



# Program Statement

OPI: CPD/PSB  
NUMBER: P5324.08  
DATE: 4/5/2007  
SUBJECT: Suicide Prevention  
Program

RULES EFFECTIVE: 3/15/2007

1. **PURPOSE AND SCOPE.** The Bureau of Prisons (Bureau) operates a suicide prevention program to assist staff in identifying and managing potentially suicidal inmates. Each Warden will ensure that a suicide prevention program is implemented consistent with this policy. In addition, Wardens will facilitate a discussion regarding the issue of suicide at department head meetings, staff recalls, lieutenants' meetings, etc., to heighten staff awareness about the need to detect and report any changes in inmate behavior that might suggest suicidal intent.

2. **SUMMARY OF CHANGES.** This re-issuance adds the following new procedures for preventing inmate suicides:

a. Suicide prevention training will include three mock suicide emergencies per year, one on each shift. One of these exercises must be conducted in the Special Housing Unit (SHU) during the morning or evening watch.

b. Specific minimum criteria that must be included in a Suicide Risk Assessment and a Post-Watch Report are delineated.

c. Designation of a room for suicide watch outside of the Health Services area requires written approval of the Regional Director.

d. Specific criteria that exclude an inmate from consideration for an inmate companion position are delineated.

e. Correctional Services will notify Psychology Services when an inmate requests protective custody (PC). Psychology Services will no longer be required to monitor SENTRY for entry of a PC code.

3. **PROGRAM OBJECTIVES.** The expected results of this program are:

a. All institution staff will be trained to recognize signs and information that may indicate a potential suicide.

b. Staff will act to prevent suicides with appropriate sensitivity, supervision, and referrals.

c. Any inmate clinically found to be suicidal will receive appropriate preventive supervision, counseling, and other treatment.

**4. DIRECTIVES AFFECTED**

**a. Directive Rescinded**

P5324.05 Suicide Prevention Program (3/1/04)

**b. Directives Referenced**

P5270.07 Inmate Discipline and Special Housing Units  
(12/29/87)

P5290.14 Admission and Orientation Program (4/3/03)

P5310.12 Psychology Services Manual (8/13/93)

P5566.06 Use of Force and Application of Restraints  
(11/30/05)

P6031.01 Patient Care (1/15/05)

P6340.04 Psychiatric Services (1/15/05)

c. Rules cited in this Program Statement are contained in 28 CFR 552.40 through 552.41.

**5. STANDARDS REFERENCED**

a. American Correctional Association Standards for Adult Correctional Institutions, 4th Edition: 4-4084, 4-4084-1, 4-4370M, 4-4371M, and 4-4373M.

b. American Correctional Association Performance Based Standards for Adult Local Detention Facilities, 4th Edition: 4-ALDF-7B-08, 4-ALDF-7B-10, 4-ALDF-7B-10-1, 4-ALDF-4C-29M, 4-ALDF-4C-30M, and 4-ALDF-4C-32M.

**6. INSTITUTION SUPPLEMENT.** See Section 7a.

**7. POLICY.** Each Bureau institution, other than Medical Referral Centers (MRCs), will implement a suicide prevention program that conforms to the procedures outlined in this policy. Each Bureau medical center is to develop specific written procedures consistent with the specialized nature of the institution and the intent of this policy.

a. **Medical Referral Centers.** MRCs serve a unique evaluation/treatment function addressing the needs of a wide range of inmates, while meeting community standards of care. Psychology Services is responsible for developing an Institution Supplement that describes local procedures for managing the

Suicide Prevention Program's components.

MRC psychologists are to document significant treatment information in the Psychological Data System (PDS) so that the information is readily available for post-discharge treatment.

b. **Residential Reentry Center Contract Facilities.** When contracts for outside facilities (including Residential Reentry Centers (RRCs)) are used, the Statement of Work will include a suicide prevention plan or program that meets accepted Bureau standards.

Community Corrections Managers (CCMs) will monitor contract facilities regularly to determine their capability to manage at-risk populations effectively. The CCM will consult the Regional Psychology Services Administrator if questions arise about the adequacy of a contract facility's Suicide Prevention Program or about the need to transfer a suicidal inmate to a different facility. The CCM will contact Central Office Psychology Services when there is system-wide or interagency issues.

In the event of a suicide, all possible evidence and documentation will be preserved to provide data and support for subsequent investigators doing a psychological reconstruction. Ordinarily, the Regional Director will authorize an after-action review of a suicide at a RRC, to be conducted by the Regional Psychology Administrator. The findings will be documented as a Psychological Reconstruction Report as outlined in Attachment A.

c. **Privately-Managed Contract Prisons.** Private security contract facilities maintain a suicide prevention and intervention program in compliance with American Correctional Association (ACA) standards. Ordinarily, the Assistant Director, Correctional Programs Division, will authorize an after-action review of a suicide at a contract private prison, to be conducted under the direction of the Central Office Psychology Services Administrator. The findings will be documented as a Psychological Reconstruction Report as outlined in Attachment A.

## 8. **PROGRAM ADMINISTRATION.**

a. **Program Coordinator.** Each institution must have a Program Coordinator for the institution's suicide prevention program. The Program Coordinator shall be responsible for managing the treatment of suicidal inmates and for ensuring that the institution's suicide prevention program conforms to the guidelines for training, identification, referral, assessment, and intervention outlined in this policy.

Ordinarily, the Chief Psychologist will be the Program Coordinator. The Program Coordinator's responsibilities will not be delegated to staff other than a doctoral-level psychologist.

The Program Coordinator, in conjunction with institution executive staff, must ensure that adequate coverage is available when he or she is absent from the institution for training, annual leave, etc.

b. **Training.** While the initial period of incarceration is often a critical time for detecting potential suicides, serious suicidal crises may arise at any time. Line staff are often the first to identify signs of potential suicidal behavior based on their frequent interactions with inmates.

The Program Coordinator is responsible for ensuring that appropriate training is available to staff. The Program Coordinator will ensure that all staff will be trained (ordinarily by psychology services personnel) to recognize signs indicative of a potential suicide, the appropriate referral process, and suicide prevention techniques.

Wardens will include discussions of suicide prevention at department head meetings, staff recalls, etc., to remind staff of the need to observe inmates constantly for signs of suicidal behavior.

1) **Training for All Staff.** Suicide prevention training will be included in the Introduction to Correctional Techniques curriculum. Training in local suicide prevention procedures will be provided during Institution Familiarization Training and Annual Training (AT) at all institutions.

Training for staff will focus on:

- ◆ identifying suicide risk factors;
- ◆ typical inmate profiles of completed suicides;
- ◆ recognition of potentially suicidal behavior;
- ◆ appropriate information associated with identifying and referring suicidal inmates;
- ◆ responding to a suicide emergency (e.g., a suicide in progress), including location and proper use of suicide cut-down tool; and
- ◆ name of Program Coordinator, location of suicide watch room, etc.

2) **Supplemental Speciality Training.** The Program Coordinator will offer supplemental training to staff having frequent inmate contacts. Ordinarily, supplemental specialty training for health services staff (i.e., Physician's Assistants, Nurse Practitioners, Emergency Medical Technicians, Registered

Nurses), lieutenants, and correctional counselors is offered approximately six months after the conclusion of institution AT. It is encouraged that this training be provided during regularly scheduled meetings when possible.

3) **Supplemental Training for Special Housing Unit (SHU) Staff.** Information about recognizing potentially suicidal inmates and procedures to follow will be included in the SHU post orders. Attachment B is an example of post orders for suicide prevention in a SHU.

4) **Emergency Response Training.** At a minimum, the Captain and Chief Psychologist will jointly conduct three mock suicide emergencies yearly, one on each shift, approximately four months apart. Complexes will complete the exercises separately at each institution within the complex.

- ◆ Within the calendar year, at least one of these exercises will be conducted in the SHU during the evening or morning watch. (Institutions that do not have a SHU [e.g., Camps] are exempted from this requirement, but are still required to conduct three mock suicide emergencies yearly).
- ◆ Confirmation of mock suicide emergency training will occur in writing to the Associate Warden over Psychology Services with a copy to the Suicide Prevention Program Coordinator for placement in a training documentation file. See sample memorandum format in Attachment C.
- ◆ This training is in addition to the supplemental speciality training for lieutenants, health services staff, and correctional counselors.

#### 9. IDENTIFICATION OF AT-RISK INMATES.

a. **Medical Staff Screening.** Medical staff are to screen a newly admitted inmate for signs that the inmate is at risk for suicide. Ordinarily, this screening is to take place within twenty-four hours of the inmate's admission to the institution.

- ◆ The Physician's Assistant/Nurse Practitioner (PA/NP) will refer suicidal or emotionally disturbed inmates on an emergency basis to the Program Coordinator or designee.

#### b. Psychological Intake.

1) **Pre-Trial Detainees, Pre-Sentence Detainees, and Holdovers in MCCs, MDCs, FDCs, FTCs, or Jails.** Because of the high rate of admissions and short length of stay in MCCs, MDCs,

FDCs, FTCs and Detention units, the comprehensive psychological intake conducted by Psychology Services ordinarily will be performed only on inmates who are suspected of being suicidal or appear psychologically unstable (e.g., mental illness or significant substance abuse withdrawal), or who request services via the Psychology Services Inmate Questionnaire.

2) **Newly Assigned or Writ-Return Inmates.** For newly assigned designated inmates or writ-return inmates, a psychologist will conduct a comprehensive psychological intake within 14 days of the inmate's admission to the institution.

3) **Transferred Inmates.** For transferred inmates, a psychologist will conduct a comprehensive psychological intake within 30 days of the inmate's admission to the institution if the psychologist determines it is clinically warranted based upon the PSIQ and other available inmate records.

c. **Inmates in SHUs.** Inmates in Administrative Detention or Disciplinary Segregation status often may be at higher risk for suicidal behavior. Inmates being transferred into the SHU will be monitored for signs of potential suicide risk (e.g., crying, emotionally distraught, threats of self-harm, or engaging in misconduct to purposefully effect removal from the general population). Inmates exhibiting such behavior will be referred to the Shift Lieutenant.

1) **Protective Custody (PC) Inmates.** Inmates requesting protective custody or demanding to be housed alone may actually be contemplating suicide. When an inmate requests protective custody or demands to be celled alone, Correctional Services staff will immediately:

- ◆ notify the Program Coordinator or designee in Psychology Services during normal business hours, or
- ◆ during non-routine working hours notify the on-call psychologist.

The PC inmate should be screened for suicidal ideation **within 72 hours** of being placed into SHU. When clinically indicated by this screening, a formal Suicide Risk Assessment will be conducted.

The Program Coordinator will work closely with custody staff to monitor each PC inmate's mental status for behavior (e.g., hopelessness, anxiety, increasing agitation, depression, psychoses) that suggests a need for an increased level of services.

2) **Inmates Requiring Special Precautions.** The Program Coordinator will provide SHU staff with a list ("hot list") of

inmates with mental health conditions who may become dangerous, self-destructive, or suicidal when placed into the SHU.

- ◆ This list will be updated as needed and distributed to Correctional Services, Health Services, and Unit Team staff. This list will be made available to all staff.
- ◆ When an inmate on this "hot list" is placed into the SHU, a Correctional Services Supervisor will notify Psychology Services immediately.

### 3) **SHU Custodial Issues.**

A) **Program Coordinator Involvement.** At a minimum, the Program Coordinator or designee will make weekly rounds of SHUs and consult with staff in those areas concerning any inmates needing special attention.

B) **Review of Lieutenant's Log.** The Program Coordinator will review the Lieutenant's log each working day to determine if an inmate with mental health problems has been placed in the SHU. A psychologist will see the inmate as soon as possible to assess the inmate's mental status and alert SHU staff.

C) **Health Services.** Health Services policy contains procedures to ensure inmates placed in SHU continue to receive needed medications.

- ◆ Psychology Services will be notified whenever an inmate refuses or misses his/her medication. If the inmate has the potential to become violent, self-destructive, or suicidal without the medication, psychologists will notify SHU staff of this.

D) **Suicide Rescue Tool.** Every SHU will be equipped with a suicide rescue tool(s) that is sharp, stored in a secure location, and readily available. All SHU staff will be trained to use the tool and in the procedures for responding to a suicide emergency.

E) **Inmate Removal from the SHU.** The Program Coordinator will arrange to have an inmate exhibiting significant potential for suicide removed from the SHU and placed on suicide watch. Ordinarily, once the crisis is over, the inmate will be returned to the SHU to satisfy any sanction that was imposed.

d. **Staff Referral.** Any staff may identify an inmate as potentially suicidal at any time based upon the inmate's observed behavior.





**STAFF MUST NEVER TAKE LIGHTLY ANY INMATE SUICIDE THREATS OR ATTEMPTS OR ANY INFORMATION OR HINTS FROM OTHER INMATES ABOUT AN INMATE BEING POTENTIALLY SUICIDAL.**

Any staff member who has reason to believe an inmate may be suicidal should:

- ♦ ordinarily maintain the inmate under direct, continuous observation,
- ♦ contact the Shift Lieutenant for assistance, and
- ♦ during regular working hours, contact the Program Coordinator or designee (i.e., any other available psychologist).
- ♦ During non-routine working hours, the Shift Lieutenant will contact the on-call psychologist and continue direct, continuous observation, or immediately place the inmate on suicide watch.

In emergency situations, the Shift Lieutenant will immediately place the inmate on suicide watch. It should be noted that in emergency situations **any staff** member may place an inmate on suicide watch. Special procedures may apply to MRCs where the initiation of suicide watch may be limited to specific clinical staff.

e. **Inmate Referral.** In addition to staff, inmates can play a vital role in helping to prevent inmate suicides. To facilitate this process each institution will encourage inmate referrals by:

- ♦ including a statement in the institution inmate handbook/orientation materials encouraging inmates to notify staff of any behavior or situation that may suggest an inmate is upset and potentially suicidal,
- ♦ incorporating the topic of inmate referrals into the Admissions and Orientation lesson plan for Psychology Services,
- ♦ placing posters in each housing unit addressing the topic, and
- ♦ ensuring that the information is made available to inmates in multiple languages as appropriate, particularly Spanish.

10. **SUICIDE RISK ASSESSMENT OF IDENTIFIED INMATES.** During regular working hours inmates referred for assessment of suicide potential will be seen on a priority basis. During non-regular hours, the Program Coordinator or designee should consult with institution staff and may choose to see the inmate immediately or have the inmate placed on suicide watch. In either case, the inmate will receive an individual assessment within 24 hours of referral.

A Suicide Risk Assessment will be completed when:

- ◆ staff refer an inmate to Psychology Services because the inmate may be at risk for suicide (e.g., the inmate refuses his or her property, talks about ending his or her life),
- ◆ an inmate's written or verbal behavior is suggestive of suicide,
- ◆ an inmate exhibits behavior suggestive of self-harm, or
- ◆ any other condition is present that would lead the clinician to believe an assessment is warranted.

Ordinarily, the Suicide Risk Assessment will be completed in PDS within 24 hours of the incidents outlined above. At a minimum, the Suicide Risk Assessment will include:

- ◆ reason for / source of referral,
- ◆ risk factors assessed,
- ◆ risk assessment findings,
- ◆ diagnosis, and
- ◆ follow-up recommendations.

When a staff member has made a referral based on observed behavior, the psychologist who interviews the inmate will also make every effort to interview the staff member who observed the behavior. The staff member's comments will be included in the report/clinical notes.

11. **INTERVENTION.** Upon completion of the suicide risk assessment, the Program Coordinator or designee will determine the appropriate intervention that best meets the needs of the inmate. Because deliberate self-injurious behavior does not necessarily reflect suicidal intent, a variety of interventions other than placing an inmate on suicide watch may be deemed appropriate by the Program Coordinator, such as heightened staff or inmate interaction, a room/cell change, greater observation,

placement in restraints, or referral for psychotropic medication. In any case, the Program Coordinator or designee will assume responsibility for the recommended intervention and clearly document the rationale.

a. **Non-suicidal Inmates.** If the Program Coordinator determines that the inmate does not appear imminently suicidal, he/she shall document in writing the basis for this conclusion and any treatment recommendations made. This documentation will be placed in the inmate's medical, psychology, and central file.

b. **Suicidal Inmates.** If the Program Coordinator determines the individual to have an imminent potential for suicide, the inmate will be placed on suicide watch in the institution's designated suicide prevention room. The actions and findings of the Program Coordinator will be documented, with copies going to the central file, medical record, psychology file, and the Warden.

## **12. SUICIDE WATCH.**

a. **Housing.** Each institution must have one or more rooms designated specifically for housing an inmate on suicide watch. The designated room must allow staff to maintain adequate control of the inmate without compromising the ability to observe and protect the inmate.

- ◆ The primary concern in designating a room for suicide watch must be the ability to observe, protect, and maintain adequate control of the inmate.
- ◆ The room must permit easy access, privacy, and unobstructed vision of the inmate at all times.
- ◆ The suicide prevention room may not have fixtures or architectural features that would easily allow self-injury.

Inmates on watch will be placed in the institution's designated suicide prevention room, a non-administrative detention/segregation cell ordinarily located in the health services area. Despite the cell's location, the inmate will not be admitted as an in-patient unless there are medical indications that would necessitate immediate hospitalization.

Placement of a suicide watch room in a different area may be warranted given the unique features of some institutions.

- ◆ However, designating a room for suicide watch outside of the Health Services area requires written approval of the Regional Director. Such rooms must meet all of the requirements identified above.

- ◆ Administrative detention and disciplinary segregation cells will not be designated or approved as suicide watch cells.
- ◆ Under emergency conditions a suicidal inmate may be placed temporarily on suicide watch in a cell other than the institution's designated watch room. The inmate must be moved to a designated suicide watch room as soon as one becomes available.

b. **Conditions of Confinement.** While on suicide watch, the inmate's conditions of confinement will be the least restrictive available to ensure control and safety. The inmate on watch will ordinarily be seen by the Program Coordinator on at least a daily basis. Unit staff will have frequent contact with the inmate while he/she is on watch. Ordinarily, the Program Coordinator or designee will interview or monitor each inmate on suicide watch at least daily and record clinical notes following each visit.

The Program Coordinator or designee will specify the type of personal property, bedding, clothing, magazines, that may be allowed.

- ◆ If approved by the Warden, restraints may be applied if necessary to obtain greater control, but their use must be clearly documented and supported.
- ◆ Any deviations from prescribed suicide watch conditions may be made only with the Program Coordinator's concurrence.
- ◆ The Program Coordinator will develop local procedures to ensure timely notification to the inmate's Unit Manager when a suicide watch is initiated and terminated. Correctional Services staff, in consultation with the Program Coordinator or designee, will be responsible for the inmate's daily custodial care, cell, and routine activities.
- ◆ Unit Management staff in consultation with the Program Coordinator will continue to be responsive to routine needs while the inmate is on suicide watch.

c. **Observation.** For **all** suicide watches:

- ◆ Any visual observation techniques used to monitor the suicide companion program will focus on the inmate companion and/or the inmate on suicide watch only.
- ◆ The observer and the suicidal inmate will not be in the same room/cell and will have a locked door between them.
- ◆ The person performing the suicide watch must have a means to summon help immediately (e.g., phone, radio)

if the inmate displays any suicidal or unusual behavior.

- ◆ The Program Coordinator will establish procedures for documenting observations of the inmate's behavior in a Suicide Watch log book, which will be maintained as a secure document. Staff and inmate observers will document in separate log books. Post Orders will provide direction to staff on requirements for documentation.

1) **Staff Observers.** The suicide watch may be conducted using staff observers. Staff assigned to a suicide watch must have received training (Introduction to Correctional Techniques or in AT) and must review and sign the Post Orders before starting the watch. The Program Coordinator will review the Post Orders annually to ensure their accuracy.

2) **Inmate Observers.** Only the Warden may authorize the use of inmate observers (inmate companion program). The authorization for the use of inmate companions is to be made by the Warden on a case-by-case basis. If the Warden authorizes a companion program, the Program Coordinator will be responsible for the selection, training, assignment, and removal of individual companions. Inmates selected as companions are considered to be on an institution work assignment when they are on their scheduled shift and shall receive performance pay for time spent monitoring a potentially suicidal inmate.

d. **Watch Termination and Post-Watch Report.** Based upon clinical findings, the Program Coordinator or designee will:

1) Remove the inmate from suicide watch when the inmate is no longer at imminent risk for suicide, or

2) Arrange for the inmate's transfer to a medical referral center or contract health care facility.

Once an inmate has been placed on watch, the watch may not be terminated, **under any circumstance**, without the Program Coordinator or designee performing a face-to-face evaluation. Only the Program Coordinator will have the authority to remove an inmate from suicide watch. Generally, the post-watch report should be completed in PDS prior to terminating the watch, or as soon as possible following watch termination, to ensure appropriate continuity of care. Copies of the report will be forwarded to the central file, medical record, psychology file, and the Warden. There should be a clear description of the resolution of the crisis and guidelines for follow-up care.

At a minimum, the post-watch report will include:

- ◆ risk factors assessed,
- ◆ changes in risk factors since the onset of watch,
- ◆ reasons for removal from watch, and
- ◆ follow-up recommendations.

**13. INMATE OBSERVERS - INMATE COMPANION PROGRAM.**

a. **Selection of Inmate Observers.** Because of the very sensitive nature of such assignments, the selection of inmate observers requires considerable care. To provide round-the-clock observation of potentially suicidal inmates, a sufficient number of observers should be trained, and alternate candidates should be available.

Observers will be selected based upon their ability to perform the specific task but also for their reputation within the institution. In the Program Coordinator's judgement, they must be mature, reliable individuals who have credibility with both staff and inmates. They must be able, in the Program Coordinator's judgement, to protect the suicidal inmate's privacy from other inmates, while being accepted in the role by staff. Finally, in the Program Coordinator's judgement, they must be able to perform their duties with minimal need for direct supervision.

In addition, any inmate who is selected as a companion **must not**:

- ◆ Be in pre-trial status or a contractual boarder;
- ◆ Have been found to have committed a 100-level prohibited act within the last three years; or
- ◆ Be in FRP, GED, or Drug Ed Refuse status.

b. **Inmate Observer Shifts.** Observers ordinarily will work a four-hour shift. Except under unusual circumstances, observers will not work longer than one five-hour shift in any 24-hour period. Inmate observers will receive performance pay for time on watch.

c. **Training Inmate Observers.** Each observer will receive at least four hours of initial training before being assigned to a suicide watch observer shift. Each observer will also receive at least four hours of training semiannually. Each training session will review policy requirements and instruct the inmates on their duties and responsibilities during a suicide watch, including:

- ◆ the location of suicide watch areas;
- ◆ summoning staff during all shifts;

- ◆ recognizing behavioral signs of stress or agitation;  
and
- ◆ recording observations in the suicide watch log.

d. **Meetings with Program Coordinator.** Observers will meet at least quarterly with the Program Coordinator or designee to review procedures, discuss issues, and supplement training. After inmates have served as observers, the Program Coordinator or designee will debrief them, individually or in groups, to discuss their experiences and make program changes, if necessary.

e. **Records.** The Program Coordinator will maintain a file containing:

- ◆ An agreement of understanding and expectations signed by each inmate observer;
- ◆ Documentation of attendance and topics discussed at training meetings;
- ◆ Lists of inmates available to serve as observers, which will be available to Correctional Services personnel during non-regular working hours; and
- ◆ Verification of pay for those who have performed watches.

f. **Supervision of Inmate Observer During a Suicide Watch.** Although observers will be selected on the basis of their emotional stability, maturity, and responsibility, they still require some level of staff supervision while performing a suicide watch.

- ◆ This supervision will be provided by staff who are in the immediate area of the suicide watch room or who have continuous video observation of the inmate observer.
- ◆ In all cases, when an inmate observer alerts staff to an emergency situation, staff must immediately respond to the suicide watch room and take necessary action to prevent the inmate on watch from incurring debilitating injury or death. In no case will an inmate observer be assigned to a watch without adequate provisions for staff supervision or without the ability to obtain immediate staff assistance.

**THE DECISION TO USE INMATE OBSERVERS MUST BE PREDICATED ON THE FACT THAT IT TAKES ONLY THREE TO FOUR MINUTES FOR MANY SUICIDE DEATHS TO OCCUR.**

- ◆ Supervision must consist of at least 60-minute checks conducted in-person. Staff will initial the chronological log upon conducting checks.

g. **Removal.** The Program Coordinator or designee may remove any observer from the program at his/her discretion. Removal of an inmate observer should be documented in the records kept by the Program Coordinator.

14. **TRANSFER OF INMATES TO OTHER INSTITUTIONS.** The Program Coordinator will be responsible for making emergency referrals of suicidal inmates to the appropriate medical center. No inmate who is determined to be imminently suicidal will be transferred to another institution, except to a medical center on an emergency basis.

a. **Medical Center Referral.** Inmates who do not respond to treatment interventions and remain imminently suicidal require emergency hospitalization. Although a psychiatric referral may be indicated at any time, ordinarily the inmate shall be referred to a MRC after he or she has been on continuous watch for 72 hours. If the watch exceeds 72 continuous hours, the Program Coordinator must:

- ◆ Contact the Regional Psychology Administrator to discuss the case and determine if an emergency transfer is appropriate.
- ◆ If the decision is not to transfer the inmate to a MRC, the rationale for **not** initiating a request for emergency transfer must be documented in the PDS.

b. **Psychology Services at MRCs.** Psychology Services at each MRC will provide an appropriate intervention program for inmates who have been admitted for suicidal behavior. The program will include:

- ◆ assessment,
- ◆ therapeutic interventions, and
- ◆ discharge planning.

The discharge planning may include a request to designate an institution for the inmate that can provide the custody and level of psychological service needed to prevent re-hospitalization.

c. **Consultations.** As part of the referral consideration process, it may be beneficial to consult with other mental health resources, MRC staff, or the Regional Psychology Services Administrator.

- ◆ To ensure maximum communication and tracking of suicidal inmates, the Program Coordinator will notify



his or her Regional Psychology Administrator when a suicide watch is begun or terminated and when a suicide watch exceeds 72 hours.

- ◆ The Program Coordinator or designee will document the referral considerations and all actions taken in the inmate's PDS record.

d. **SENTRY "Psych Alert" Assignments.** It is critically important that other institutions are notified when they are to receive inmates with recent suicidal indications and are at risk for self-harm.

- ◆ The Program Coordinator must ensure that a suicidal inmate being transferred to a MRC is given the SENTRY "Psych Alert" assignment to signal all staff that serious psychological management problems and "continuity of care" issues are present.

15. **ANALYSIS OF SUICIDES.** If an inmate suicide does occur, the Program Coordinator will immediately notify the Regional Administrator, Psychology Services.

The suicide scene will be treated in a manner consistent with an inmate death investigation. All measures necessary to preserve and document the evidence needed to support subsequent investigations will be maintained or otherwise recorded adequately.

- ◆ In the event of a suicide, institution staff, particularly Correctional Services staff, and other law enforcement personnel, will handle the site with the same level of protection as any crime scene in which a death has occurred.
- ◆ All possible evidence and documentation will be preserved to provide data and support for subsequent investigators doing a psychological reconstruction.

Ordinarily, the Regional Director will authorize an after-action review of the suicide to be completed by a psychologist from another institution or administrative office. Psychologists who have previously been involved in treatment of the inmate or in peer consultation in the case shall not participate in the suicide reconstruction. The report will address all the areas listed in the "Guide for the Psychological Reconstruction of an Inmate Suicide" (Attachment A).

The Regional Psychology Administrator will also review the Mortality Review Report prepared by Health Services for additional information and to explain any discrepancies with the Psychological Reconstruction Report.

a. **Central Office Review.** The Regional Director will forward copies of the Psychological Reconstruction Report to:

- ◆ the Assistant Director, Correctional Programs Division;
- ◆ the Assistant Director, Health Services Division; and
- ◆ the Senior Deputy Assistant Director, Program Review Division.

b. **Special Review Committee.** The PRD Senior Deputy Assistant Director will submit the report to the Special Review Committee. The Special Review Committee will review the report and assess whether recommendations for corrective action will be addressed at the national or local institution level.

- ◆ The PRD Senior Deputy Assistant Director will be responsible for tracking corrective actions and verifying the corrective action is accomplished.

16. **CODE OF FEDERAL REGULATIONS.** Federal Regulations appear in bracketed bold text, as reproduced from volume 28 of the Code of Federal Regulations, Chapter 5. The federal regulations that bind Bureau staff to specific program practices are primarily intended to describe Bureau programs and inmate rights, privileges, or responsibilities to inmates and members of the public.

**[§ 552.40 Purpose and scope.**

The Bureau of Prisons (Bureau) operates a suicide prevention program to assist staff in identifying and managing potentially suicidal inmates. When staff identify an inmate as being at risk for suicide, staff will place the inmate on suicide watch. Based upon clinical findings, staff will either terminate the suicide watch when the inmate is no longer at imminent risk for suicide or arrange for the inmate's transfer to a medical referral center or contract health care facility.

**§ 552.41 Program procedures.**

(a) **Program Coordinator.** Each institution must have a Program Coordinator for the institution's suicide prevention program.

(b) **Training.** The Program Coordinator is responsible for ensuring that appropriate training is available to staff and to inmates selected as inmate observers.

(c) **Identification of at risk inmates.**

(1) Medical staff are to screen a newly admitted inmate for signs that the inmate is at risk for suicide. Ordinarily, this screening is to take place within twenty-four hours of the inmate's admission to the institution.

(2) Staff (whether medical or non-medical) may make an identification at any time based upon the inmate's observed behavior.

(d) Referral. Staff who identify an inmate to be at risk for suicide will have the inmate placed on suicide watch.

(e) Assessment. A psychologist will clinically assess each inmate placed on suicide watch.

(f) Intervention. Upon completion of the clinical assessment, the Program Coordinator or designee will determine the appropriate intervention that best meets the needs of the inmate.

§ 552.42 Suicide watch conditions.

(a) Housing. Each institution must have one or more rooms designated specifically for housing an inmate on suicide watch. The designated room must allow staff to maintain adequate control of the inmate without compromising the ability to observe and protect the inmate.

(b) Observation.

(1) Staff or trained inmate observers operating in scheduled shifts are responsible for keeping the inmate under constant observation.

(2) Only the Warden may authorize the use of inmate observers.

(3) Inmate observers are considered to be on an institution work assignment when they are on their scheduled shift.

(c) Suicide watch log. Observers are to document significant observed behavior in a log book.

(d) Termination. Based upon clinical findings, the Program Coordinator or designee will:

(1) Remove the inmate from suicide watch when the inmate is no longer at imminent risk for suicide, or

(2) Arrange for the inmate's transfer to a medical referral center or contract health care facility.]

/s/  
Harley G. Lappin  
Director

**GUIDE FOR THE PSYCHOLOGICAL  
RECONSTRUCTION OF AN INMATE SUICIDE**

Name: \_\_\_\_\_ Prepared by: \_\_\_\_\_

Reg. No: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Date of Death: \_\_\_\_\_

**I. Background Information**

Education  
Marital/Family Status  
Religious Preference/Involvement  
Race/Ethnic Background  
Offense  
Sentence/Time Served  
Occupational/Military History  
Release Plans

**II. Health Care and Personality Description**

Physical Status-Functioning  
    Previous/Current  
Social Status-Functioning  
    Previous/Current  
Psychological Status-Functioning  
    Previous/Current  
Suicidal History  
Medication History  
Mental Health History  
    Diagnosis/Treatment  
Abuse History  
    Drug/Alcohol  
Assaultive History  
Institutional Infractions

**III. Antecedent Circumstances**

Identifiable Stressors  
Staff Opinions  
Inmate Opinions  
Last Person to Have Contact  
Last Staff Contact

**IV. Full Description of Suicide Act and Scene (to include diagrams were appropriate)**

Date/Time of incident  
Location  
Method  
Predictors of Suicidal Actions  
Suicide Note  
Other Relevant Information

**V. Conclusions/Recommendations**

**VI. List of Documents Examined**

**VII. List of Staff and Inmates Interviewed**

**"SAMPLE"**  
**SUICIDE PREVENTION INFORMATION**  
**SPECIAL HOUSING UNIT ADDENDUM TO POST ORDERS**

**BOP HIGH RISK GROUPS**

- ◆ **New Inmates** - The first few hours and days after admission can be critical. Newly incarcerated inmates may experience feelings such as shame, guilt, fear, sadness, anger, agitation, depression, relationship problems, legal concerns, hopelessness, and helplessness, which can contribute to increased suicide risk.
- ◆ **Protective Custody** - Inmates who volunteer to enter protective custody are at high risk for suicide, especially during the first 72 hours in SHU. These inmates should be referred to psychology services immediately.
- ◆ **Long-term Protective Custody Inmates** - These inmates are particularly vulnerable to depression that can lead to a suicide attempt, and should be monitored closely while they are in SHU.
- ◆ **Inmates Taking Medication for Mental Health Reasons** - These inmates are vulnerable to developing suicidal thoughts and attempting suicide by overdosing on their medication. Inmates on medication should be monitored to make sure they are not hoarding medication. Any signs of distress, deterioration in hygiene, or sudden changes in behavior should be reported to psychology.

**FACTORS THAT CAN INCREASE THE PROBABILITY THAT AN INMATE MAY BECOME SUICIDAL:**

- ◆ **Mental Health Factors**
  - History of mental illness
  - 1. Is the inmate depressed, actively psychotic?
  - 2. Has the inmate been compliant with psychotropic medication?
  - 3. Have there been changes in eating, sleeping, hygiene, weight, recreation, activity level?
- Prior suicide attempt
  - 1. How lethal was the attempt?
  - 2. How many attempts have been made?

Inmate's current mood, affect, and behavior

1. Is the inmate emotionally upset, angry, easily agitated?
2. Are the inmate's thoughts clear and goal directed (vs. delusional or psychotic in nature)?
3. Is the inmate depressed, has there been a recent loss?
4. Has hopelessness persisted even after the depression has lifted?
5. Has the inmate given away property, revised a will, requested a phone call to say his goodbyes?

◆ **Medical Condition(s)/Chronic Pain**

1. Does the inmate have a chronic life threatening medical illness?
2. Has the inmate's overall health diminished recently?
3. Is the inmate experiencing pain or other negative symptoms?

◆ **Relationship Difficulties**

1. Has the inmate received a Dear John letter?
2. Have communications and or visits decreased?
3. Has there been a change in the relationship?

◆ **Situational Factors**

1. Legal issues - pending indictment; loss of appeal to reduce sentence.
2. Difficulties with staff or other inmates.
3. Gambling debts, drugs.
4. Ending of a close relationship with another inmate.
5. Possible victim of a sexual assault.

**REPORTING AND DOCUMENTING INMATE BEHAVIOR**

- ◆ **Report Your Concerns** - Any inmate behavior(s) that is questionable and may reflect a change in mental health status should be reported to the Shift Lieutenant immediately.
- ◆ **During non-working hours** - Inform the Shift Lieutenant of any questionable inmate behavior. He/she will determine if the on-call psychologist needs to be contacted.
- ◆ **Segregation Log Book** - Any changes in inmate behaviors should be noted in the log book. A detailed note regarding the observed behavior is advisable. Documenting in the log book serves two purposes. First, the entry serves as a means of communication for other staff members. Second, it provides an accurate account of activity during your shift. Documentation should be neat, legible, and professional.

**RESPONDING TO A SUICIDE EMERGENCY**

- ◆ A Segregation Officer observing an inmate in the act of committing suicide, causing other self-injurious behavior, or who appears to have committed suicide will call for back-up before entering the cell. The officer will notify the Control Center and the Lieutenant's Office by radio of the situation and request immediate back-up. BACK-UP MUST BE PRESENT IN ORDER TO ENTER A CELL.
- ◆ The "cut-down" tool is located in the storage closet on a shadow board. It is the #1 officer's responsibility to locate this item at the start of the shift. This tool is only authorized to be used in emergency situations. Miscellaneous use of this tool is not permitted and will result in dulling the blade of the tool.
- ◆ In the event an inmate commits suicide, the scene of the suicide will be treated in a manner consistent with the investigation of an inmate death. All measures necessary to preserve and document the evidence needed to support subsequent investigations will be maintained or otherwise adequately recorded.



**"SAMPLE"**

**MEMORANDUM DOCUMENTING MOCK SUICIDE EMERGENCY TRAINING**

**DATE:** 4/5/2007  
**TO:** Name, Associate Warden  
**FROM:** Name, Operations Lieutenant  
**Subject:** Mock Suicide Emergency Training

This memorandum documents a mock suicide emergency training exercise. This training exercise occurred in the Special Housing Unit on Morning Watch on today's date at 5:30 a.m.

Staff present were:

- Name, Psychologist
- Name, Operations Lieutenant
- Name, Correctional Officer
- Name, Correctional Officer
- Name, Correctional Officer

The mock suicide emergency involved a hanging in a SHU cell. Staff responded quickly in notifying the Operations Lieutenant and Control. The Cut Down tool, AED, appropriate keys to allow access to the cell, and sufficient staff to open the cell door were assembled quickly (within XX minutes).

Staff discussed the exercise and response for training purposes.

**(IN CASES WHERE RECOMMENDATIONS ARE MADE, TEXT CAN BE ADDED TO DESCRIBE THE RECOMMENDATION AND CORRECTIVE ACTION TAKEN, e.g.)**

Staff suggested the key to the security cage housing the Cut Down tool be placed on the Operations Lieutenant's and Compound Officer's key rings. A security work order has been initiated to do this.

cc: Psychology Services, Suicide Prevention Training File