EVALUATION OF CALENDAR YEAR 2025 DEATHS BY SUICIDE WITHIN THE MASSACHUSETTS DEPARTMENT OF CORRECTION

January 30, 2026

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I. INTRODUCTION AND SCOPE OF REVIEW

On November 14, 2025, I was engaged by the Massachusetts Department of Correction (MADOC) to review incidents of deaths by suicide of individuals incarcerated within the MADOC during calendar year 2025. I was asked to assess the totality of events, examine any common themes in these incidents, and ensure policy and practice were addressing the needs of the MADOC population. Additionally, I was asked to offer any additions or recommendations for changes to training for mental health professionals and correctional professionals based on my review.

II. SOURCES OF INFORMATION

Below is the list of the documents and information I reviewed to support my statements in this report.

A. Individual records and reports of the six individuals who died by suicide in calendar year 2025 including:

- Information documented in the electronic healthcare record in the year prior to the death by suicide.
- Confidential Administrative Summary of the death by suicide
- Incident Reports related to the death by suicide.
- Performance Improvement Mortality Review recommendations following each death by suicide.

- Behavior Assessment Unit (BAU) appraisals documented in the Inmate Management System (IMS) by the Interdisciplinary Appraisal Team (IAT), as applicable.

- Spectrum Health Systems substance use treatment records for the year prior to death, as applicable.

B. MADOC policies:

- 103 DOC 650, *Mental Health Services*, dated 10/25/2025

- 103 DOC 622, *Death Procedures*, dated 1/9/2026

- 103 DOC 562, *Code 99 Emergency Procedure Guidelines*, dated 7/22/2025

- 103 DOC 427, *Behavior Assessment Units*, dated 12/16/2025

C. Interview with Kayoon Addison, LMHC, Director of Behavioral Health – Health Services Division (MADOC) and Jessica Roy, LICSW, Program Mental Health Director (VitalCore)

D. Unsolicited correspondence from four individuals incarcerated at MCI-Norfolk (received through the U.S. Postal Service)

III. FINDINGS AND RECOMMENDATIONS

A. Common Findings among the Deaths

There were several commonalities noted among the incidents of death by suicide in 2025. Many of these commonalities are not unique to MADOC, but are factors noted in deaths by suicide in correctional settings across the United States. These include:

- *Common Factor Among Deaths by Suicide of Incarcerated Individuals in the U.S.:* Suicidal acts occur during overnight hours.
    - *Finding in MADOC in 2025*: All but one of the deaths occurred during the early morning hours between midnight and 7:15am.
- *Common Factor Among Deaths by Suicide of Incarcerated Individuals in the U.S.:* Risk of suicide increases among individuals who are housed alone.
    - *Finding in MADOC in 2025*: All of the individuals who died by suicide in were housed without a cellmate.
- *Common Factor Among Deaths by Suicide of Incarcerated Individuals in the U.S.:* Incarcerated individuals who die by suicide most often do so by hanging.
    - *Finding in MADOC in 2025*: Five of the six individuals who died by suicide did so by hanging.
- *Common Factor Among Deaths by Suicide of Incarcerated Individuals in the U.S.:* Individuals who commit violent crimes are more likely to die by suicide than those who engage in non-violent crimes.
    - *Finding in MADOC in 2025*: All individuals who died by suicide were incarcerated for violent crimes.
- *Common Factor Among Deaths by Suicide of Incarcerated Individuals in the U.S.:* Individuals with long sentences are at higher risk for dying by suicide.

- *Finding in MADOC in 2025*: Five of the individuals had sentences exceeding 25 years, with four being sentenced to life in prison.

- *Common Factor Among Deaths by Suicide of Incarcerated Individuals in the U.S.:* Receiving a recent disciplinary report increases risk for dying by suicide.
    - *Finding in MADOC in 2025*: Four individuals who died by suicide received disciplinary reports within the previous three weeks.

- *Common Factor Among Deaths by Suicide of Incarcerated Individuals in the U.S.:* Substance use history and active substance use increase risk for suicide.
    - *Finding in MADOC in 2025*: All individuals who died by suicide had histories of substance use.

- *Common Factor Among Deaths by Suicide of Incarcerated Individuals in the U.S.:* The majority of individuals who die by suicide have contact with a health care professional during the month prior to their deaths.
    - *Finding in MADOC in 2025*: Four of the six individuals who died by suicide were seen for a crisis contact (either medical or mental health) in the 16 days prior to death.
    - *Finding in MADOC in 2025*: Four of the individuals were on the mental health caseload and were seen within the previous 17 days by a mental health professional.

- *Common Factor Among Deaths by Suicide of Incarcerated Individuals in the U.S.:* Recent or pending transfer increases the risk for death by suicide.
    - *Finding in MADOC in 2025*: Four individuals who died by suicide had recently experienced a housing transfer and/or were expecting to be transferred in the near future.

- *Common Factor Among Deaths by Suicide of Incarcerated Individuals in the U.S.:* Prior suicide attempts increase the risk for death by suicide.
    - *Finding in MADOC in 2025*: Four of the individuals who died by suicide reported previous suicide attempts.

The majority of the common factors listed above are considered static risk factors, meaning that once they are present, they cannot be absent (e.g., history of previous suicide attempts, history of substance use). On the other hand, a few of the listed common factors warrant some attention. Specifically, the issue of recent disciplinary reports, recent substance use, recent/pending transfer, and recent/current placement in the BAU (and thus a single cell) deserve discussion, especially considering that for a number of individuals who died by suicide, these factors were concurrent. When these factors are present for an individual, increased attention to suicide risk and active engagement in safety planning are warranted. Both custody and health care staff should remain vigilant to signs of risk for individuals who experience these risk factors, especially simultaneously. Additionally, active substance use, especially among those in treatment for substance use, requires increased collaboration among health care, mental health, and substance use treatment staff. This collaboration should assist the individual in identifying what factors are contributing to the substance use, including both internal and external factors, and treatment should target those factors to decrease their impact on the individual and support behaviors and coping skills other than substance use. Substance use also impacts clarity of thinking and decision making. For individuals who are actively intoxicated, judgment is impaired. Two of the individuals who died by suicide in 2025 were found to be intoxicated, received disciplinary reports, and were transferred to the isolated setting of the BAU. Another two individuals reported daily drug use prior to placement in the BAU.

In addition to these factors often seen in carceral deaths by suicide, there were three additional commonalities among those individuals who died by suicide in MADOC in 2025.

- *Finding in MADOC in 2025*: Five of the six individuals who died by suicide had history of placement in BAU with three of the individuals being held in BAU at time of death and one individual being transferred out of the BAU to general population the day prior to death.

- *Finding in MADOC in 2025*: Four individuals were intoxicated or reported daily drug use prior to transfer to the BAU.

- *Finding in MADOC in 2025*: For three of the individuals who died by suicide, their last contact with a mental health professional was an initial BAU assessment.

These MADOC-specific commonalities warranted further review into the processes and procedures associated with BAU placement as well as the locations of BAUs. In the BAUs where the deaths by suicide occurred (i.e., Souza & Norfolk), both were previously restrictive housing units. BAU transfers are emergent and prompted by "unacceptable risk to the safety, security, and orderly operations of the correctional institution, have a possible personal safety need that need to be investigated, or who pose a threat to others, and require separation from the general population."[1] These criteria, and the resulting housing placement, are akin to the processes historically used when placing individuals in restrictive housing and could be experienced by individuals as isolating and restricting having a similar impact as restrictive housing. Further, individuals are "cleared" prior to placement in the BAU, are housed alone, are seen during routine healthcare rounds, and experience committee decisions regarding their ongoing placement in the BAU, all of which are akin to restrictive housing procedures. The significance of these similarities is that while MADOC has specifically defined the BAUs as "a housing unit that is not Restrictive Housing"[2] the experience for individuals transferring into the BAU may be the same as being placed in restrictive housing thus resulting in increased risk for suicide that if often seen in these settings.

Recommendation: Consideration should be given, ideally with input from the incarcerated population, about changes which can be made to the BAU transfer process to ensure that the experience is not similar to restrictive housing resulting in risks associated with placement in restrictive housing. This may involve the need to clarify admission/placement criteria, the initial appraisal/assessment process, interdisciplinary collaboration, and the provision of services on the BAU.

[1] 103 DOC 427.01
[2] 103 DOC 427.01

B. Policy Review Results and Recommendations

- 103 DOC 427

There is no definition of "unacceptable risk"[3] and it is unclear who has the authority to determine that a risk is "unacceptable." The policy attempts to separate "unacceptable risk" from "disciplinary or observation of behavior"[4] processes. The language here appears to attempt to delineate that placement in the BAU is neither a sanction, nor a healthcare/behavioral health placement.

Recommendation: Consideration should be given to providing a clear definition of an unacceptable risk (as opposed to an acceptable risk) as well as delineating who is able to make the determination that an individual poses an unacceptable risk. Training will be required to ensure that all staff have a clear understanding of the criteria and procedures to ensure that the use of BAU placement is in keeping with expectations and the intended purpose of the unit.

- 103 DOC 650.12

This section of the *Mental Health Services* policy specifies the actions required for individuals placed in the BAU. Specifically, the policy requires that a mental health assessment be completed "for clinical indication that the incarcerated individual is in need of a higher level of care."[5] No additional factors are to be assessed. The policy then states that individuals placed in the BAU shall be evaluated every 30 days. While evaluating an individual's level of care needs is critical and necessary at times of transition, mental health assessments should also include a review of the individual's current mental health needs and determination of the frequency of follow-up required given the individual's current presentation and situation. Determining at a single point in time if an individual requires a higher level of care and then not requiring that the individual be seen again for another 30 days is not acceptable, especially when risk factors are present. Weekly rounds by mental health clinicians can supplement ongoing assessment, but are not equivalent to individual, confidential assessments or clinically meaningful contacts.

[3] 103 DOC 427.01
[4] 103 DOC 427.02
[5] 103 DOC 650.12

Recommendation: The initial BAU assessment should include more than a point-in-time determination of the need for a higher level of care. For all individuals, the policy should clearly dictate the need for thorough mental status assessment and review of the individual's mental health history as well as the individual's previous adjustment to BAU or other special housing. For individuals on the mental health caseload, the policy should require a review of the individual's current treatment plan along with recent clinical documentation to ensure continuity of care. Individuals should receive support commensurate with the risk levels posed by their recent intoxication, pending disciplinary action, single cell placement, and recent/pending transfer. It is recommended that when these factors are present for an individual, which appears to be common among those placed in the BAU, comprehensive assessments of suicide risk should be completed along with safety planning and weekly treatment engagement, rather than the minimal contacts required by general mental health policy. These enhanced assessments and subsequent treatment interventions should be outlined in policy. Discussion of comprehensive suicide risk assessment is outlined later in this report.

C. Practice Review Findings and Recommendations

- Continuity of care

The healthcare records for the individuals who died by suicide during 2025 revealed concerns regarding continuity of care. These concerns were twofold. First, records of the four individuals who were on the mental health caseload revealed that these individuals were seen by a different clinician every two to three contacts, on average, in the six months prior to their deaths. Psychiatric providers were different for nearly every contact, with only one individual seeing the same provider twice in the six months prior to death. This lack of continuity of clinicians and psychiatric providers is likely to have a negative impact on an individual's ability to build therapeutic alliance, rapport, and trust with mental health professionals. Seeing a different clinician at most contacts is likely to result in individuals feeling that their unique concerns are unimportant and that their need for privacy and continuity can easily be disregarded. Especially for individuals suffering from depression, anxiety, and thoughts of suicide, this frequent change in clinicians is likely to increase a sense of isolation and does not support the individual disclosing personal and intimate feelings, such as thoughts of death. The second concern regarding continuity is the

clinician's lack of familiarity with the individuals, their baseline levels of functioning, and their ongoing needs and risks. While discussed later in my report, there were concerns noted regarding the specificity and accuracy of documentation entered into the clinical record. When clinicians are unfamiliar with an individual, they must rely on previous documentation to make clinical decisions. When previous entries are generic, or worse, inaccurate, the resulting ability to provide continuity of care is impaired.

Recommendation: Institutional mental health leadership should be asked to track continuity of care with individuals over time, especially individuals placed in specialty housing like a BAU or residential treatment unit. When findings reveal chronic concerns with poor continuity of clinicians and psychiatric providers, solutions should be developed to address the challenges. Additionally, it was noted during the record reviews that the Primary Care Clinician designation is not readily available within the healthcare record. Mental health leadership reported that Primary Care Clinician assignments are maintained on a separate spreadsheet at the institution. Attempts should be made to include the individual's treatment team members in the healthcare record, including primary care clinician, assigned psychiatric provider, and assigned substance use treatment clinician, as applicable. Including these assignments on the banner bar or other readily visible location is preferred.

- Length of clinical contacts

In many of the records reviewed during this process, I was struck by the excessively short length of clinical contacts, especially within the BAU. The vast majority of contacts documented with individuals in the BAU lasted for under five minutes, with some being documented as lasting less than one minute. This short length of time is not sufficient to adequately assess the stability and level of functioning of the individual. Given the high-risk nature of the environment (e.g., isolation, single cell, recent transfer, recent intoxication for some individuals), the ability to provide adequate time to assess the individual's needs and risks is essential. Even when the contact is in the service of clinical rounds, the contact should be of sufficient length to determine the individual's mental status, assess the nature of the individual's cell and hygiene, as well as discuss and assess the individual's ability to engage in coping strategies.

Recommendation: Minimum expectations should be set for the length of clinical contacts, especially in higher risk settings. Clinical contacts held in confidential settings should be expected to last no less than five minutes, with the ideal length of time being 15 minutes or more. Contacts at cell front, including clinical rounds or occasions when the individual refuses a confidential session, should be of sufficient length to conduct an adequate assessment of status and functioning. Ideally, cell-front contacts[6] should take place for at least two minutes. Even when individuals are non-responsive or belligerent, this extra time can provide clarity regarding the individual's needs and risks through observation and on-going attempts at engagement and/or deescalation. The rationale for inability to provide contacts of sufficient length should be clearly documented, with indication as to when follow-up will be attempted such that a contact of sufficient length can be completed. When contacts of sufficient length cannot be completed, another contact should be attempted as soon as possible, not scheduled for the next required contact (e.g., weekly rounds or 30-day follow-up).

- Lack of integration across disciplines

For the individuals receiving substance use treatment services, the documentation of comprehensive assessments and clinical contacts was notable. Substance use treatment providers completed routine assessments of individuals, asking specifically about the individual's mood, functioning, thoughts, and engaged the individuals in active safety planning, when indicated, to support coping strategies and resist the urge to use substances. There was little to no evidence that this information was available to, accessed by, or shared with mental health staff. When asked, mental health leadership noted that informal conversations are had across disciplines, but not with formality or regularity. It was reported that neither discipline has access to the records kept by the other discipline.

Recommendation: There should be a mechanism by which interdisciplinary meetings are scheduled and held routinely to discuss the overall needs of individuals who are being treated by mental health and substance use clinicians. These meetings should be held with the individual in

[6] For clarification, cell-front contacts are not clinically meaningful contacts. When cell-front contacts are completed as "rounds" their purpose is to observe the individual, assess the individual's living quarters, and determine if further mental health assessment or intervention with the individual is warranted. Similar observations and determinations are to be completed when cell-front contacts are made following an individual's refusal to attend a confidential session with a clinician but should not be considered a clinically meaningful contact.

treatment present, when possible, along with the clinicians providing care. Individual needs should be discussed and supported across disciplines. Identified risks, problems in functioning, and safety plans should be shared and supported across all disciplines. These discussion should occur at least weekly within special housing settings and at least every 90 days in general population.

- Lack of safety planning when indicated

Despite a number of the individuals who died by suicide in 2025 having histories positive for prior suicide attempts, suicidal ideation, or self-harm, none of the records included a safety plan created with the individual's mental health clinician. For some individuals being treated for substance use disorders, safety planning around substance use was included in substance use treatment records, but not in the healthcare record. Safety planning is an evidence-based intervention that supports suicide prevention.

Recommendation: Collaborative safety planning should occur routinely with individuals for whom the chronic risk for suicide is elevated, and/or for whom more immediate risk is present. As noted later in this report, this will likely require training. Resources to assist in training are provided in the training recommendations section below.

- Security response to intoxication

In record reviews and in the correspondence received from incarcerated individuals, there was evidence that individuals who are found to be intoxicated within MADOC could face disciplinary action and social isolation, such as placement in the BAU. What was not clear was whether the placement of intoxicated individuals in BAU was required by policy or was a decision of the security staff working in a specific location on a specific day. As noted in policy, BAU placement can be prompted by the presence of an unacceptable risk, safety concerns, or threats which require separation from others in the general population. What is not clear is how and when intoxication represents one of these concerns. There did not appear to be consistency in the response to intoxication, with some individuals receiving medical attention and others being placed in the BAU with evidence of pending disciplinary action, even when the individual was discovered to be non-responsive or significantly impaired following substance use. There are two concerns here. One is the lack of consistency of response and the other is the lack of clinical response to a

clinical problem. Many of the individuals who were found to be intoxicated had known substance use problems and some were in treatment for the same.

Recommendation: Cross-discipline leadership should discuss a plan of action to address intoxication within the MADOC. Specifically, the impact of treating intoxication as a disciplinary or clinical issues requires clarity as does the response when an individual is found to be intoxicated. There is no simple or easy answer, yet the frequency with which the deaths by suicide in 2025 included substance use and BAU placement cannot be overlooked.

- Over-reliance on self-report in the assessment of suicide risk

Suicide risk assessment is an in-depth process involving a comprehensive examination across a number of domains using several sources of information. Assessments typically integrate results from psychological tests, clinical interviews, behavioral observations, clinical records, and collateral information. In many of the cases reviewed, assessment of suicide risk appeared to rely almost exclusively on the individual's self-report. Most often, the assessment was minimal and was contained within the mental status examination noting that the individual did not report, or denied, suicidal ideation or intent. This is insufficient as a means to assess risk. A risk assessment needs to identify those factors which increase an individual's risk for suicide, including distant, proximal, chronic, and acute factors, as well as protective factors which help to mitigate risk for suicide. Additionally, treatment targets, specifically those risk factors which can be reduced through intervention, should be identified during risk assessment and integrated into the individual's treatment plan and/or safety plan.

Recommendation: MADOC, along with leadership from the health care provider, should consider adoption or development of a comprehensive suicide risk assessment protocol. This will be especially important with individuals in higher risk settings or undergoing stressful life events known to increase suicide risk. As noted later in this report, training will be required. Resources are offered in the training section of this report.

- Psychological Autopsy

A psychological autopsy, as defined in 103 DOC 622.09 is a "retrospective reconstruction of the individual's life with an emphasis on the risk factors that may have contributed to the

individual's death."[7] The psychological autopsy is defined in policy as being part of the Performance Improvement Mortality Review process. In most correctional systems, the psychological autopsy includes a review of documentation, review of recent written and telephonic conversations by the decedent, and interviews with staff and peers of the deceased individual. My discussions with mental health leadership revealed that the process of psychological autopsies does not routinely include peer interview.

Further, findings from the psychological autopsy are often included in the overall mortality review report or produced separately but included with a summary of findings included in the mortality review report, much like the findings from a medical examiner's autopsy, to assist in understanding the psychological causes of the individual's death. Psychological autopsy findings were not evident in the confidential administrative review reports produced in MADOC. During my interview with mental health leadership, I was informed that the psychological autopsy was considered to be a protected peer-review document and was not available for broader review. In addition to a psychological autopsy, 103 DOC 622.09 indicates that the Morbidity-Mortality Review committee will conduct a peer review of clinical care provided to the deceased individual. The policy is clear that these two processes are separate.

Recommendation: Consideration should be given to including the findings of the psychological autopsy in the final administrative report following a suicide to assist in understanding the causes surrounding the individual's decision to die by suicide. Protected peer-review findings can be produced separately. Further, inclusion of psychological autopsy findings will assist the annual continuous quality review process of examining sentinel events and identifying areas for improvement.

- Content and format of confidential administrative summary reports

While 103 DOC 622 Attachment D includes a listing of what information is to be considered during the Performance Improvement Mortality Review committee meeting, the expected contents of the resulting reports are not clear. There are a number of elements that should

[7] 103 DOC 622.09, page 13-14

be considered for inclusion in the final administrative report to assist with annual and other comprehensive continuous quality improvement reviews of deaths by suicide.

Recommendation: The policy should clearly indicate the standard contents of the final report. Recommended contents include the individual's cell type (e.g., single, double), security status, time 911 was contacted, time the emergency response team arrived on the scene, presence or absence of a suicide note, listing of institutional and/or housing transfers with dates, listing of disciplinary actions, listing of any grievances filed by the individual, list of the individual's employment or programming while incarcerated, overview of the individual's mental health and medical history while incarcerated, events which precipitated the death by suicide, and the individual's level of functioning prior to death. While a number of these elements were found in some of the reports, they were not consistently documented.

- Problems with documentation and adequate record review

As noted above, problems with continuity of care result in the need for accurate and specific entries into the healthcare record, such that subsequent clinicians can make important determinations of a given individual's needs. Once documentation is entered into the individual's record, subsequent clinicians need to review the documentation. Concerns with both of these issues were noted during this review process. There were examples of inaccurate or missing documentation (e.g., open mental health case noted as closed; safety plan not found when the process was documented as having occurred) and lack of comprehensive record review (e.g., psychiatric history not accurate; recommendations not incorporated into subsequent treatment planning).

Recommendations: Improvements in accurate documentation entries and adequate record review are necessary. Consideration should be given to updating clinical documentation requirements to ensure that clinicians are required to indicate whether previous treatment documentation and/or the treatment plan was reviewed. Adding a required box to be checked during clinical contacts could serve as a prompt to remind clinicians to review important documentation and serve as evidence that the review was completed. Training for staff, as discussed below, is also indicated. During record reviews, it was noted that supervisors cosigned many entries. It is recommended that supervisors pay attention to the accuracy of documentation

entries especially when reviewing initial assessments, treatment plans, risk assessments, and other documentation that is likely to be relied upon by other clinicians in the future.

D. Training Recommendations

- Documentation practices – Clinical Staff

Clinicians and psychiatric providers should be trained in documentation practices. Training should include what to review prior to clinical contacts, how to gather collateral information, the process for conducting and documenting a mental status examination, the risks and benefits of copying clinical documentation across contacts, documenting clinical interventions provided during a session along with the individual's response to those interventions, and a specific plan including what will be targeted or assessed in future clinical contacts. Staff may need a refresher on the purpose of clinical documentation. The purpose is two-fold. First, it serves as a legal record of a contact and should clearly indicate the same. Second, it furthers the treatment of the individual. Documentation of the current contact should provide a foundation for the next contact, indicating not only what was done, but what should be done next, to further treatment efforts to address the individual's mental health needs. Simply documenting the individual's current status is not sufficient. The individual's current status should be assessed in the context of previous contacts, along with a plan to address any changes that are desired for the individual.

- Suicide risk assessment – Clinical Staff

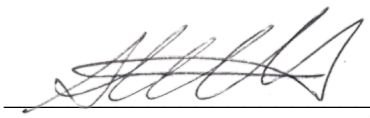
Mental health clinicians should be trained in comprehensive suicide risk assessment, which incorporates a number of sources of information. The risk of over-relying on self-report should be highlighted, along with strategies for identifying risk and protective factors. The NCCHC Suicide Prevention Resource Guide includes recommended resources to support development or adoptions of a comprehensive suicide risk assessment protocol. (*https://www.ncchc.org/wp-content/uploads/Suicide_Prevention_Resource_Guide.pdf*).

- Safety planning – Clinical Staff

Collaborative safety planning should be used routinely with individuals who are at risk for suicide or other self-directed violence. Mental health clinicians should be trained in the process

of safety planning as well as how to engage individuals regularly in enacting the steps of their safety plans as well as routinely reviewing the ability of the plans to mitigate risk.

Resources available include: (https://suicidesafetyplan.com/training/; https://sprc.org/wp-content/uploads/2023/01/SafetyPlanningGuide-Quick-Guide-for-Clinicians.pdf; https://zerosuicide.edc.org/resources/resource-database/safety-planning-intervention-suicide-prevention)



1/30/2026

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