintendent of medical services. According to the BCSO and CPS officials, the reviews did not find any deficiencies and that all current policies and procedures were followed. In addition, with the exception of a mental health recommendation on 'do not house alone" (that was actually commenced in November 2016), revision in the EHR-C include a "detox alert box," and a more thorough review of the mental health case factors of inmates being considered for transfer to the Ash Street Jail, mortality reviews arising from the all of the inmate suicides between 2017 and January 2023 did not result in any other corrective actions. Based upon this writer's review of various investigative reports and psychological reconstruction reports, as well as findings from

[26]Given the fact that arrestees housed in the Regional Lock-Up of the Ash Street Jail are under the physical custody of the Bristol County Sheriff's Office, BCSO has promulgated a policy regarding housing these arrestees within a BCSO facility (Bristol County Sheriff's Office, Policy No. 25.01.00, "Bristol County Regional Lockup," revised February 2021), BCSO booking officers complete intake screening upon their entry into the facility, and the BCSO has designated cells for arrestees identified suicidal (but cleared by a local hospital and/or crisis center), it is very problematic that mortality reviews are not conducted and corrective actions taken when appropriate. Of note, 2 of the 10 suicides in the Bristol County jail system between 2017 through January 2023 occurred in the Regional Lock-Up.

this assessment, it was concerning that no deficiencies were identified by this review process, as well as additional corrective actions generated.

With that said, although BCSO/CPS officials cited only a few corrective actions arising out of the mortality review process, there have been other corrective actions recently taken to address the high number of inmate suicides within the Bristol County jail system, including, but not limited to:

- all housing units in the HOC now require rounds at 30-minute intervals (since July 2022);
- a risk assessment specialist from CPS has been assigned to provide follow-up assessments for inmates discharged from mental health watch for a period of 30 days (since 2020);
- installation of larger windows in cell doors within ED, EA, and HSA Units;
- better screening of inmates assigned to restrictive housing; and
- a suicide prevention poster, encouraging family members and friends of inmates to report concerns regarding an inmate's well-being, is scheduled to be displayed in all visiting areas.[27]

RECOMMENDATIONS: Several recommendations are offered to improve the morbidity and mortality review process within the Bristol County jail system. *First*, it is strongly recommended that the BCSO and CPS suicide prevention policies be revised to include a more thorough description of the process to include the following: "The mortality and/or morbidity review will be conducted within 30 days of the incident with the purpose of providing a critical inquiry of: 1) the circumstances surrounding the incident; 2) facility procedures relevant to the incident; 3) all relevant training received by involved staff; 4) pertinent medical and mental health

[27] While onsite, this writer also recommended that the BCSO website include similar contact information.

services/reports involving the victim; 5) possible precipitating factors leading to the suicide or serious suicide attempt; and 6) recommendations, if any, for corrective actions to change policy, training, physical plant, medical or mental health services, and operational procedures. Any corrective action plan (CAP) arising out of the review process should specifically identify the issue(s) that needs to be addressed, responsible party(s) to address the issue(s), and deadlines provided to complete the CAPs."

Second, it is strongly recommended that BCSO and CPS officials implement procedures to better ensure that each serious suicide attempt (i.e., an incident requiring outside medical treatment and/or hospitalization) results in a morbidity review.

Third, it is strongly recommended that the morbidity and mortality review process include any serious suicide attempt or suicide within the BCSO's Regional Lock-Up.

Fourth, it is strongly recommended that Sheriff Heroux appoint a committee, with membership similar to the current mortality review committee, to review the findings from this writer's assessment report, and implement all approved recommendations.

D. SUMMARY OF RECOMMENDATIONS

Staff Training

1) Although the standard of care in correctional facilities does not set a minimum requirement for the number of hours devoted to both pre-service and annual suicide prevention training, it is strongly recommended that the pre-service suicide prevention training requirement be expanded to include at least four (4) hours of instruction. Additional topics for inclusion into the curriculum should include: 1) guiding principles to suicide prevention, 2) avoiding negative attitudes to suicide prevention, 3) identifying suicidal inmates despite the denial of risk, 4) presentation of case studies, and 5) liability issues associated with inmate suicide. There are a number of resources available to supplement and revise such a training curriculum.

2) It is strongly recommended that the BCSO and CPS ensure that its correctional, medical, and mental health personnel regularly achieve at least 90 percent compliance with annual suicide prevention training.

Intake Screening/Assessment

3) It is strongly recommended that both the Correctional Psychiatric Services, Policy J-B-05/O-G-01, "Inmate Suicide Prevention and Intervention" and Bristol County Sheriff's Office, Policy No. 12.13.00, "Inmate Suicide Prevention and Intervention" provide a better description of intake screening requirements, particularly at the Ash Steet Jail and Regional Lock-Up.

4) It is strongly recommended that the following suicide risk questions be added to the "Medical History and Screening" form currently contained in the EHR-C and utilized at the HOC:

- Have you ever considered suicide?
- Have you recently experienced a significant loss (relationship, death of family member/close friend, job, etc.)?
- Has a family member/close friend ever attempted or committed suicide?
- Do you feel there is nothing to look forward to in the immediate future (inmate expressing helplessness and/or hopelessness)?

5) It is strongly recommended that intake nurses (including the nurse practitioner) be required to verify whether an in-coming detainee had previous been placed on mental health in the Bristol County jail system by accessing the Mental Health tab within the EHR-C.

6) It is strongly recommended that the "Mental Health Screening" form utilized for all inmates housed in the HOC for more than 14 days, as well as for initial mental health referrals, be revised to correct a defect by including the following suicide risk inquiry: "Do you have any current thoughts or plans to hurt yourself?"

7) It is strongly recommended that measures be taken to ensure better privacy and confidentiality during the intake screening process conducted by nursing staff at the HOC. As such, doors to the nurse's offices currently utilized for medical screening should be replaced with doors containing a glass enclosure to ensure full visibility into the room by custody staff in the corridor. During the intake screening process, the door to the offices should be closed with officers posted outside each office. Should nursing staff feel uncomfortable with the door closed, the detainee should be handcuffed.

8) It is strongly recommended that, if the Bristol County Sheriff's Office continues to utilize the Ash Street Jail for the housing of Regional Lock-Up arrestees, such utilization should include the basic provision of both medical and mental health services. At a minimum, nursing staff should review all intake screening forms that are completed by booking officers at the facility. A better practice would be that, because they are onsite at the facility 24 hours a day, nursing staff should complete the intake screening process. In addition, mental health clinicians should assess all Regional Lock-Up arrestees placed on mental health watch in the facility (and not exclusively rely on decisions from a local hospital or community crisis center that the individual is "cleared").

9) It is strongly recommended that, if booking officers at the Ash Street Jail continue to be exclusively responsible for the intake screening process, the defective weighted scale mechanism on the Receiving Screening Form be repaired immediately by the BCSO's IT department.

10) It is strongly recommended that, if booking officers at the Ash Street Jail continue to be exclusively responsible for the intake screening process, the original version of the Suicide Prevention Screening Guidelines form be utilized, including insertion of the critical question of – "Detainee is thinking about killing self," as well as all of the automatic referrals to a shift supervisor and placement on mental health watch until assessed by a mental health clinician.

Communication

None

Housing

11) It is strongly recommended that BCSO officials inspect any cell designated to house suicidal inmates in both the House of Corrections and Ash Street Jail to ensure that they are suicide-resistant, including, but not limited to, the replacement or retrofitting of metal bunk frames, replacement of ventilation grates on walls and ceilings and holes with grates that are no more than 3/16 inches in diameter, covering of cell and window bars with Lexan sheeting (similar to what currently exists in the HSU), and covering of exposed conduit piping. This writer's "Checklist for the 'Suicide-Resistant' Design of Correctional Facilities," included as Appendix A of this report, can be utilized as a guideline for such an inspection.

12) It is strongly recommended that, consistent with existing BCSO and CPS suicide prevention policies, safety smocks should not be utilized as a default, and decisions regarding issuance of clothing or safety smocks should be individualized and commensurate with the suicidal inmate's level of risk as determined by a mental health clinician following assessment. It is critically important for a clinician to realize that safety smocks are designed to have the limited purpose of thwarting suicide attempts by hanging and, as such, their use should be restricted for that purpose.

13) It is strongly recommended that that decisions regarding issuance of clothing, possessions, and privileges should be individualized and commensurate with the suicidal inmate's level of risk as determined by a mental health clinician following assessment. As such, current BCSO and CPS suicide prevention policies should be appropriately revised as follows:

- All decisions regarding the removal of an inmate's clothing, bedding, possessions (books, slippers/sandals, eyeglasses, tablet, etc.) and privileges shall be commensurate with the level of suicide risk as determined on a case-by-case basis by a clinician and documented in the EHR-C;

- If a clinician determines that an inmate's clothing needs to be removed for reasons of safety, the inmate shall always be issued a safety smock and safety blanket;

- A safety mattress shall be issued to all inmates on mental health watch unless the inmate utilizes the mattress in ways in which it was not intended (i.e., attempting to tamper with/destroy, utilize to obstruct visibility into the cell, etc.);

- All inmates on mental health watch shall be allowed all routine privileges (e.g., showers, family visits, telephone calls, etc.), unless the inmate has lost those privileges as a result of a disciplinary sanction, and

- All inmates on mental health watch shall not automatically be locked down. They should be allowed dayroom, yard, and/or out-of-cell access commensurate with their security level and clinical judgment of mental health clinicians

Levels of Supervision/Management

14) It is strongly recommended that both the BCSO and CPS suicide prevention policies be revised to delete reference for the option of observing two inmates on constant observation by one officer.

15) In order to better ensure that observation of suicidal inmates occurs as required, it is strongly recommended that observation sheets for each inmate be kept on cell doors and not documented in the OMS at the officer's station.

16) It is strongly recommended that reasonable efforts should be made, especially when considering the discharge of an inmate from mental health watch, to avoid a cell front encounters. Rather, suicide risk assessments should take place in a private and confidential setting. Should an inmate refuse a private interview, the reason(s) for the refusal should be documented in the EHR-C. As noted above, there are currently a few options (i.e., strip cage room and program room) in both the ED and EA Units of the HOC to accommodate a reasonable private and confidential setting.

17) Consistent with the standard of care, all inmates initially placed on, as well as discharged from, mental health watch should be assessed by a clinician utilizing a comprehensive suicide risk assessment form. As such, it is strongly recommended that a Suicide Risk Assessment form be created and embedded within EHR-C that allows for sufficient description of the current behavior and justification for either, placement on, or discharge from, suicide precautions, as well as a brief mental status examination, listing of chronic and acute risk factors, listing of any protective factors, level of suicide risk (e.g., low, medium, or high), changes in behavior since the last assessment to warrant change in observation, and a treatment plan. Sample narrative for a comprehensive suicide risk assessment is attached in Appendix B for consideration. Daily assessment of inmates that continue to need mental health watch should be documented with the current DAP progress note.

18) It is strongly recommended that, regardless of their length of stay on mental health watch, any arrestee placed on mental health watch in the Regional Lock-Up should be assessed by a clinician on a daily basis (including Sundays and holidays).

19) It is strongly recommended that, consistent with national correctional standards, all inmates held on mental health watch for more than 24 hours and then subsequently discharged from mental health watch should have a treatment plan developed describes 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 do occur.

20) It is strongly recommended that, in order to safeguard the continuity of care for suicidal inmates, all inmates held on mental health watch for more than 24 hours and then subsequently discharged from that watch should remain on the mental health caseload and receive regularly scheduled follow-up assessments by clinicians until their release from custody. As such, unless an inmate's individual circumstances direct otherwise (e.g., an inmate inappropriately placed on suicide precautions by non-mental health staff and released less than 24 hours later following an assessment), the follow-up schedule should be: within 24 hours, again within 72 hours, again within 1 week, and then periodically as determined by the inmate's status on the CPS caseload.

Intervention

None

Reporting

None

Follow-Up/Mortality-Morbidity Review

21) It is strongly recommended that the BCSO and CPS suicide prevention policies be revised to include a more thorough description of the process to include the following: "The mortality and/or morbidity review will be conducted within 30 days of the incident with the purpose of providing a critical inquiry of: 1) the circumstances surrounding the incident; 2) facility procedures relevant to the incident; 3) all relevant training received by involved staff; 4) pertinent medical and mental health services/reports involving the victim; 5) possible precipitating factors leading to the suicide or serious suicide attempt; and 6) recommendations, if any, for corrective actions to change policy, training, physical plant, medical or mental health services, and operational procedures. Any corrective action plan (CAP) arising out of the review process should specifically identify the issue(s) that needs to be addressed, responsible party(s) to address the issue(s), and deadlines provided to complete the CAPs."

22) It is strongly recommended that BCSO and CPS officials implement procedures to better ensure that each serious suicide attempt (i.e., an incident requiring outside medical treatment and/or hospitalization) results in a morbidity review.

23) It is strongly recommended that the morbidity and mortality review process include any serious suicide attempt or suicide within the BCSO's Regional Lock-Up.

24) It is strongly recommended that Sheriff Heroux appoint a committee, with membership similar to the current mortality review committee, to review the findings from this writer's assessment report, and implement all approved recommendations.

E. CONCLUSION

It is hoped that the suicide prevention assessment provided by this writer, as well as the recommendations contained within this report, will be of assistance to the Bristol County Sheriff's Office and Correctional Psychiatric Services. It was noteworthy that this writer met numerous agency officials and supervisors, as well as officers, nurses, and mental health clinicians, who appeared genuinely concerned about inmate suicide and committed to taking whatever actions necessary to reduce the opportunity for such tragedy in the future.

Although there are numerous recommendations contained within this report, as well as the need to revise both the BCSO and CPS suicide prevention policies to incorporate such recommendations, this writer found that the Bristol County jail system had the foundation of a good suicide prevention program. As such, with full implementation of the 24 recommendations contained within this report, this writer is confident that collaborative efforts of the BCSO and CPS will result in successful efforts to reduce inmate suicides.

In conclusion, this writer would be remiss by not extending sincere appreciation to not only Sheriff Paul Heroux, but to Judy Borges, Assistant Deputy Superintendent of Medical Services for the BCSO, Alda Teixeira, Director of Mental Health, and Monica Southwick, Assistant Director of Mental Health, both from CPS. Without the total candor, cooperation and assistance from these individuals, as well as from all other personnel who were interviewed, this writer would not have been able to complete this assignment.

Respectfully Submitted By:

/s/ Lindsay M. Hayes
Lindsay M. Hayes

April 4, 2023

APPENDIX A

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

Lindsay M. Hayes

The safe housing of suicidal individuals 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 jail suicides occur by hanging, it is certainly reasonable to ensure that all cells utilized to house potentially suicidal individuals 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 individuals 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 (individuals 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) ADA-compliant grab bars that are located around the sink and/or toilet areas should be designed with a closed bottom (i.e., no open space) that prevents attachment of a ligature.

8) 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. All possible anchoring points, including 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 ligatures. Lying flat on the floor, the individual attaches the noose from above, runs it under their neck, turns over on their stomach and asphyxiates themselves within minutes). Ideally, metal bunks should simply be replaced;

9) Electricity should be turned off from wall outlets;

10) 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 individuals 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;

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

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

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

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

12) 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 individual 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;

13) Cells should have an audio monitoring intercom for listening to calls of distress (*only* as a supplement to physical observation by staff). While the individual 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.);

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

15) 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;

16) Some individuals 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;

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

18) 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;

19) 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;

20) 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;

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

22) 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

23) 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 Lindsay M. Hayes in January 2022.

APPENDIX B

SUICIDE RISK ASSESSMENTS

The standard of care requires that documentation of a comprehensive assessment of suicide risk include sufficient description of the current behavior and justification for either placement on, or discharge from, suicide precautions. For example, the assessment should include a brief mental status examination (MSE), listing of chronic and acute risk factors (including prior history of suicidal behavior), listing of any protective factors, level of suicide risk (e.g., low, medium, or high), and a treatment plan.[28]

Specifically, the clinician's thought process and documentation should include the following:[29]

- History of suicidal intent or suicide attempts:
  - Is there a history of admitted suicidal intent or suicide attempt?
  - Severity of ideation or attempt?
  - Most recent?
- Degree of current suicidal ideation:
  - Has the person thought about how he or she might end his or her life?
  - Did or does the person have a plan?
  - Does the person have the means to carry out the plan?
  - Was or is the plan reasonable?
  - Does the person express feelings of peace/resolution?
  - Is the person attending to personal effects?
  - Did the person write good-bye letters?
- Systematic inquiry into:
  - Current mood
  - Known risk factors—individual and group
  - Known protective factors
  - Stated intentions about suicide
- What has changed since attempt and/or last assessment?
  - Evidence or absence of futuristic thinking
  - Evidence of connectedness
  - Effect of suicide precautions on denial of suicidal ideation: Is the person's current denial of suicidal ideation being influenced by the restrictive nature of the suicide precautions (e.g., restrictive clothing, shower, food, possessions, out-of-cell time)?
- Treatment plan: If the inmate is removed from suicide precautions, what is the treatment plan (i.e., a specific strategy that describes signs, symptoms, and the circumstances in which the risk for suicide is likely to recur, how recurrence of suicidal thoughts can be avoided, and specific actions the patient or staff can take if suicidal thoughts do occur)?

---

[28]See American Psychiatric Association (2003), "Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors," *American Journal of Psychiatry*, (160) 11: 1-60 (Supplement).
[29]Metzner, J.M. and Hayes, L.M., "Jails and Prisons," in L. Gold and R. Frierson (Eds.), *Textbook of Suicide Risk Assessment and Management*, 3rd Edition, Washington, DC: American Psychiatric Publishing, Inc., 2020.

Reassessment

Following the initial assessment, if the clinician subsequently determines that downgrading or discontinuing suicide precautions is justified, a reassessment should occur and include the following lines of inquiry:

- What are your current feelings and thoughts? (Look for feelings of depression, i.e., decrease in energy or appetite, increase in helplessness, hopelessness, or sadness.)
- Do you have any thoughts or feelings about hurting yourself or anyone else?
- How have your feelings and thoughts been over the last 24 hours? (Look for changes in thoughts process or patterns of thinking.)
- Do you feel that things are going to get better or does it seem they will stay the same or get worse? (This will tell us whether the youth has hope or is helpless, and the seriousness of their thinking.)
- How would you harm/kill yourself or how would you harm/kill others? (This will tell us if they have a plan, which is more serious.)
- What are some of the things you have done to deal with these thoughts and feelings? (This will tell us their coping ability at this time.)
- What has worked in the past to help you cope when these feelings have come up? (This will hopefully help them to draw from what they already know and may help give them ideas of what they can do now.)
- Do you think you are capable of coming to staff if your thoughts increase or if you feel less in control? (This should not be interpreted as "contracting for safety.")

Lindsay M. Hayes
Last revised, January 2020