

# Critical Incident Case Summaries

The OIG's Critical Incident case summaries are a description of the California Department of Corrections and Rehabilitation's (department) critical incident cases the OIG monitored and closed.

Filtered Cases: 1

## Incident Date

November 23, 2019

## Incident Type

Inmate Suicide

## Indicator Ratings\*

Indicators 1-3



Poor

\*Ratings subject to change

## OIG Incident Number

19-0031831-CI

## Incident Summary

On November 23, 2019, an officer found an incarcerated person hanging from a noose in cell. The officer removed the noose and performed life-saving measures with a nurse, who also administered two doses of an opiate antidote. The officer and nurse transported the incarcerated person to the triage and treatment area, where another nurse administered a third dose of an opiate antidote. A second officer, two additional nurses, and a paramedic continued life-saving measures and administered three doses of epinephrine until a physician pronounced the incarcerated person dead.

## Disposition

The department's Death Review Committee determined the cause of death was asphyxiation, the manner of death was suicide, and the death was unexpected. The department's Suicide Case Review Committee identified that mental health clinicians did not evaluate acute suicide risk factors, made errors in documenting clinical contacts, and failed to place the incarcerated person on suicide watch or in a mental health crisis bed after his mother's death. Therefore, the hiring authority conducted an audit of the clinicians' treatment and provided training to address the deficiencies.

## Incident Rating

Overall, the department handled the critical incident poorly because, based on the department's Suicide Case Review Committee, mental health clinicians failed to evaluate acute suicidal risk factors, made errors in documenting clinical contacts, and failed to place the incarcerated person on suicide watch or in a mental health crisis bed after his mother's death.

Indicator 1: Did the department's actions prior to the critical incident sufficiently comply with policies, procedures, and best practices?

Before the critical incident, the department performed poorly because, based on the department's Suicide Case Review Committee, mental health clinicians failed to evaluate acute suicidal risk factors, made errors in documenting clinical contacts, and failed to place the incarcerated person on suicide watch or in a mental health crisis bed after his mother's death.

Indicator 2: Did the department's actions during the critical incident sufficiently comply with policies, procedures, and best practices?

During the critical incident, the department performed in a *satisfactory* manner.

Indicator 3: Did the department's actions after the critical incident sufficiently comply with policies, procedures, and best practices?

After the critical incident, the department performed in a *satisfactory* manner.