

REPORT TO THE LEGISLATURE
Public Act 59 of 2013
Section 305
Prisoner Suicide Report

This report provides information as requested in Section 305 of PA 59 of 2013 regarding prisoners who committed suicide during the previous calendar year (January 1- December 31, 2013). In order to protect confidentiality the data is being provided in summary narrative by section, rather than in table format specific to each prisoner. All unique identifiers have been removed.

(a) The prisoners' age, offense, sentence and admission date for twelve (12) suicides occurring in 2013:

- Age - Prisoners' ages were 42 years, 62 years, 30 years, 62 years, 27 years, 55 years, 40 years, 75 years, 35 years, 32 years, 42 years and 57 years.
- Offense –
 - Home Invasion 1st degree, Carrying Concealed Weapon, Assault with a Dangerous Weapon, Felony Firearm (concurrent)
 - Retail Fraud 1st degree, Habitual Offender (4th)
 - Assault with Intent to Murder
 - Homicide-Attempted Murder
 - Assault with Intent to do Great Bodily Harm less than Murder, Assault on Employee, Assault-Resisting Arrest
 - Prisoner in Possession of a Weapon, Murder 2nd degree, Carrying a Concealed Weapon
 - Assault with Intent to do Great Bodily Harm
 - Arson of a Dwelling
 - Bank Robbery, Attempted False Report or Threat of Terrorism
 - Unarmed Robbery 2nd offense, Possession of Drug Paraphernalia
 - Murder 3rd degree, Habitual offender
 - Possession of Controlled Substance
- Sentence –1 yr. 6 mos to 20 yrs, 2 yrs. to 20 yrs, 10 yrs. 6 mos. to 17 yrs., 15 yrs. to 60 yrs., 1 yr. 10 mos. to 10 yrs., 4 yrs. 6 mos. to 90 yrs., 1 yr. to 15 yrs., 2 yrs., to 20 yrs., 2 yrs. 6 mos. to 20 yrs., 3 yrs. 11 mos. to 21 yrs. 10 mos., 56 yrs. to 85 yrs., 1 yr. 6 mos. to 4 yrs.
- Admission Dates – 12/12/13, 12/21/09, 7/22/10, 4/3/13, 7/26/07, 5/18/89, 8/1/11, 3/18/13, 10/22/12, 7/13/05, 3/28/13, 4/23/13.

(b) Each prisoner's facility and unit:

- Reception and Guidance Center, 2-2-1
- Detroit Reentry Center, 7C-30L (In custody as a parole violator)

- Marquette Branch Prison, segregation EB-13
- Reception and Guidance Center, 1-03-037
- Macomb Correctional Facility, 7-106-B
- Carson City Correctional Facility, segregation 2-4-II
- Gus Harrison Correctional Facility, 4-123-B
- Reception and Guidance Center, 02-02-004
- Lakeland Correctional Facility, F-02,153
- Michigan Reformatory, segregation 1-2-64
- Michigan Reformatory, J-3-95
- Clare County Jail (out of MDOC custody on Writ of Habeas Corpus)

(c) Circumstances: nine (9) deaths were a result of hanging and three (3) deaths were a result of jumping from the gallery.

(d) The dates of the suicides:

- The deaths occurred one (1) in January 2013, three (3) in April 2013, one (1) in May 2013, one (1) in July 2013, one (1) in August, two (2) in September 2013 and three (3) December 2013.

(e) Whether the suicide occurred in a housing unit, a segregation unit, a mental health unit, or elsewhere on the grounds of the facility:

- Six (6) deaths occurred in general housing units, three (3) deaths occurred in segregation, two (2) deaths occurred in mental health RTP units and one (1) occurred in an outside county jail.

(f) Whether the prisoner had been denied parole and the date of any denial:

- One (1) prisoner was in custody as a parole violator and as such this factor does not apply. Of the remaining 11 individuals, seven (7) had not yet been interviewed by the parole board, one (1) was interviewed by the parole board 2 months prior to his death and given a continuance, one (1) prisoner was interviewed by the parole board 10 months prior to his death and given a continuance, one (1) prisoner was reviewed by the parole board approximately 4 months prior to his death and designated a D47 parole. He was referred for special needs re-entry services. One (1) prisoner was last seen by the parole board in November 2004 with an additional 65 years to serve on his minimum sentence.

(g) Whether the prisoner had received a mental health evaluation or assessment:

- Two (2) prisoners, who died during brief stays at Reception and Guidance Center, received the required mental health suicide risk screening in a timely fashion. The scores of the screening did not indicate elevated suicide risk or need for urgent mental health appraisal or assessment. One (1) prisoner, who died in a county jail after transfer there on court writ, received the required mental health and suicide risk screening and appraisal in a timely fashion. The results did not indicate elevated suicide risk or need for mental

health services and he was not followed by MHS during his prison stay. Two (2) prisoners were evaluated within 2-4 days of the suicide event resulting in no recommended mental health treatment. One (1) was evaluated 2 days prior to his death and prisoner was placed on a MH management plan by a QMHP with an intermediate suicide risk. He was placed on first floor restriction. One (1) prisoner was evaluated 2 months prior to event, assessed as low risk for suicide and recommended for possible placement in ASRP. Two (2) prisoners were evaluated within 4-5 months of the suicide and were assessed as low risk. Both if these prisoners were actively receiving treatment in the RTP level of care. One (1) prisoner was most recently assessed as low risk for suicide approximately 1 month prior to the event. One (1) prisoner was assessed 2 months prior to his death as a low risk for suicide and was referred to CSI. One (1) prisoner was assessed 4 months prior to the suicide event and denied suicidal thoughts or intent at that time; he was referred to OPT.

(h) Details on the department's responses to each suicide, including immediate on-site responses and subsequent internal investigations:

- In eleven (11) cases emergency medical response was immediately initiated by custody staff upon discovery of prisoner and recognition of a suicide attempt. Health care staff at each facility were immediately notified and in each case responded to the emergency. Per protocol, local emergency medical services were also contacted and responded to the facility. In one case, the prisoner was not in the custody of MDOC and detailed critical incident information is not available. However, this prisoner was transported to a local hospital where he subsequently expired 3 days after the suicide attempt. Of the remaining cases, 9 prisoners were pronounced dead at the facility, 2 were pronounced dead at the hospital and eleven (11) cases were transported off the facility to hospitals.
- All cases were the subject of critical incident reports and reviews at the local level and Central Office CFA administrative level. Each case underwent mortality review at the Regional Health Care level and the Statewide Mortality Review committee.

(i) A description of any monitoring and psychiatric interventions that had been undertaken prior to the prisoner's suicide, including any changes in placement or mental health care:

- Of the twelve (12) cases seven (7) cases were on a mental health program caseload. Four (4) of these prisoners were receiving psychotropic medications under the care of a psychiatrist or psychiatric nurse practitioner and therapy from a QMHP, one (1) was receiving counseling from a QMHP and two cases had received mental health evaluations and were being admitted to the Counseling Services Interventions case load at the time of their deaths in the Reception and Guidance Center.

(j) Whether the prisoner had previously attempted suicide:

- One (1) prisoner had a prior suicide attempt in 2012, one (1) prisoner had 5 prior serious suicide attempts with the most recent occurring in 2007 and one (1) prisoner had a self-reported, unsubstantiated recent prior attempt.

