This report provides information as requested in Section 305 of PA 188 of 2010 regarding prisoners who committed suicide during the previous calendar year (January 1 - December 31 2010). In order to protect confidentiality the data is being provided in summary by section, rather than in table format specific to each prisoner.

(a) The prisoner’s age, offense, sentence, and admission date for nine suicides occurring in 2010:

- Age - Prisoners’ ages were 40 yrs., 34 yrs., 20 yrs., 70 yrs., 57 yrs., 27 yrs., 29 yrs., 25 yrs. and 34 yrs.
- Offense- Armed Robbery (3); Murder 2nd Degree (4); CSC 2nd degree; Home Invasion.
- Sentences 3 to 20 yrs., 5 to 15 yrs., 12 to 20 yrs., 2 to 15 yrs., 6 to 20 yrs., 32 to 50 yrs., 25 to 50 yrs., 18 to 30 yrs. and 30-50 yrs.

(b) Each prisoner’s facility and unit:

- Macomb Correctional Facility 3-082-T
- Parnall Correctional Facility 050-2-09
- Women’s Huron Valley 1C-310
- Women’s Huron Valley 2-B-302U
- Women’s Huron Valley 4-C-105U
- Gus Harrison Correctional Facility 1-118-B
- Charles Egeler Reception and Guidance 10B-023
- Oaks Correctional Facility 3-137-L
- Woodland Correctional Center P10-7

(c) Circumstances:

- 6 deaths resulted from hanging, 1 jumping from a gallery, 1 from cutting and 1 from placing a plastic bag over the head

(d) The dates of the suicide:

- The deaths occurred in; February, March, May, July, September, September, October, October and December.

(e) Whether the suicide occurred in a housing unit, a segregation unit, a mental health unit, or elsewhere on the grounds of the facility:
• 6 suicides occurred in general housing units, 2 occurred in segregation units and 1 occurred in psychiatric inpatient

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

• 1 prisoner was denied parole 3 months prior to suicide. The other 8 were not eligible for parole consideration.

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

• 7 of the nine individuals who committed suicide received a mental health evaluation or assessment 2 months or less prior to their death.

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

• In all nine cases emergency medical response was immediately initiated by custody staff upon discovery of prisoner and recognition of the suicide attempt. Facility health care were immediately notified, and in all cases responded to the emergency. In each case, local emergency medical services were also contacted and responded to the facility. In three cases, prisoners were pronounced dead at the site. In six cases, prisoners were transported to hospitals.
• All nine 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 level.

(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 nine cases, three were on the Corrections Mental Health Programs caseloads and one was in acute care. All four received psychotropic medication.

(j) Whether the prisoner had previously attempted suicide:

• Three of the prisoners had no history of suicide attempts. Six had histories of prior attempts within two years or less of their deaths.