

REPORT TO THE LEGISLATURE
Public Act 200 of 2012
Section 305
Prisoner Suicide Report

This report provides information as requested in Section 305 of PA 200 of 2012 regarding prisoners who committed suicide during the previous calendar year (January 1- December 31, 2012). 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 seven suicides occurring in 2012:

- Age - Prisoners' ages were 44 years, 44 years, 53 years, 23 years, 24 years, 43 years and 53 years.
- Offense – Armed Robbery 2nd degree, Assault with intent to commit Armed Robbery 2nd degree and Possession of a firearm and Felony Firearm, 3 counts of Robbery and Possession of Controlled Substance, Assault with intent to commit sexual assault 2 counts, Home invasion 2nd degree, Murder 1st degree and Murder 1st degree.
- Sentence – 7-20 years, 6 years 9 months- 20 years, 4 years 6 months -15 years, 2 years 10 months to 10 years, 1 year 6 months - 15 years, Life and Life.
- Admission Dates - August 25, 2003, March 5, 2005, March 23, 1992, January 31, 2008, February 22, 2011, October 29, 1990 and August 9, 2011.

(b) Each prisoner's facility and unit:

- Marquette Branch Prison, Q-3
- Macomb Correctional Facility, 7-60T
- Reception and Guidance Center, 1-B-54
- Reception and Guidance Center. 2-3-25
- Women's Huron Valley Correctional Facility, 2-C-102
- Chippewa Correctional Facility, Neebish Unit
- Michigan Reformatory, 1-2-69

(c) Circumstances:

- One (1) death was determined to be by overdose and six (6) deaths were a result of hanging

(d) The dates of the suicides:

- The deaths occurred in March 2012, April 2012, three (3) in May 2012, September 2012 and December 2012.

(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, one (1) death occurred in mental health RTP unit.

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

- Of the seven individuals, one (1) was recently interviewed by the parole board and given a 10 month continuance, one (1) was interviewed by the parole board 5 days prior to his death and given a continuance, one (1) prisoner was given a positive parole action and four (4) prisoners were not scheduled to see the parole board in the near future.

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

- One (1) prisoner was evaluated within one month of his death, assessed as a low risk for suicide but was admitted to the mental health Out-patient level of care, one (1) prisoner was evaluated 24 hours prior to his death and was assessed as low risk for suicide and was currently enrolled in mental health services at the RTP level of care, two (2) prisoners were evaluated within 5 weeks of their deaths and assessed as low risk for suicide and were not receiving active mental health treatment, one (1) prisoner was evaluated at the time of his arrival to the facility and he was determined not to require treatment at that time. He did not have an evaluation after the initial assessment. One (1) prisoner was evaluated 8 days prior to his death, assessed as being low risk for suicide but was admitted to the Counseling Services and Intervention program. One (1) prisoner was assessed four months prior to his death, was assessed as a low suicide risk and was admitted to the Counseling Services and Intervention program.

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

- In all seven (7) 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. Five (5) of the prisoners were pronounced dead at the facility, two (2) prisoners were pronounced dead at the hospital and all seven (7) 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 seven (7) cases, two (2) cases were on a mental health program caseload. Both of these prisoners were receiving psychotropic medications and therapy.

(j) Whether the prisoner had previously attempted suicide:

- Five (5) of the prisoners had no documented history of suicide attempt in the past. One (1) prisoner had at least 2 prior suicide attempts via hanging while incarcerated, the most recent in May of 2010. One (1) prisoner had 2 prior suicide attempts while in the community by attempted shooting with the most recent attempt occurring 10 years ago.