



Suicide in Prison

**PREVENTION STRATEGY AND
IMPLICATION FROM HUMAN RIGHTS
AND LEGAL POINTS OF VIEW**



**National Human Rights Commission
India**

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India**

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AND LEGAL POINTS OF VIEW

Resource Person :

Shri Sanjay Kumar Jain, IPS
SSP, NHRC

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Abbreviation

- NHRC - National Human Rights commission
- NCRB - National Crime Record Bureau
- CBI - Central Bureau of Investigation
- FIR - First Information Report
- WHO - World Health Organisation
- JSAT - Jail Suicide Assessment Tool
- NGO - Non-governmental Organisation
- CCTV - Close Circuit Television
- MS - Medical Staff

SECTION

I

Overview of the problem-Suicide in Prison

Introduction

Occurrence of two suicide cases including suicide by one of the accused in Delhi gang rape cases within 72 hours in March 2013 in Tihar Central Prison underscore the need to understand the factors behind committing suicide in prison and framing a comprehensive action plan to prevent such suicide in future. While suicide is recognized as a critical problem within the jail environment, the issue of prison suicide has not received comparable attention. This monograph is aimed at to review the relevant national and international literature and conduct a data analysis of recent prison suicides so as to scrutinize the factors behind suicide and provides recommendations for the better identification and management of 'at-risk' prisoners as well as changing the general prison environment. It provides some general background on suicide and identifies a number of key activities that can be used as part of a comprehensive suicide prevention programme to reduce suicide in correctional settings. Till date, little research has been done or prevention resources offered in this critical area.

This monograph is produced by Investigation Division of NHRC as an effort to fill a critical void in the knowledge base about prison suicide. In addition to a thorough review of the literature for prevention, the document offers the most recent national data on the incidence and rate of prison suicide, effective prison suicide prevention programs, and discussion on legal liability issues. This monograph will encourage continued research, training, and development of comprehensive prevention policies that are imperative to the continued reduction of prison suicides throughout the country.



Research Methodology

This monograph is basically an exploratory or formulative and descriptive research study using inferential approach based on the extensive study of the various national and international research reports, survey reports available on website, published official documents and academic literature. While conducting the research, mostly secondary data available through official documents are used. Some of the observations are qualitative in nature based on the personal observation of prison visits and unstructured discussion with the prison authorities. The information generated through documents and unstructured interviews was analysed consistently.

Objectives- Research problem

Through this formulative and descriptive research, the aim and object is to derive some convincing and credible solutions and elucidations to the intricate problem of suicide in prison along-with formulating a dependable and steadfast suicide prevention programme. Following are the issues/problems that will be dealt in the research:

1. To understand and highlight the magnitude of suicide in prison in India
2. To comprehend the reasons behind committing of suicide in prison- the causative and contributory factors of suicide in prison
3. To elucidate the legal implication and resultant legal obligation in case of suicide in the prison
4. To decipher the signs and symptoms of a possible suicide
5. To design a suicide resistant prison cell that minimise the chances of committing suicide in the prison
6. To design and devise a credible and workable suicide prevention strategy and action programme

Magnitude of Suicide reported in Indian prisons

Data Interpretation and Analysis of Deaths reported in Prison

Before venturing further, it is imperative to sensitive ourselves about the magnitude and extent of the problem so that we can gauge the gravity and urgency of the issue at hand. To hit the nail on the head, the deaths reported in Indian prison during last 5 year (year 2007-2011) were analyzed based on the NCRB data¹. The average of 5 years is denoted while analyzing the trend or for making comparison. However, while making State-wise comparison, 4 year period (year 2008-2011) is considered in case of Karnataka State.

Based on the statistical and trend analysis, following pattern and findings are deciphered about the deaths reported in prison in general and suicide in particular. Furthermore, a comparison is also made between the general suicide rate vis-à-vis suicide rate in prison to bring home the depressing and stress generating environment of incarceration that induce the prisoner to commit suicide. It also reveals the variation between various prisons and significance of adequate medical staff and prison staff to prevent the suicide rate in the prison.

1. During last 5 years (year 2007-2011), the average prison population in India is 3,76,000 (with minimum as 3,69,000 and maximum as 3,84,700). The overall average death rate² in prison is 375 whereas the average suicidal death rate³ is 16.9. (See Table 1)
2. Based on 5 year average, it is found that 1411 deaths were

¹Accidental deaths and suicides in India, and Prison Statistics India, NCRB-- Annual Report for the year 2007 to 2011

²Death Rate in Prison- Number of death reported in prison per one lakh of prison population during a given period of time

³Suicide Death Rate- Number of suicidal death reported in prison per one lakh of prison population during a given period of time

reported every year in prison whereas 63.4 cases of suicides were reported in prison. (See Table 1)

3. Death on account of suicide form 71% of total unnatural deaths reported during last 5 years from 2007-2011.
4. The overall average suicide rate among general public (for the year 2007-2011) is 11 whereas average suicide rate in prison is 16.9. That means, propensity to commit suicide in prison is almost one and half times more than normal conditions. (See Table 2)
5. The average male suicidal rate in prison is 16.12 as compared to 34.6 in case of female inmates. It amply shows that female inmates are two times more prone to commit suicide in prison as compared to their male counterpart. (See Table 3 and Table 4)
6. However, contrary to above findings, the average death rate of female inmate is much less than the overall death rate of male inmates. The average female death rate is 269 against 379 in case of male inmates..(See Table 3 and Table 4)
7. There is wide regional variation in custodial death reported in prison. Against the average (5 years average) national death rate of 375, Karnataka has a death rate of 600 (for last 4 year – year 2008-2011), 480 (Tamil Nadu) and in between 430-450 for Punjab, Maharashtra and Rajasthan.
8. Similarly, against the national average suicide death rate of 16.9, average suicide death rate in Karnataka 76.14 (for last 4 year – year 2008-2011), 58.3 (Tamil Nadu) and 43.27 for Rajasthan. It reflects that incidence of deaths are reported more in prisons of some particular States (including suicidal death) as compared to others.

9. A positive correlation was found between ratio of medical staff over inmates viz-a-viz incident of deaths in prison while analyzing the relationship in 6 major States namely Maharashtra, Rajasthan, UP, TN, Punjab and Karnataka. With decline in ratio of medical staff ⁴, there is decline in overall incident of deaths in prison. For example, in Karnataka, in year 2007, when one medical staff was posted to look after 448 inmates, the total incident of reported death was 161 which get reduced to 57 in year 2011 when inmate-medical staff ratio to inmates declined to 309. Similar is the case of Maharashtra, where total reported death in prison fell from 139 (year 2007) to 88 (year 2011) when inmate-medical staff ratio declined from 375 inmates (year 2007) to 321 (year 2011). The reverse trend is also witnessed where inmate- medical staff ratio get adverse. For instance, in case of Punjab, the total reported death rose from 51 (year 2007) to 105 (year 2011) when inmate- medical staff ratio rose from 470 (year 2007) to 524 (year 2011). (See Table 5). This shows that with due medical attention, the overall death rate in prison could be brought down.
10. As per the guidelines issued by the NHRC, all cases of custodial death in the prison need to be intimated within 24 hours to the NHRC. (Letter no. 66/SG/NHRC/93 dated 14 Dec. 1993 followed by another letter no.- F.No. 40/3/95-LD dated 21 June, 1995). On the other hand, NCRB collects the statistical data pertaining to jail inmates and deaths reported in prison from the States and publish annual report titled as 'Prison Statistics India'. However, there is data discrepancy between the number of deaths reported in prison/judicial custody to the NHRC and NCRB. In the year 2007-2009, the NHRC received more intimations than

⁴Medical Staff Ratio means number of inmates looked after by one Medical Officer (i.e. no. of inmates/no. of medical officer)

number of deaths reported in NCRB report. The difference was as high as 402 in the year 2007. The number of custodial deaths reported to NHRC was 1739 as against 1337 reported by NCRB in the year 2007. However, this get reversed in the year 2010 and 2011 when number of intimations received at NHRC is lower than number of deaths reported in NCRB. For instance, in the year 2011, the NHRC received 1265 intimations of custodial death in judicial custody whereas the NCRB reported 1332 number of deaths in prison. Therefore, there is a discrepancy of 67 cases. (See Table 6)

11. There has been wide variation in the provision of medical staff among various States' prisons. As per NCRB report, 2011 the Central Prison, Tihar, Delhi has 152 medical staffs over inmate population of 12,124, thereby having one medical staff to look after 80 inmates. However, on other hand, the State of Madhya Pradesh with inmate population of 32,916 is having 49 medical staff. Thus, one medical staff is looking after as many as 672 inmates. The State of Jharkhand comes at second number with inmate/medical staff ratio of 553 followed by Punjab having inmate/medical staff ratio of 524. Therefore, it reflects the imperative to have a uniform standard on inmates-medical staff ratio and adequate medical facility in the prison to ensure adequate and timely treatment to the inmates as part of their right to life and right to health.
12. Though the incidence of suicidal death out of total reported deaths in prison is only 4.52% (5 years national average) but suicide incidence rate in respect of Central Prison, Tihar is three times high, i.e. 15% of total reported deaths. During last 5 years, on an average, 3 inmates committed suicide in Central Prison, Tihar.

13. Due to better medical facility and improved inmate-prison staff ratio, there is wide variation in overall death rates among States. The Central Prison, Tihar with one of the lowest death rate (180) is on one end of the spectrum while States like Karnataka (600), Tamil Nadu (480), Rajasthan (453), Maharashtra (445) and Punjab (433) on other end of the spectrum as against the national average of 375. It underscores the need and usefulness of sharing of best practices and common standards among various prisons as part of overall prison reform.
14. According to an international research⁵, pre-trial detainees have a suicide attempt rate of about 7.5 times, and sentenced prisoners have a rate of almost six times the rate of males out of prison in the general population. However, in Indian context, the rate of suicide in prison is quite low i.e., 1.5 times.

However, for making meaningful analysis and to understand pattern from the suicide deaths occurring in prisons, it is essential to understand the age group of the deceased, period of detention, time of committing suicide, place and manner of suicide, method used, medical history including mental health, precipitating/ triggering factors, environmental factors, any prior history of suicide /self-harm etc. so that necessary preventive and corrective measures could be devised to remove the factors that facilitate or assist in commission of the suicide and strengthening the protective factors that could help in mitigating the risk of committing suicide.

⁵Jenkins R, Bhugra D, Meltzer H, Singleton N, Bebbington P, Brugha T, Coid J, Farrell M, Lewis G, Paton J. Psychiatric and social aspects of suicidal behaviour in prisons. *Psychological Medicine*, 2005, 35: 257-

Table 1: Overall death rate and suicide death rate in Prison of last 5 years

Year	Total Prison Population	No. of deaths in prison	Death rate in prison (per lakh)	Deaths due to natural reasons	Death rate on account of natural reasons	Unnatural deaths	% of unnatural death out of total reported death	deaths due to suicide	Suicide Rate (per lakh)
2007	376396	1337	355.21	1248	331.57	89	6.66	58	15.41
2008	384753	1518	394.54	1449	376.61	69	4.55	48	12.48
2009	376969	1430	379.34	1321	350.43	109	7.62	75	19.90
2010	368998	1436	389.16	1344	364.23	92	6.41	68	18.43
2011	372926	1332	357.18	1244	333.58	88	6.61	68	18.23
G. Total	1880042	7053	1875.43		1756.41			317.00	84.44
Avg.	376008.4	1410.6	375.09		351.28			63.40	16.89
Note:									
<p>Suicide Death Rate- Number of suicidal death reported in prison per one lakh of prison population during a given period of time</p> <p>Death Rate in Prison- Number of death reported in prison per one lakh of prison population during a given period of time</p>									

Graph 1: Graph showing overall death rate and suicide rate in prison

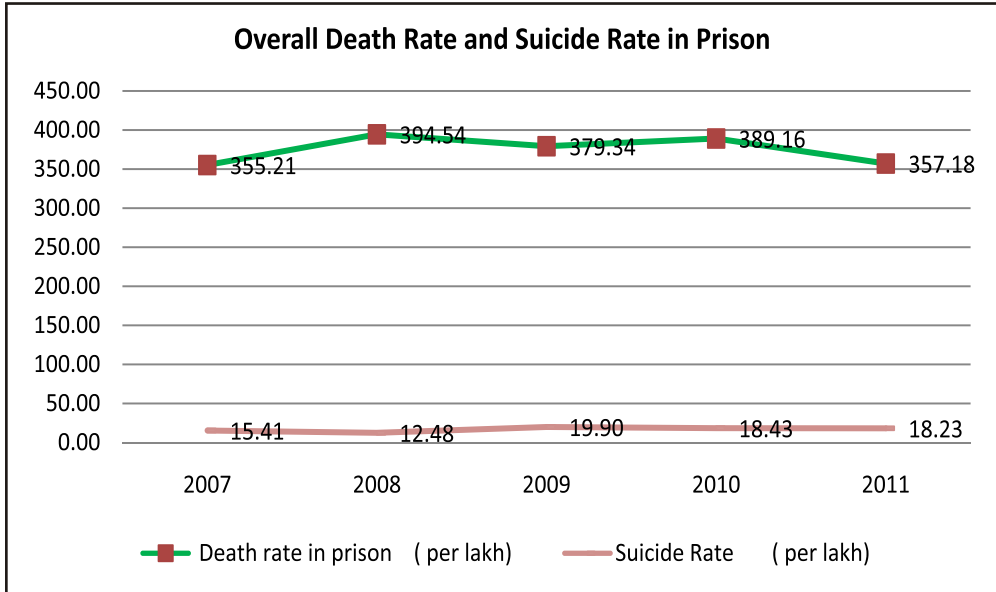


Table 2 : Comparison between General Suicide Rate and Suicide Rate in Prison

Year	General Suicide Rate	Prison Suicide Rate
2007	10.8	15.40
2008	10.8	12.47
2009	10.9	19.89
2010	11.4	18.43
2011	11.2	18.23
G. Total	55.1	84.42
Avg.	11.02	16.88

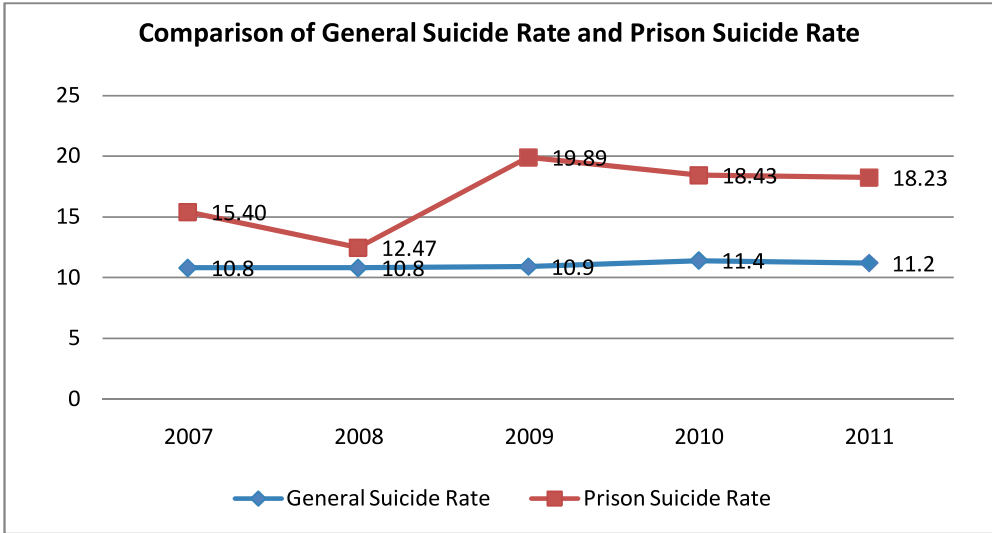
**Table 3 : Death rate of Male inmates in Prison
for the year from 2007-2011**

Year	Male Death Rate					
	Male Prisoners	Total death	Unnatural death	Suicide death	overall death rate	Male Suicide Rate
2007	360995	1304	86	55	361.22	15.24
2008	368824	1467	64	43	397.75	11.66
2009	361563	1381	100	69	381.95	19.08
2010	353961	1402	87	63	396.09	17.80
2011	356902	1289	79	60	361.16	16.81
G. Total		6843			1898.18	80.59
Avg.					379.64	16.12

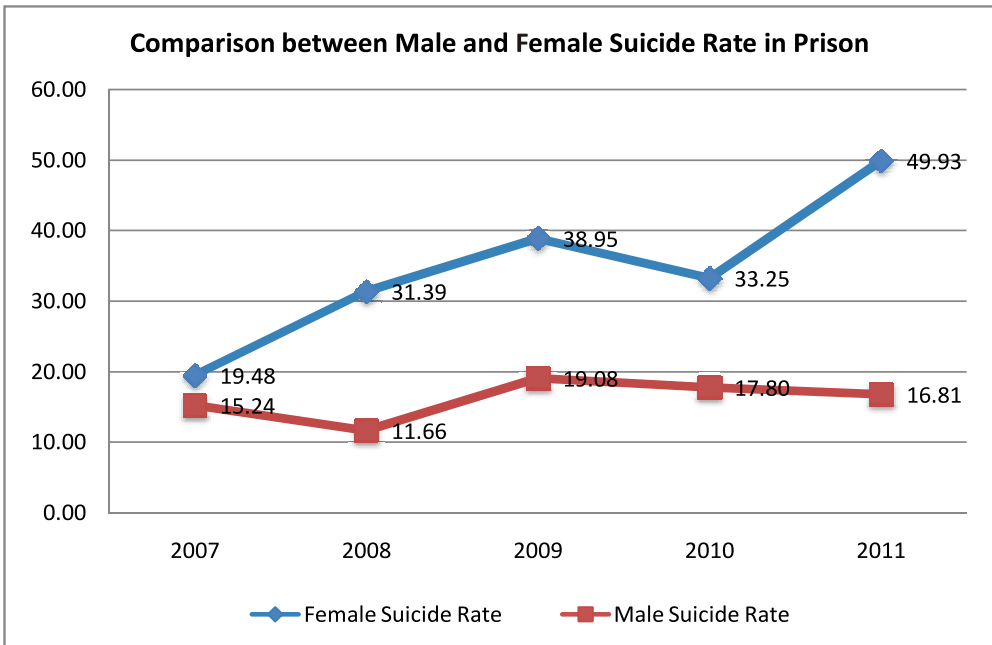
**Table 4: Death rate of female inmates in
Prison for the year 2007-2011**

Year	Female Death Rate					
	Female Prisoners	Total death	Unnatural death	Suicide death	Overall death rate	Female Suicide Rate
2007	15401	33	30	3	214.27	19.48
2008	15929	51	5	5	320.17	31.39
2009	15406	49	9	6	318.06	38.95
2010	15037	34	5	5	226.11	33.25
2011	16024	43	9	8	268.35	49.93
G. Total					1346.96	172.99
Avg.					269.39	34.60

Graph 2: Comparison between general Suicide Rate and custodial Suicide Rate



Graph 3: Gender based Custodial Suicide Rate



Graph 4: Gender based overall Death Rate in Prison

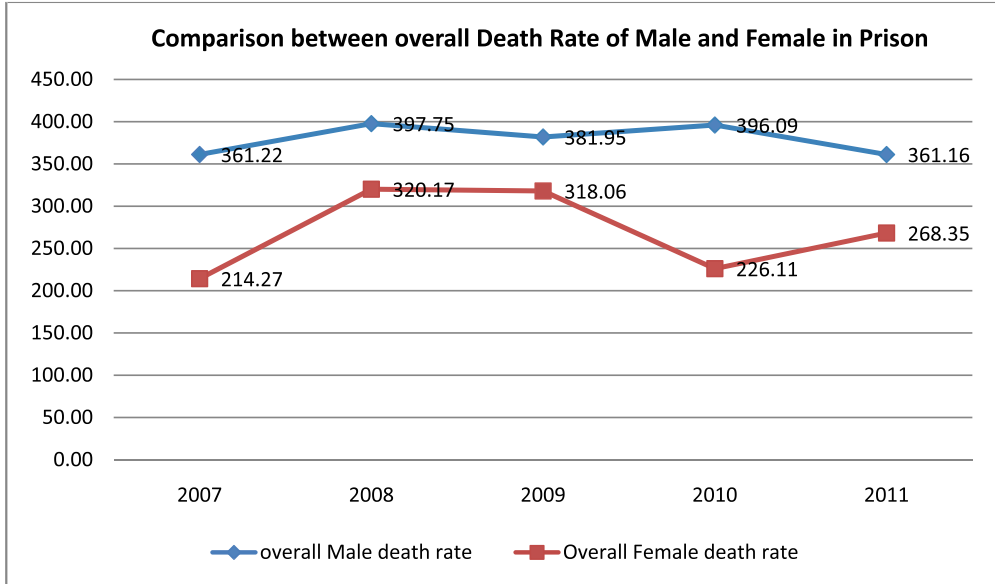


Table 5: Data showing relationship between deaths reported in Prison and Medical Staff

Year	Karnataka		Tamil Nadu		Uttar Pradesh		Maharashtra		Punjab		Rajasthan	
	No. of total death	No. of inmates per MS	No. of total death	No. of inmates per MS	No. of total death	No. of inmates per MS	No. of total death	No. of inmates per MS	No. of total death	No. of inmates per MS	No. of total death	No. of inmates per MS
2007	161	448	78	241	183	387	139	375	51	470	63	334
2008	85	410	74	231	304	350	120	380	69	474	57	361
2009	85	389	65	194	315	355	109	332	49	525	91	448
2010	88	368	78	187	320	332	102	328	98	519	87	366
2011	57	309	64	173	287	380	88	321	105	524	83	385

MS- means Medical Staff

Table 6: Data discrepancy between custodial deaths reported to NCRB and NHRC

Year	Death reported in Prison (Judicial Custody) as per NCRB	Death reported in Judicial Custody as per NHRC	Difference between data reported to NHRC and NCRB
2007	1337	1739	402
2008	1518	1662	144
2009	1430	1491	61
2010	1436	1434	-2
2011	1332	1265	-67

Data Requirement for analysis purposes

Prison suicide rates have been associated with a number of common demographic variables (Bonner, 1992). The analysis should be based on three broad categories namely

Personal variables- Personal Characteristics of the Victims

It includes variables such as gender, age, race, and psychiatric and suicidal history. It includes variables such as:

- Gender
- Age
- Marital Status
- Criminal Charge(s)
- Four offence categories: personal and/or violent (murder, sexual assault), serious property, alcohol and/or drug related, and minor other

- Additional Charges and Jail Status
- Past criminal history- first timer or habitual
- History of Substance Abuse
- History of Medical Problems
- History of Mental Illness
- History of Psychotropic Medication
- History of Suicidal Behaviour

Non- Personal variables

It includes several non-personal variables associated with the suicides, such as

- Method used,
- Housing,
- Length of sentence and type of institution,
- Time of day and time of year the suicides occurred,
- Precipitating factors
- Profile of the typical inmate who committed suicide in custody.

Institutional Variables

It includes several variables associated with the prison, such as

- Type, Administration, Population, and Capacity
- Identification and/or Screening for Suicide Risk
- Verification of Suicide Risk During Prior Confinement
- Suicide-Prevention Training

- CPR Certification- medical training
- Suicide Watch and Levels of Observation
- Safe Housing
- Mortality Review Process

Data Limitations and Further Research Needed

In India, there is lack of proper data to have in-depth analysis of suicidal death in custody. Only the basic figures of suicidal deaths in prison are available without its further details such as period of detention, mode of suicide, place of suicide, time and day, use of ligature material, triggering factors, circumstances, previous history, mental and physical health condition of the victim etc. Moreover, there is lack of completeness of data as well.

This call for standardization of input form wherein all relevant information is filled up in case of any suicide death occurred in custody- be in police custody or in judicial custody. One such model input form is annexed herewith at **Appendix A**.

Future research could explore in more detail the reason(s) behind the occurrence of more suicides during the first 24 hours to 14 days of confinement. Additional research is needed to explore a possible relationship between suicide and an inmate's confinement for sexual assault and/or murder of a child, and to explain the reasons for this relationship. Further research is also necessary to explore the relationship between the occurrence of inmate suicides and recent court hearings, telephone calls, and visitation, as well as other possible precipitating factors that study respondents could not identify. The identification of precipitating factors to inmate suicide is critically important to the field's further understanding of the problem.

SECTION

II

Understanding suicide in prison

Introduction

This section dwells upon causes/factors that propel or instigate the inmates to commit suicide and conducting risk assessments through intake screening to identify the 'high risk' inmates. What are the pre warning signals and precipitating factors that precede the commission of suicide? It extensively elaborates on the measures that can mitigate the incidence of suicide including creating 'suicide resistant cell'. The international research on prevention of suicide in prison including study of WHO, US department of Justice and HM of Chief Inspector of Prisons for England and Wales is summarized here along-with various check-list and suicide assessment tools. The action plan for suicide prevention programme and NHRC's recommendations on prison reforms is also explained.

Understanding Suicide in Prison

I. Prison Suicide - Causes, Contributors and Predictors

The causes of suicide are complex. Some individuals seem especially vulnerable to suicide when faced with a difficult life event or combination of stressors. Inmates in general are a high-risk group. For example, the suicide rate of pre-trial detainees is 10 times higher than the rate for the general population, and the suicide rate for sentenced prisoners is 3 times higher⁶. However, it's possible to analyse the common risk factors and create a general profile that can be used to identify and situations that present the highest risk.

The challenge for suicide prevention is to identify people who are most

⁶ Preventing Suicide: A Resource for Prison Officers, World Health Organization Department of Mental Health,

vulnerable, under which circumstances, and then effectively intervene. Towards this end, researchers have identified a number of broad factors that interact to place an individual at higher risk of suicide including socio-cultural factors, psychiatric conditions, biology, genetics, and social stress. The ways in which these factors interact to produce suicide and suicidal behaviours is complex and not well understood. Nevertheless, in various combinations, they have been used to identify specific high-risk groups. Knowledge about suicide risk in custody (judicial custody or police custody) is important. It allows us to be able to put into perspective the increased risk of suicide inside a correctional facility/prison. Suicide is the single most common cause of unnatural death in prison. **In Indian context, suicide death accounts for almost 71%⁷ of unnatural deaths reported in prison.**

It is also important to note a suicide in a prison can have long term effects on its culture (i.e., cause high level of stress on staff and inmates that have to deal with the aftermath of an inmate suicide) and cause long term legal and political problems. Survivors of suicides (i.e., family and friends of a person that commits suicide) are also often at a higher risk of suicide as they deal with the grief of the loss of a loved one. While suicide is recognized as a critical problem within the jail environment, the issue of the precipitating factors of suicidal behaviour in jail is well established (Rowan and Hayes, 1995). It has been theorized that there are two primary causes for jail suicide — first, **jail environment** is conducive to suicidal behaviour and, second, the inmate is facing **a crisis situation**.

From the inmate's perspective, certain features of the jail environment enhance suicidal behaviour: *fear of the unknown, distrust of the authoritarian environment, lack of apparent control over the future, isolation from family and significant others, shame of incarceration, and the dehumanizing aspects of incarceration.*

⁷This is average of suicide reported as proportion of unnatural death during 5 years from 2007-2011

CHARACTERISTICS OF PRISON ENVIRONMENTS

The following are characteristics that make suicides in prisons more likely:

1. Authoritarian environment

Persons unaccustomed to a regimented environment can encounter traumatic difficulty in a prison setting.

2. No apparent control over the future

Following incarceration, many inmates experience a feeling of helplessness and hopelessness. They feel powerless and overwhelmed.

3. Isolation from family, friends, and community

For incarcerated individuals, support from family and friends may seem far away, especially with restricted visiting and telephone privileges.

4. The shame of incarceration

Feelings of shame (often found in misdemeanants) are often inversely proportionate to the gravity of the offences committed. Frequently, such feelings develop in those persons who have never been arrested before or who have a limited arrest history.

5. Dehumanizing aspects of incarceration

Viewed from the inmate's perspective, confinement in even the best of jails is dehumanizing. Lack of privacy, association with acting-out individuals, inability to make your own choices, and strange noises and odours can all have a devastating effect. Many facilities are old and overcrowding can create stress.

6. Fears

Fears, based on stereotypes of jails seen on television and in movies, and stories carried by various media, heighten anxieties on the part of some individuals about other inmates and sometimes, about staff.

7. Staff insensitivity to the arrest and incarceration phenomenon

Most, if not all persons working in the criminal justice field has never personally experienced the trauma of arrest and incarceration. Experience has shown that, in many instances, the longer people work in the criminal justice field, the more insensitive they can become to the emotional effects of arrest and incarceration. This is particularly true for the first time arrestee. This is considered one of the factors, which influences suicides in jails and prisons. Staff often overlooks signs and symptoms because of their own insensitive attitudes and thinking.

8. Hostility and bullying by other inmates

9. Lack of adequate medical and psychological counseling and treatment facility

10. Delay in deciding the parole

CHARACTERISTICS OF CRISIS SITUATION

1. Recent excessive drinking and/or use of drugs

In many instances, when intoxicated persons sober up, depression sets in. However, a number of persons with blood alcohol levels in excess of the legal limit commit suicide while still intoxicated. For some, even a small amount of alcohol or drugs can have a depressing effect, influencing suicidal behaviour.

2. Recent loss of stabilizing resources

i. Any of the following can influence suicidal behaviour:

- Loss of spouse/loved one. For juveniles this could be a peer who is missed more than a parent;
- Job, expulsion from school;
- Loss of home or harm; or
- Loss of finances.

3. Severe guilt or shame over the offence

While some inmates involved in serious crimes commit suicide, most that take their own lives are charged with minor offences or civil violations. For most suicidal inmates, the guilt or shame may well be inversely proportionate to the seriousness of the offence. A person of high status in the community who commit shameful crimes (e.g., child molestation or sexual assault) may need close attention.

4. Same-sex rape

In interviews with inmates who were prevented from committing suicide, many of them said that they had been raped or strongly coerced for sexual favours.

5. Current mental illness

Persons who are depressed or suffering from delusions/hallucinations (e.g., have voices telling them what to do) are prime subjects for suicide.

6. Poor health or terminal illness

Any person suffering from serious illness (e.g., aids, cancer) can be at risk for suicide.

7. Approaching an emotional breaking point

Each individual has a breaking point where they can no longer deal with their stressors. This point can be influenced by the duration, time and situation of the stressors.

Inmates attempting suicide are often under the influence of alcohol and/or drugs and placed in isolation. In addition, many jail suicide victims are young and generally have been arrested for non-violent, alcohol-related offences. Although prison suicide victims share some of these characteristics, the precipitating factors in suicidal behaviour among prison inmates are somewhat different and fester over time.

Identifying individuals who are higher risk for attempting suicide is important to prevent suicide. **Seventeen variables** are considered including *mental health designation, days in current cell, type of housing, marital status at intake, time remaining on their sentence, custody classification, gender, number of prior incarcerations, sexual offender status, type of offence, heinous bodily crimes Vs minor crime, gang affiliation, age, number of disciplinary reports, number of assault-related disciplinary reports, life/death sentence, and other variables*. There are **six factors** highly related to suicide – *mental health designation, custody classification, days in current cell, type of housing, age, and number of disciplinary reports*. Another **four factors** are associated with increased risk – *time left on sentence, marital status at intake, number of assault-related disciplinary reports, and life/death sentence*. Individuals are higher risk if they have more mental health need, live in specialized housing, have recently moved to a new cell, are younger, and have more disciplinary reports. Prison Officers need to recognize what factors are more important, what factors might combine with other factors that greatly increase risk, what number of risk factors constitutes high risk, and what factors may decrease risk.

The report finds that if there are enough **protective factors** to offset the risk factors and prisoners with mental illness can be returned to health,

suicidal behaviours may be reduced. Accordingly, the report recommends improving protective factors across the prison system. It is evident that many of the stresses that precipitate self-harming and suicidal behaviour are personal events which may be kept private. Successful prevention of suicide is consequently dependent upon the identification of **‘at-risk’ factors**.

Stress-Vulnerability model

Bonner (1992a) offers the **“stress-vulnerability model,”** the theory that suicide must be viewed in the context of a process by which an inmate is (or becomes) ill-equipped to handle the common stresses of confinement. As the inmate reaches an emotional breaking point, the result can be varying degrees of suicidal intention, including ideation, contemplation, attempt, or completion. Initially, these stressors mirror those of jail suicide victims, such as fear of the unknown and isolation from family, but over time incarceration may bring about added stressors, such as loss of outside relationships, conflicts within the institution, victimization, further legal frustration, physical and emotional breakdown, and a wide variety of other problems in living. Coupled with such negative life stress, individuals with psychosocial vulnerabilities (including psychiatric illness, drug/alcohol intoxication, marital/ social isolation, suicidal coping history, and deficiencies in problem-solving ability) may be unable to cope effectively and in time may become hopeless (Bonner, 1992a, p. 407).

Such factors, in combination or interaction with the common stresses of confinement, could break down the ability to cope and create the emotional avenue for suicidal behaviour. Yet, although research has not sufficiently addressed the psychosocial process of prison suicide, court decisions and developing national standards have, to a degree, filled the void by advocating the view that suicide is a process that typically displays observable signs of maladaptive coping and suicidal intention. If identified

in time, the process can be reversed or prevented in most cases (Bonner, 1992b).

The following model explained at **Chart 1** shows some of the background and individual factors that increase a person's vulnerability to suicide. It shows some of the prison-specific factors and situational triggers that are associated with increased risk, as well as some of the protective factors. As suggested by the interconnecting arrows on the model, the relationship is two-way. For example, an individual may have experienced one or several elements on the 'vulnerability' element (such as depression, poor family support and social deprivation). If these experiences co-occur with 'prison induced stress' it is perhaps more likely that they will be influenced by 'situational triggers (such as the break-up of a relationship). This is particularly likely in the absence of protective factors (such as hopes and plans for the future or good peer support). Before a person actually kills themselves, it is likely that they would have climbed several steps on the 'Suicide Ladder'⁸. They may have experienced thoughts of suicide ('suicide ideation'), may have injured themselves or attempted suicide and may have made concrete plans (such as making a noose, writing a note, giving away possessions or saying goodbye to relatives or friends).

A discussion of prison suicide would be incomplete without a few words about suicide and the manipulative inmate. Few issues challenge prison officials and staff more than the management of manipulative inmates. It is not unusual for inmates to call attention to themselves by threatening suicide or feigning an attempt to avoid a court appearance, bolster an insanity defence, be relocated to a different cell, be transferred to the prison infirmary or a local hospital, receive preferential staff treatment, or seek compassion from a previously unsympathetic spouse or other family member.

⁸ Eldrid J, 1988 'Caring for the suicidal', Constable, London

The success of efforts to prevent suicide in prisons will depend on our ability and willingness to identify the vulnerable inmate, provide the necessary supervision, and offer alternative ways of coping and reducing emotional distress (Bonner, 1992b). A diagram placed at Chart 1 explains the various factors- vulnerability, stress and situational factors that are push/ contributory causes whereas there are certain 'protective factors' that mitigate the suicidal tendency. The intricate web of these factors is responsible behind the custodial suicide.

Box 1

Reasons behind Suicide in Custody from Operational Point of view to take Corrective Action

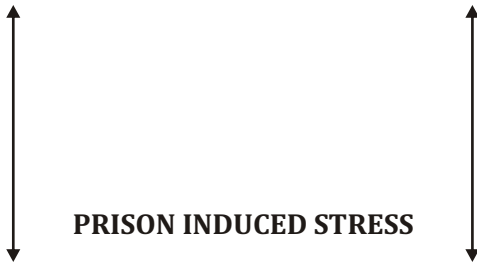
1. Inadequate or unavailable psychological services at initial intake and during incarceration,
2. Poor communication among staff,
3. Perception of self-injurious behaviour as a means of manipulation,
4. Basic elements of the institutional environment that constrain personal efficacy and control,
5. Limited staff training and direction in suicide prevention,
6. Limited staff direction in responding to suicide incidents, and
7. Investigations directed primarily toward establishing an appropriate response by staff without the accompanying thorough investigation of the causes of the suicide.

VULNERABILITY

Lack of attention/ care as child Anxiety/depression Poor family support Low self-esteem Poor prospects Delinquency Social deprivation	Psychotic illness Personality disorder Impulsiveness Isolation from family Economic deprivation
--	---

SITUATIONAL TRIGGERS

Psychotic illness Personality disorder Impulsiveness Isolation from family Economic deprivation



Guilt over nature of offence Concern over court appearance Loneliness/boredom Lack of purposeful activity Breakdown of relationships Victimisation/bullying Lack of family contact
--

PROTECTIVE FACTORS

Visits and contact with family Constructive occupation in prison	Hopes and plans for the future Support from staff
---	--

Chart 1

Diagram Explaining the Vulnerability factor, Stress factors, Situational factors and Protective factors that are causative behind the custodial suicide

SIGNS AND SYMPTOMS OF A POSSIBLE SUICIDE

The following is a list of signs and symptoms that a possible suicidal individual might display before attempting to try to take their own life.

1. Current depression or paranoia;
Depression is the single best indicator of potential suicides. Approximately 70 to 80 percent of all suicides are committed by persons who are severely depressed.
2. Expresses or evidences a strong guilt or shame over offence;
3. Talk about or threatens suicide;
4. Under influence of alcohol/drugs;
5. Staff knowledge of previous suicide attempts of history of mental illness;
6. Severe agitation or aggressiveness;
7. Projects hopelessness or helplessness or no sense of future;
8. Expresses unusual or great concern over what will happen to them;
 - Noticeable mood and/or behaviour changes;
9. Acts very calm once decision is made to kill self;
10. Speaks unrealistically about getting out of jail;
11. Has increased difficulty relating to others;
12. Does not effectively deal with present/preoccupied with past;
13. Begins packing belongings;
14. Starts giving away possessions;
15. May try to hurt self;

16. Paranoid delusions or hallucinations;
17. Feeling of inability to go on, hopelessness, or helplessness;
18. Extreme sadness and crying;
19. Withdrawal or silence;
20. Loss or increase of appetite and/or weight;
21. Pessimistic attitudes about the future;
22. Insomnia or awakening early, or excessive sleeping;
23. Mood and/or behaviour variations;
24. Tenseness;
25. Lethargy (i.e., slowing of movements or non-reactive);
26. Loss of self-esteem;
27. Loss of interest in people, appearance, or activities;
28. Excessive self-blaming;
29. Strong guilt feelings;
30. Difficulty concentrating or thinking;
31. Agitation frequently precedes suicide;
32. High level of tension;
33. Extreme anxiety; and
34. Strong emotions.
 - i. Guilt
 - ii. Rage
 - iii. Wish for revenge

A checklist for warning signals and approach to deal with them is annexed herewith as **Appendix B**

II. TIME PERIODS FOR HEIGHTENED SUICIDE RISK

The following is a list of time periods during incarceration that an inmate is more likely to try to commit suicide.

1. The first 24 hours of confinement;
2. Intoxication/withdrawal;
3. Waiting for trial;
4. Sentencing;
5. Impending release;
6. Holidays;
7. Darkness;
8. Decreased staff supervision;
9. Bad news of any kind; and
10. The first 30 days after incarnation or movement into a new facility.

Misunderstanding Suicide- Obstacle to Prevention

Negative attitudes often impede meaningful suicide prevention efforts. Such attitudes form ***obstacles to prevention***, and can be seen on both a local and universal basis. Simply stated, obstacles to prevention are empty excuses that inmate suicides, while tragic, cannot be prevented. For example, a **Local Obstacle**, espoused by a jail administrator, might sound something like this:

- “If someone really wants to kill themselves, there’s generally nothing you can do about it;”

- “There’s no way you can prevent suicides unless you have someone sitting watching the prisoner all the time, and no one can afford to be a baby sitter;”
- “We didn’t consider him suicidal, he was simply being manipulative and I guess it just went too far;”
- “If you tell me you’re suicidal, we’re going to have to strip you of all your clothes and house you in a bare cell;”
- “Suicide prevention is a medical problem...it’s a mental health problem...it’s not our problem.”
- “Our concern is more if we suspect foul play...we always go back and review our policies and procedures to see if there’s anything we could do to prevent it... I have no idea why they do it. If I ever did, I could probably do a better job of preventing it.”
- “I suppose that with fewer prisoners in jail, the jailer on duty would make his rounds more frequently. However, the current policy we follow states that the jailers make routine inspections every 20 to 30 minutes. Generally, that is not enough time for prisoners to hurt themselves.” (*Jail Superintendent*)
- “There was nothing unusual about the arrest. I was very satisfied with the way the officers involved handled the situation. The only real unanswered question is why the inmate chose to do what he did. Personally, I do not believe it is any of the police department’s business nor is it in the scope of our employment to determine why.”

Then there are Universal Obstacles to prevention — regressive attitudes that are far more dangerous because of their far-reaching ability to negatively influence correctional policy on a larger scale. We often find the roots of this attitude in both the academic and/or psychiatric communities:



- “Statistically speaking, suicide in custody is a rare phenomenon, and rare phenomena are notoriously difficult to forecast due to their low base rate. We cannot predict suicide because social scientists are not fully aware of the casual variables involving suicide;”
- “Even those skilled mental health professionals, who have the time for extensive personal interaction with troubled individuals, either cannot forecast suicide or are unable to prevent patient suicide even if it had been somewhat anticipated;”
- “To speak bluntly, custodial suicide may constitute less a readily solvable problem than a situation which, in view of our present knowledge and our financial limitations, may be expected to continue.”

To sum up

However, it is neither practicable nor appropriate to manage every prisoner as if they are suicidal, consequently a strategy of screening and assessment has been used to identify so-called “at-risk prisoners” and thereby better manage the incidence of suicide.

Unfortunately, suicide risk prediction generates a large number of false positives, since the predictors are non-specific and suicide itself is a rare event. Thus, it is unlikely that a totally reliable screening tool will ever be developed for suicide. Therefore, while we will continue to improve screening tools, it will also be important to focus on the extent to which the whole prison environment contributes towards the good mental health of inmates and how to identify, manage and treat prisoners who are at-risk, particularly those prisoners who present as an acute risk. Prison suicide is a complex phenomenon that is best understood (and prevented) by an assessment of individual *psychosocial factors*. These factors act to increase the risk of suicide and, in combination with the better management of



those *systemic factors* that act to exacerbate suicidal feelings. Early family dislocation, destructive community relationships, death or a relationship breakdown, distressing communications while in prison and bullying, were also identified as significant factors.

Legal implication and Liability of the State and prison authorities

Introduction

Several incidents are reported wherein the detainee or arrested person commits suicide while in the police custody. The general response of the police officials is that since it is a case of suicide which is voluntarily act of the deceased, so police officials (under whose custody the detainee was kept) are not responsible as there is no overt act of commission on their part. Moreover, how can police/prison officials can stop or prevent such incidents. Therefore, they should not be held responsible for such suicidal death.

However, the legal position is somewhat different than what is commonly perceived by the police/prison officials.

The legal position with respect to the custodial death due to suicide or assault by other co-inmates or due to medical negligence is quite clear and well settled. The Hon'ble Supreme Court and High Courts in number of judgments have upheld the vicarious liability of the State to pay compensation to the next of the kin of the deceased in such cases. The Hon'ble Court has upheld that the inmates in prison are under the care and protection of the State and the State is responsible for their safety, security and well-being. A duty is cast on the jail authorities to look after the well-being including the protection of lives and liberties of the jail inmates. The **Hon'ble Supreme Court in Nilabati Behera case** asserted that convicts, prisoners or under-trials are not denuded of their fundamental rights under Article 21 [Right to life and personal liberty] of the Constitution and there is a corresponding responsibility on the police and prison authorities

to make sure that persons in custody are not deprived of the Right to Life. The State has a duty of care, to ensure that the guarantee of Article 21 is not denied to anyone. This duty of care is strict and admits no exceptions. The State must take responsibility by paying compensation to the near and dear ones of a person, who has been deprived of her/ his life by the wrongful acts of its agents. However, the Court affirmed that the State has a right to recover the compensation amount from the wrongdoers. There is a great responsibility on the police or prison authorities to ensure that the citizen in its custody is not deprived of his right to life.

In another landmark judgment, **Hon'ble Supreme Court in D. K. Basu case** said that it is now a well-accepted proposition in most of the jurisdictions, that monetary or pecuniary compensation is an appropriate and indeed an effective and sometimes perhaps the only suitable remedy for redressal of the established infringement of the fundamental right to life of a citizen by the public servants and the State is vicariously liable for their acts. The claim of the citizen is based on the principle of strict liability to which the defence of sovereign immunity is not available and the citizen must receive the amount of compensation from the State, which shall have the right to be indemnified by the wrongdoer.

Based on the legal pronouncement, the following points can be deduced:

1. **Vicarious Liability of the State-** Since inmates in prison are under the safe custody of the State, thus, it is the responsibility of the State to ensure safety, security and wellbeing. In case of any negligence or violation, the State is vicariously liable for the acts of omission or commission on the part of jail authorities
2. **Liability under Public Tort-** As compared to civil liability under the laws of private torts, for violation of fundamental rights, the remedy is also available in public law since the purpose of public law is not only to civilize public power but also to assure the

citizens that they live under a legal system wherein their right and interests shall be protected and preserved. The compensation is in the nature of the exemplary damages' awarded against the wrong-doer for the breach of its public law duty and is independent of the rights available to the aggrieved party to claim compensation under the private law in an action based on tort, through a suit instituted in a court of competent jurisdiction or/and prosecute the offender under the penal law.

- 3. Recovery of amount of compensation from wrong-doer-**
Though the State is responsible to pay compensation on account of principle of vicarious liability but it is entitled to recover the amount from wrong-doer or delinquent officials responsible for negligence or commission of act.

Landmark Legal Pronouncement

Supreme Court of India

NILABATI BEHERA V STATE OF ORISSA 1993 SCC 746

CITATION:

1993 AIR 1960 1993 SCR (2) 581

1993 SCC (2) 746 JT 1993 (2) 503

1993 SCALE (2)309

Brief Facts of the Case

Nilabati Behera, a distressed mother, wrote a letter to the Supreme Court asking that she be monetarily compensated for the death of her 22 year old son in police custody. She said that her son, Suman Behera was beaten to death at a police post after being detained in connection with a theft. The Supreme Court immediately admitted a writ petition on her behalf and took up the case.

Decision of the Hon'ble Court

Rejecting the police version that Suman Behera was killed by a running train after he escaped from police custody; the Court asserted that the post-mortem report clearly showed that he died as a result of being beaten up. It is to be noted that in this matter, an inquiry was conducted by the District Judge who concluded that petitioner's son died on account of multiple injuries inflicted to him while he was in police custody at the Police Outpost. The question before the Court was whether Nilabati Behera had a right to claim compensation for the wrongful acts of the policemen who caused her son's death.

Supreme Court Observations

Article 9 (5) of the International Covenant on Civil and Political Rights, 1966 lays down that anyone who has been the victim of unlawful arrest or detention shall have an enforceable right to compensation. This Covenant has been ratified by India, which means that the State has undertaken to abide by its terms. The Supreme Court asserted that convicts, prisoners or under-trials are not denuded of their fundamental rights under Article 21 [Right to life and personal liberty] of the Constitution and there is a corresponding responsibility on the police and prison authorities to make sure that persons in custody are not deprived of the Right to Life. The State has a duty of care, to ensure that the guarantee of Article 21 is not denied to anyone. This duty of care is strict and admits no exceptions the Court said. The State must take responsibility by paying compensation to the near and dear ones of a person, who has been deprived of her/ his life by the wrongful acts of its agents. However, the Court affirmed that the State has a right to recover the compensation amount from the wrongdoers.

The Hon'ble Court said that the purpose of law is not only to civilize public power but also to assure people that they live under a legal system which protects their interests and preserves their rights. Therefore, the High Courts and the Supreme Court as protectors of civil liberties not only



have the power and jurisdiction but also the obligation to repair the damage caused by officers of the State to fundamental rights of citizens.

Award of compensation in a proceeding under Article 32 by this Court or by the High Court under Article 226 of the Constitution is a remedy available in public law, based on strict liability for contravention of fundamental rights to which the principle of sovereign immunity does not apply, even though it may be available as a defence in private law in an action based on tort. This is a distinction between the two remedies to be borne in mind which also indicates the basis on which compensation is awarded in such proceedings. Enforcement of the constitutional right and grant of redress embraces award of compensation as part of the legal consequences of its contravention.

A claim in public law for compensation for contravention of human rights and fundamental freedoms, the protection of which is guaranteed in the Constitution, is an acknowledged remedy for enforcement and protection, of such rights, and such a claim based on strict liability made by resorting to a constitutional remedy provided for the enforcement of a fundamental right is distinct from, and in addition to, the remedy in private law for damages for the tort resulting from the contravention of the fundamental right. The defence of sovereign immunity being inapplicable, and alien to the concept of guarantee of fundamental rights, there can be no question of such a defence being available in the constitutional remedy. It is this principle which justifies award of monetary compensation for contravention of fundamental rights guaranteed by the Constitution, when that is the only practicable mode of redress available for the contravention made by the State or its servants in the purported exercise of their powers, and enforcement of the fundamental right is claimed by resort to the remedy in public law under the Constitution by recourse to Articles 32 and 226 of the Constitution.

The Court is not helpless and the wide powers given to this Court by

Article 32, which itself is a fundamental right, imposes a constitutional obligation on this Court to forge such new tools, which may be necessary for doing complete justice and enforcing the fundamental rights guaranteed in the Constitution, which enable the award of monetary compensation In appropriate cases, where that is the only mode of redress available.

The power available to this Court under Article 142 is also an enabling provision in this regard. The contrary view would not merely render the court powerless and the constitutional guarantee a mirage, but, may, in certain situations, be an incentive to extinguish life, if for the extreme contravention the court is powerless to grant any relief against the State, except by punishment of the wrongdoer for the resulting offence, and recovery of damages under private law, by the ordinary process.

If the guarantee that deprivation of life and personal liberty cannot be made except in accordance with law, is to be real, the enforcement of the right in case of every contravention must also be possible in the constitutional scheme, the mode of redress being that which is appropriate in the facts of each case.

This remedy in public law has to be more readily available when invoked by the have-nots, who are not possessed of the wherewithal for enforcement of their rights in private law, even though its exercise is to be tempered by judicial restraint to avoid circumvention of private law remedies, where more appropriate.

Convicts, prisoners or under-trials are not denuded of their fundamental rights under Article 21 and it is only such restrictions, as are permitted by law, which can be imposed on the enjoyment of the fundamental rights by such persons. It is an obligation of the State, to ensure that there is no infringement of the indefeasible rights of a citizen to life, except in accordance with law while the citizen is in its custody.



The precious right guaranteed by Article 21 of the Constitution of India cannot be denied to convicts, under- trials or other prisoners in custody, except according to procedure established by law.

There is a great responsibility on the police or prison authorities to ensure that the citizen in its custody is not deprived of his right to life. His liberty is in the very nature of things circumscribed by the very fact of his confinement and therefore his interest in the limited liberty left to him is rather precious. The duty of care on the part of the State is strict and admits of no exceptions.

The wrongdoer is accountable and the State is responsible if the person in custody of the police is deprived of his life except according to the procedure- established by law.

The compensation is in the nature of the exemplary damages awarded against the wrong-doer for the breach of its public law duty and is independent of the rights available to the aggrieved party to claim compensation under the private law in an action based on tort, through a suit instituted in a court of competent jurisdiction or/and prosecute the offender under the penal law.

This Court and the High Courts, being the protectors of the civil liberties of the citizen, have not only the power and jurisdiction but also an obligation to grant relief in exercise of its jurisdiction under Articles 32 and 226 of the Constitution to the victim or the heir of the victim whose fundamental rights under Article 21 of the Constitution of India are established to have been flagrantly infringed by calling upon the State to repair the damage done by its officers to the fundamental rights of the citizen, notwithstanding the right of the citizen to the remedy by way of a civil suit or criminal proceedings.

In **Rudul Sah v. State of Bihar and Another, [1983] 3 S.C.R. 508**, the Hon'ble Supreme Court held that in a petition under Article 32 of the

Constitution, this Court can grant compensation for deprivation of a fundamental right. That was a case of violation of the petitioner's right to personal liberty under Article 21 of the Constitution. Chandrachud, C.J., dealing with this aspect, stated as under:-

"It is true that Article 32 cannot be used as a substitute for the enforcement of rights and obligations which can be enforced efficaciously through the ordinary processes of Courts, Civil and Criminal. A money claim has therefore to be agitated in and adjudicated upon in a suit instituted in a court of lowest grade competent to try it. But the important question for our consideration is whether in the exercise of its jurisdiction under article 32, this Court can pass an order for the payment of money if such an order is in the nature of compensation consequential upon the deprivation of a fundamental right. The instant case is illustrative of such cases..... ordinary remedy of a suit if his claim to compensation was factually controversial, in the sense that a civil court may or may not have upheld his claim. But we have no doubt that if the petitioner files a suit to recover damages for his illegal detention, a decree for damages would have to be passed in that suit, though it is not possible to predicate, in the absence of evidence, the precise amount which would be decreed in his favour.

In these circumstances, the refusal of this Court to pass an order of compensation in favour of the petitioner will be doing mere lip-service to his fundamental right to liberty which the State Government has so grossly violated. Article 21 which guarantees the right to life and liberty will be denuded of its significant content if the power of this Court were limited to passing orders to release from illegal detention. One of the telling ways in which the violation of that right can reasonably be prevented and due compliance with the mandate of Article 21 secured, is to mulct its violators in the payment of monetary compensation. Administrative sclerosis leading to flagrant infringements of fundamental rights cannot be



corrected by any other method open to the judiciary to adopt. The right to compensation is some palliative for the unlawful acts of instrumentalities which act in the name of public interest and which present for their protection the powers of the state as shield. If Civilisation is not to perish in this country as it has perished in some others too well-known to suffer mention, it is necessary to educate ourselves into accepting that, respect for the rights of individuals is the true bastion of democracy. Therefore, the State must repair the damage done by its officers to the petitioner's rights. It may have recourse against those officers"

(pp.513-14)(*emphasis added*)

D.K.Basu Vs. State of W.B. 1997 (1) SCC 416

Supreme Court

Observations of Hon'ble Supreme Court in above-said landmark judgment:

“to sum up, it is now a well-accepted proposition in most of the jurisdictions, that monetary or pecuniary compensation is an appropriate and indeed an effective and sometimes perhaps the only suitable remedy for redressal of the established infringement of the fundamental right to life of a citizen by the public servants and the State is vicariously liable for their acts. The claim of the citizen is based on the principle of strict liability to which the defence of sovereign immunity is not available and the citizen must receive the amount of compensation from the State, which shall have the right to be indemnified by the wrongdoer. In the assessment of compensation, the emphasis has to be on the compensatory and not on punitive element. The objective is to apply balm to the wounds and not to punish the transgressor or the offender, as awarding appropriate punishment for the offence (irrespective of compensation) must be left to the criminal courts in which the offender is prosecuted, which the State, in law, is duty-bound to do. The award of compensation in the public law

jurisdiction is also without prejudice to any other action like civil suit for damages which is lawfully available to the victim or the heirs of the deceased victim with respect to the same matter for the tortious act committed by the functionaries of the State. The quantum of compensation will, of course, depend upon the peculiar facts of each case and no straitjacket formula can be evolved in that behalf. The relief to redress the wrong for the established invasion of the fundamental rights of the citizens, under the public law jurisdiction is, thus, in addition to the traditional remedies and not in derogation of them. The amount of compensation as awarded by the Court and paid by the State to redress the wrong done, may in a given case, be adjusted against any amount which may be awarded to the claimant by way of damages in a civil suit.”

Custodial death is perhaps one of the worst crimes in a civilized society governed by the rule of law. The rights inherent in Articles 21 and 22(1) of the Constitution require to be jealously and scrupulously protected. The expression "life or personal liberty" in Article 21 includes the right to life with human dignity and thus it would also include within itself a guarantee against torture and assault by the State or its functionaries. The precious right guaranteed by Article 21 cannot be denied to convicts, under trials, detenus and other prisoners in custody, except according to the procedure established by law by placing such reasonable restrictions as are permitted by law. It cannot be said that a citizen 'shed off his fundamental right to life the moment a policeman arrests him. Nor can it be said that the right to life of a citizen can be put in 'abeyance' on his arrest. Any form of torture or cruel, inhuman or degrading treatment would fall within the inhibition of Article 21, whether it occurs during investigation, interrogation or otherwise. If the functionaries of the Government law-breakers, it is bound to breed contempt for law and would encourage lawlessness and every man would have the tendency to become law unto himself thereby leading to anarchy. No civilized nation can permit that to happen. The Supreme Court as the

custodian and protector of the fundamental and the basic human rights of the citizens cannot wish away the problem. The right to interrogate the detenus, culprits or arrestees in the interest of nation, must take precedence over an individual's right to personal liberty. The latin maxim *salus populi suprema lex* (the safety of the people is the supreme law) and *salus republicae supreme lex* (safety of the State is the Supreme law) coexist and are not only important and relevant but lie at the heart of the doctrine that the welfare of an individual must yield to that of the community. The action of the State, however, must be "right, just and fair". (Emphasis added)

Other landmark judgments of the Hon'ble Court

I. Ajab Singh & Anr. vs State Of Uttar Pradesh & Ors. on 9 March, 2000

(Equivalent citations: 2000 ACJ 470, AIR 2000 SC 3421, 2000 (1) ALD Cri 692)

Supreme Court of India

Brief Facts of the Case

The parents of Rishipal, age 32 years who died while in judicial custody on 1st June, 1996 filed a writ petition before the Hon'ble Supreme Court praying for investigation by the CBI and payment of compensation for his death. According to the jail authorities, Rishipal died due to illness while undergoing treatment in hospital. The deceased died within 3 days after lodging into prison and as per Post Mortem Report, there are 5 injuries on his body and cause of death is due to "shock and haemorrhage as a result of ante mortem injuries".

Decision of the Hon'ble Court

While directing for the investigation of the case by CBI, the Hon'ble

Court held the State of Uttar Pradesh responsible in public law for the death of Rishipal and awarded compensation of Rs. 5 lakhs to the petitioner. The Hon'ble Court observed that:

“We do not appreciate the death of persons in judicial custody. When such deaths occur, it is not only to the public at large that those holding custody are responsible; they are responsible also to the courts under whose orders they hold such custody.” (Para 8)

II. Sundaram vs National Human Rights Commission on 5 January, 2010 (W.P.NOs.27281 to 27283 of 2009)

Madras High Court

Facts of the case:

Sh. Muniraj, a remand prisoner, committed suicide by hanging in the strong room of Mohan Kumaramangalam Government Medical College Hospital, Salem on 24.12.2000. This custodial death was attributed due to negligence and carelessness of three police officials who were in charge of strong room. Based on directions of the NHRC, State Government sanctioned a compensation of Rs. 50,000 to the legal heir of the deceased and directed to recover the said amount from the erred police officials. The alleged police officials challenged the order of the State Government in Madras High Court.

Decision of the Hon'ble Court

While upholding the directions of the NHRC for awarding compensation to the legal heirs of the deceased, the Hon'ble Court observed that

“the question about recovery of money from a guilty Government servant responsible for public tort liability faced by the State came up for consideration by the Division Bench of this Court presided by A.P. Shah,

Chief Justice (as he then was) vide its judgment in T. Loganathan Vs. State Human Rights Commission, Tamil Nadu reported in 2007 (7) MLJ 1067. This Court after referring to various decisions of the Supreme Court held that there was no illegality in ordering recovery from the salary of the guilty Government servant if the Human Rights Commission imposes liability on the State.” (Para 12)

III. Amandeep Vs State Of Punjab & Another on 12 October, 2012

CWP No.5939 of 1994

Punjab-Haryana High Court

Brief facts of the case

Surinder Mohan, a life convict, was assaulted by one co-inmate in Ferozpur Central Jail who later succumbed to injuries in the hospital. The petitioner, son of the deceased, alleged that the prison authorities failed to protect his father and due to delay in medical treatment, his father died and prayed for compensation and suitable actions against jail authorities. However, as per prison authorities, since the co-inmate assaulted the deceased, an FIR was registered against the offender and necessary steps were promptly taken to save the life of the deceased by providing medical aid. It is, therefore, contended that the State is not liable to pay compensation, as there was no negligence on the part of the State/Jail Authorities in the performance of its duties.

Decision of the Hon’ble Court

The Hon’ble Court while awarding the compensation of Rs. 2 lakhs to the petitioner, observed that:

“State cannot escape liability to compensate the family of the deceased, because it was due to sheer negligence in ensuring safety of jail

inmates that life of Surinder Mohan was shortened. The State cannot absolve itself from the responsibility simply on the contention that it was a case of assault by a co-prisoner, who was later on tried of the offence for committing murder of Surinder Mohan for the said incident and sentenced. There has to be round the clock fool-proof security of the jail inmates. The State cannot even escape liability in a case where a prisoner commits suicide by hanging or otherwise, because that would also amount to negligence in not keeping constant watch on the prisoners. (Para 7)

“In my view there was a total failure of the Jail Authorities in keeping proper security to guarantee the life and safety of the inmates, resulting into homicidal death of Surinder Mohan.” (Para 18)

“The State cannot oppose and choke the voice of a person solely on the ground that he was suffering imprisonment. There may be unruly elements in jail but they cannot be allowed to become unruly and granted licence to kill another, may be out of vengeance or may be for reasons best known to them. When the duty of the State comes into play, it amounts to violation of the human rights.” (Para 20)

IV. Banalata Dash Vs State Of Orissa & Ors. on 13 January, 2012

W.P.(C) NO. 148 OF 2003

Orissa High Court

Brief Facts of the case

The petitioner, mother of the deceased-SmrutiRanjan Das @ Papu, has filed this writ petition seeking directions from the Court to handover investigation of the custodial death of her son to CBI for independent and fair investigation and to direct the State to give adequate compensation to her for the death of her son. According to the Jail authorities Choudwar jail, it was pleaded that the deceased had committed suicide inside jail on

02.12.2001 and was not murdered. The Superintendent pleaded that if the any of the inmate desires to commit suicide, it is difficult to prevent him that too in course of mentally depressed as happened in the present case.

Decision of the Hon'ble Court

Considering it a case of custodial death, the Hon'ble Court awarded the compensation of Rs. 3 lakhs to the petitioner. The Hon'ble Court observed that

“It is duty of the jail authorities to ensure safety and security of the inmates of the jail. Only when they have been negligent on their part, such an incident could take place. Though the authorities have termed the incident as a suicide, foul play cannot be ruled out. Therefore, this Court comes to the conclusion that it is a case of custodial death and the authorities are responsible for the same. The authorities being the employees of the State of Orissa, the State is vicariously liable for the death of the aforesaid deceased-SmrutiRanjan Das” (Para 11)

V. FattujiDajibaGedamvs Superintendent Of Police, Akola on 17 September, 2001

Bombay High Court

Brief facts of the case

The petitioner's son Suresh Fattuji Gedam, died in police lock-up of Police Station, Ramdaspath, Akola on 30-9-1999. According to the petitioner the post mortem report discloses that his son Suresh had 21 injuries on different parts of his body, out of them 20 were contusions and one linear abrasion. The medical officer who performed the post mortem opined cause of death as syncope due to sudden cardiac arrest due to multiple injuries sustained. He also opined that all injuries were ante-mortem and within 24 hours and were caused by hard blunt object. The petitioner prayed for independent inquiry into the matter and for

reasonable compensation in the circumstances of the case.

However, as per the police version, the deceased was caught red handed while committing theft and the watchman and two others had assaulted him. As a result of those injuries, the deceased died. There is no torture in police custody.

Decision of Hon'ble Court

The Hon'ble Court held that the deceased Suresh Fattuji Gedam died while he was in police custody, because of the injuries suffered out of custodial violence and awarded compensation to the legal heir of the deceased.

VI. KumariRojallinNayakvs State Of Orissa And Others on 30 July, 2012

W.P. (C) No. 16060 of 2005

Orissa High Court

Brief facts of the case

The petitioner, the daughter of Late Ganeswar Nayak filed this writ application claiming compensation of Rs. 4,00,000/- due to the death of her father in the Choudwar Jail on 09.09.2001. As per the Jail authorities, the deceased committed suicide in the jail.

Decision of Hon'ble Court

While deciding the death of the deceased Ganeswar Nayak as a custodial death and holding the jail authorities responsible for the same, the Hon'ble Court awarded the compensation of Rs. 3 lakhs. The Hon'ble Court observed that-

“It is duty of the jail authorities to ensure safety and security of the inmates of the jail. Only when there is negligence on their part, such an

incident could take place. Though the authorities have termed the incident as a suicide, foul play cannot be ruled out. Therefore, this Court comes to the conclusion that it is a case of custodial death and the authorities are responsible for the same. The authorities being the employees of the State of Orissa, the State is vicariously liable for the death of the aforesaid deceased Ganeswar Nayak. (Para 6)

VII. Musstt. Khamala Begum vs State Of Assam And Ors. on 8 December, 2003

Gauhati High Court

Brief facts of the case

The petitioner prayed compensation for the alleged death of her husband while in judicial custody. As per Jail Superintendent, Barpeta, the deceased committed suicide in the toilet. It is the stand of State that since the deceased had committed suicide, they are not liable to pay any compensation.

Decision of the Hon'ble Court

While deciding the matter, Hon'ble Court observed that even if it is held to be a case of suicide as is sought to be projected by the State (respondent) in their affidavit, can the respondents and for that matter, the State absolve its responsibility towards protection of the life even of a criminal as guaranteed under Article 21 of the Constitution of India? A duty is cast on the Jail authorities to look after the well-being including the protection of lives and liberties of the jail inmates. If the plea adopted by the respondent State and that too in a most casual and irresponsible manner is allowed to stand absolving of the responsibilities of the jail authorities, same will lead to chaotic and unsecured situation for the jail inmates. As regards the payment of compensation, it has been held that claim in public law for compensation for unconstitutional deprivation of fundamental right of life

and liberty, the protection of which is guaranteed under the Constitution, is a claim based on strict liability and is in addition to the claim available in private law for damages for tortuous acts of the public servants. Award of compensation for established infringement of the indefeasible rights guaranteed under Article 21 of the Constitution is a remedy available in public law since the purpose of public law is not only to civilize public power but also to assure the citizens that they live under a legal system where in their right and interests shall be protected and preserved. Grant of compensation in proceedings under Article 226 of the Constitution of India for the established violation of the fundamental rights guaranteed under Article 21, is an exercise of the courts under the public law jurisdiction for penalizing the wrongdoer and fixing the liability for the public wrong on the State which failed in the discharge of its public duty to protect the fundamental rights of the citizen.

The Hon'ble Court awarded a compensation of Rs. 1 lakh to the petitioner for the wrongful loss of life of her husband besides directing independent inquiry and departmental action against erring officials.

VIII. Shahnaz Begum w/o Syed Mushtaq vs State Of Maharashtra And Ors. on 13 February, 2002

Bombay High Court

Brief facts of the case

This is a case of custodial death of an accused while in police custody. Deceased Syed Mushtaq was arrested on 30-10-1994 by the City Chowk Police, Aurangabad and found dead on the night between 8th and 9th November, 1994 in the Kranti Chowk Police Station lock up in the city of Aurangabad. 1994. In the morning of 9th November 1994, it was noticed that the deceased was found tied to iron gate of the lock up cell by a shirt in standing position. The police had registered it as an Accidental Death Case No. 57/94. Aurangabad. As per the post mortem report, following 5



external injuries were noticed. The petitioner, wife of the deceased filed a writ petition seeking directions of the Court for thorough and detailed investigation by C.B.I, for the death during police custody and for payment of compensation.

Decision of the Hon'ble Court

The Hon'ble Court decided that the State of Maharashtra is responsible in public law for the death of Syed Mushtaq and, therefore, must pay compensation to the petitioner and children of the deceased Syed Mushtaq.

IX. Puppala Seetaramaiah vs Superintendent, Sub-Jail And ors ... on 24 December, 2002

Andhra High Court

Brief facts of the case

The petitioner's son Puppala Anji Babu, an accused for the offence punishable under Section 304-B IPC in Cr.No. 149/96 of Bapatla Town Police Station, was remanded to judicial custody. The deceased prisoner committed suicide by hanging himself in one of the bathrooms of Sub-Jail. The question to decide before the Hon'ble Court is whether the State is liable for damages for the voluntary act of a prisoner who committed suicide while he was in judicial custody.

Decision of the Hon'ble Court

While deciding the matter, the Hon'ble Court enunciated following principles:

1. State is liable to compensate for the death of a remand prisoner, if died, due to the negligence of the prison authorities; and
2. The police/prison authorities owe a duty of care to an arrested

person and must take reasonable care to ensure that he does not suffer physical injury as a consequence of his own acts, or the acts of a third party; and

3. Negligence on the part of prison authorities for an action in tort has to be established by claimant in a properly constituted civil suit.

The Hon'ble Court made the following observation while deciding the matter

“It is no doubt true that a prisoner enjoys all his civil/Fundamental rights except those expressly removed by statute/prison rules. It was held by English Courts that there is a substantial overlap between the maxims ***novus actus interveniens*** and ***volenti non fit injuria***. In principle both can apply to the suicide of a sane adult. A free, deliberate and informed act or omission by a sane person, which is intended to exploit the situation created by the negligence of the defendant, negatives the casual connection between the negligence and the harm. The failure of the prison authorities to take reasonable care provided only the opportunity or the setting for the act of suicide. The initial negligence was the *causa sine qua non* but the direct and proximate cause of the suicide was the deceased's own decision and act and any other approach would extend the law of negligence beyond its proper boundaries. In view of the fact that prisoners are more than usually likely to attempt suicide or self injury the risk of suicide is particularly high among prisoners on remand facing a new environment and an uncertain future. In ***Kirkham v. Chief Constable of the Greater Manchester Police, 1990 (2) QB 283***, damages were awarded to the widow of a prisoner who had committed suicide shortly after being handed over to the prison authorities from police custody. 1934. On appeal, while confirming the awarding of damage, the Court of Appeal held that neither the defence of ***volenti non fit injuria*** nor ***ex turpicausa non oritur actio*** could be available to the police”. (para 14 and 15)

X. S. Venkatachalam Vs. Government of Tamilnadu on 24 November, 2010

Madras High Court

Brief facts of the case

It is a case of custodial death in police custody. The deceased committed suicide in police lock-up using lungi as a noose. Departmental actions were taken against four police constables for negligence and carelessness on duty. Further, the NHRC directed the State to pay compensation to the next of the kin of the deceased as death was caused due to carelessness of the police personnel on duty. Acting on the direction of the NHRC, the State granted compensation and made an order to recover the same from erring police officials. Against the said order, the said constables moved a writ petition to the High Court seeking quashing of the impugned order.

Decision of the Hon'ble Court

Regarding granting of compensation to the next of the kin of the deceased, the wife of the deceased Marisamy, Smt. M. Kalithai filed a writ petition before Madras High court (W.P.No.11569 of 1999). The Division Bench of the Madras High Court in its judgment held that the arrest of late Marisamy and lack of care in saving his life while in custody was sufficiently proved and that the findings established are enough to order compensation by the State. Therefore, the State was directed to pay a sum of Rs.2 lakhs as compensation to Smt. M. Kalithai towards the death of her husband Marisamy, whose death in the lock-up was due to the illegality committed by the policemen.

The Hon'ble Court upholds the order of the State government to recover the amount of the compensation from the salary of the erring police officials and dismissed the petition of the petitioner.

XI. Sabitri Kanhar & Ors. Vs. State Of Orissa & Ors. on 18 March, 2011

W.P. (C) NO.23407 OF 2010 (Decided on 18.3.2011)

Orissa High Court

Brief facts of the case

It is the case wherein two convict prisoners namely Sudarsan Kanhar and Duryodhan Kanhar while their sentence in Special Sub-Jail, Boudh, were stoned to death on the night of 21/22.09.2010 by another convict. The petitioners, wives of both the deceased filed writ petition seeking adequate compensation.

Decision of the Court

The hon'ble Court held that since alleged ghastly incident which had taken place inside the jail custody and two convicts who are the husbands of the petitioners died on account of the assault by another convict, the petitioners are entitled to compensation for the negligence on the part of the Jail Superintendent and the Staff referred to supra for having killed the husband of the petitioners by co-convicts.

XII. Satyabhama Das Vs. State Of Orissa And Others on 20 September, 2011

Orissa High Court

Brief facts of the case

The deceased Maheswar Das was sentenced and convicted for a murder charge. While in jail custody of Choudwar jail, the deceased committed suicide. Due to delay in receipt of the information to his wife, the dead body was disposed of by jail authorities itself. According to the Jail authorities, the deceased was a psychiatric patient and was suffering from

pulmonary tuberculosis for which regular medical treatment was rendered to him. The deceased earlier also attempted to commit suicide but was saved. Since it was a clear cut case of suicide, thus the jail authorities are not responsible for negligence. The writ petition was filed by the widow of the deceased seeking independent inquiry into the death and suitable compensation.

Decision of the Hon'ble Court

The Hon'ble Court observed that the husband of the petitioner died while in jail custody. The deceased committed suicide by hanging himself with the help of his own daily wearing. Jail authorities have not stated anything as to what special preventive measures were taken by them to prevent deceased Maheswar Das from committing suicide, who according to them, was a psychiatric patient and earlier on 27.06.1998 the deceased had tried to commit suicide in jail custody, but became unsuccessful. If proper attention had been given, deceased Maheswar Das could not have committed suicide inside the jail by hanging himself by means of his daily wearing materials. The Jail Authorities could have provided such daily wearing by means of which he could not have been able to commit suicide. Further, he could have been kept inside a cell where any attempt to commit suicide could have been noticed either by jail inmates or by jail employees. The Hon'ble Court further observed that the Hon'ble Supreme Court in several decisions has observed that the precious right guaranteed under Article 21 of the Constitution of India cannot be denied to the under trial or other prisoners in custody, except according to the procedure established by law. The prison authority has a great responsibility to ensure that a citizen in custody is not deprived of his right to life. He must be afforded with minimum necessities of life.

While deciding the matter, the Hon'ble Court held that

“we are not satisfied that the opposite party-authorities have taken adequate care of the deceased-Maheswar Das in providing proper medical

treatment and preventive measures for which he died prematurely at the age of 45 years by committing suicide. Therefore, the widow-dependants of the deceased-Maheswar Das are entitled for compensation.” (Para 16).

**XIII. KewalPati (Smt.) Vs. State of U.P. and others, (1995) 3
SCC 600,**

Supreme Court of India

The deceased was a convict and working as Nambardar in the Jail. He was strict in maintaining discipline amongst the co-accused. It was due to this strictness in his behaviour as Nambardar, that he was attacked and killed by a co-accused. It was held that even though the victim was a convict and serving his sentence yet the authorities were not absolved of their responsibility to ensure his life and safety in the jail. The prisoner does not cease to have his constitutional right except to the extent he has been deprived of it in accordance with law. He was entitled to the protection. Since the killing took place when he was in jail, it resulted in deprivation of his life contrary to law. It was held that his untimely death deprived his family of his company and affection. Since it has taken place while he was serving his sentence due to failure of authorities to protect him, they were entitled to be compensated.

**XIV. In Court on its own Motion Vs. State and another, 2011
(4) R.C.R. (Criminal) 249**

Delhi High Court,

From the inquest report submitted by the Metropolitan Magistrate, who conducted the enquiry into the incident of killing of a life convict, it was found crystal clear that the death had occurred while the victim was in jail custody and certain persons were responsible for the same. No comment was made with regard to the persons who were responsible in mercilessly assaulting the said victim to death. But it was noticed that the



life spark of the victim got extinguished because of the said assault. The compensation was awarded to the family of the victim.

**XV. Malti Devi Vs. State of Bihar, 2011(6) R.C.R. (Criminal)
433,**

Patna High Court

It was observed that the Court was not concerned as to whether the death was caused by some other co-prisoners or by excessive or illegal action of any of the jail officials. The basic fact remains that when the husband of the petitioner was in custody the homicidal death had taken place. The jail authorities were to ensure the safety and protection of all the inmates and there is definitely lapse in the security. In that case uncle of the petitioner filed an FIR with the police raising suspicion on the co- villager of the deceased, who were also lodged at the relevant time and the matter was still under investigation. The compensations in that case were awarded.

SECTION

IV

Suicide Prevention Plan

Introduction

Prison suicide is a complex phenomenon. The following points cannot be over-emphasized and should inform the theoretical foundations of any prevention program:

- Suicide has no single trigger and no single solution.
- A multi-disciplinary approach is required for effective prevention.
- Common profiles of prison suicides must be viewed with caution.
- Psychopathology alone cannot explain incidents of prison suicide. Structural analysis of the prison environment is a critical aetiological factor that must be included in understanding of prison suicide.

Critical Ingredient of Suicide Prevention Plan⁹

The suicide prevention plan should include the following elements:

1. **Identification.** The receiving screening form should contain observation and interview items related to the inmate's potential suicide risk.
2. **Training.** All staff members who work with inmates should be trained to recognize verbal and behavioural cues that indicate potential suicide.
3. **Assessment.** This should be conducted by a qualified mental health professional, who designates the inmate's level of suicide risk.

⁹Adopted from National Commission on Correctional Health Care Standards for Health Services in Prisons (P - 58), US Deptt. Of Justice - reproduced from 'Prison Suicide: An Overview and Guide to Prevention' published by National Institute of Corrections, US

4. **Monitoring.** The plan should specify the facility's procedures for monitoring an inmate who has been identified as potentially suicidal. Regular, documented supervision should be maintained.
5. **Housing.** A suicidal inmate should not be placed in isolation unless constant supervision can be maintained. If sufficiently adequate staff is not available to provide constant supervision when needed, the inmate should not be isolated. Rather, he/she should be housed with another resident or in a dormitory and checked after every 10- 15 minutes. The room should be as nearly suicide-proof as possible (that is, without protrusions of any kind that would enable the inmate to hang him/herself).
6. **Referral.** The plan should specify the procedures for referring potentially suicidal inmates and attempted suicides to mental health care providers or facilities.
7. **Communication.** Procedures for communication between health care and prison personnel regarding the status of the inmate should exist, to provide clear and current information.
8. **Intervention.** The plan should address how to handle a suicide in progress, including how to cut down a hanging victim and other first-aid measures.
9. **Notification.** Procedures for notifying prison administrators, outside authorities, and family members of potential, attempted, or completed suicides should be in place.
10. **Reporting.** Procedures for documenting the identification and monitoring of potential or attempted suicides should be detailed, as should procedures for reporting a completed suicide.
11. **Review.** The plan should specify the procedures for medical and administrative review if a suicide does occur.

I. Identification- Intake Screening and Profiling

Intake screening and on-going assessment of all inmates are critical to a prison's suicide-prevention efforts. The key to identifying potentially suicidal behaviour in prison inmates is through inquiry during intake screening/assessment and other high-risk periods of incarceration.

Intake screening for suicide risk can be included on the medical screening form or it can be a separate form. The screening process should include questions about past suicidal ideation and/ or attempts; current ideation, threat, or a plan to commit suicide; prior mental health treatment or hospitalization; any recent significant loss (e.g., job, relationship, death of family member or close friend); history of suicidal behaviour by a family member or close friend; suicide risk during prior confinement; and the arresting and/or transporting officer(s)' belief that the inmate is currently at risk. Specifically, the suicide screening process should determine the following:

1. Was the inmate a medical, mental health, or suicide risk during any prior contact and/or confinement in this facility?
2. Does the arresting officer have any information (e.g., from observed behaviour, documentation from sending agency, conversation with family member) that indicates the inmate is currently a medical, mental health, or suicide risk?
3. Has the inmate ever attempted suicide?
4. Has the inmate ever considered suicide?
5. Is the inmate being treated for mental health or emotional problems, or has the inmate been treated in the past?
6. Has the inmate recently experienced a significant loss (e.g., relationship, death of family member or close friend, job)?

7. Has a family member or close friend ever attempted or committed suicide?
8. Does the inmate feel there is nothing to look forward to in the immediate future (i.e., is the inmate expressing helplessness and/or hopelessness)?
9. Is the inmate thinking of hurting and/or killing himself or herself?

An inmate's verbal responses during the intake screening process are critically important when assessing the risk of suicide. However, staff should not rely exclusively on an inmate's statement that he or she is not suicidal and/or does not have a history of mental illness or suicidal behaviour, particularly when the inmate's behaviour, actions, or previous confinement in the facility suggest otherwise. The process should also include procedures for referring the inmate to mental health and/or medical personnel for a more thorough and complete assessment.

An illustrative suicide checklist is depicted at **Box 2**.

The **Jail Suicide Assessment Tool (JSAT)** is a suggestive interview format for conducting structured suicide risk assessment interviews with adults who are incarcerated. The foundation of the JSAT is based upon two points:

- 1) The kind of information obtained through a structured clinical interview is superior to the results of any single psychological test or scale, and
- 2) The essential feature of assessing suicidal risk is informed, professional judgment.

The primary purpose of the JSAT is to cue jail staff in the gathering of information generally viewed as essential in the decision making process for assessing suicide risk. The details on **JSAT** including **Prison Suicide Risk Assessment checklist** are annexed herewith at **Appendix C and**

Appendix D respectively. They are very useful in the identification of potential suicidal inmates and act as a ready reckoner to staff. These questions are designed to elicit and formulate information as part of the assessment process.

These checklists are an important part of a comprehensive suicide prevention programme for a number of reasons:

1. They provide the intake staff with structured questions on areas of concern that need to be covered.
2. When there is little time available to conduct in-depth evaluation, they act as a memory aid for busy intake staff.
3. They facilitate communication between officers and health care and mental health staff.
4. They provide legal documentation that an inmate was screened for suicidal risk upon entrance into the facility and again, as conditions changed.

Box 2

Potential Suicide Checklist

- Has the inmate sustained a recent loss (loved one, friend, home, job) or a series of losses?
- Is the inmate depressed?
- Does he have a religious and/or philosophical background that supports suicide?
- Does he believe that suicide is an acceptable release (from prison, life)?
- Is he socially isolated from other inmates and staff (without friends and other social support systems)?

- Is this the first time in prison?
- Does he seem overly embarrassed, ashamed, or guilty about the crime committed?
- Has inmate been previously treated for mental illness, emotional disturbance?
- Does inmate have a history of self-destructive acts?
- Has a member of his family attempted suicide?
- Does he think about suicide at this time?
- Is he psychotic?
- Is he hearing voices telling him to kill himself?
- Has inmate expressed wish to die or failed to perform life-saving acts?
- Does inmate have terminal medical condition?
- Does inmate talk or think about giving possessions away or writing a will?
- Does inmate talk about a particular method/plan for killing himself?
- Is that method/plan available

Limitation of Screening Assessment

Notwithstanding the importance of screening procedures, they play a very small part in the prevention of suicides in prisons. All a screening instrument can achieve is to inform staff that a particular prisoner has an elevated risk of attempting suicide at some stage in his or her period of incarceration but they do not predict when an attempt will occur or what the specific precipitants will do in a given case. Because many prison suicides occur after the initial period of incarceration (some after many

years), it is not sufficient to only screen inmates only at the time of intake, but eventually at regular intervals.

It is pertinent to note that screening should not be a single event but a continuous process because inmates can become suicidal at any point during their confinement, including during initial admission into the facility, after adjudication when the inmate is returned to the facility from court, after receiving bad news or after suffering any type of humiliation or rejection, during confinement in isolation or segregation, and following a prolonged stay in the facility. To be effective, suicide prevention must involve on-going observation.

Box 3

Best Practices in Suicide Risk Assessment Documents

Timeliness

- Upon referral, the assessment occurs promptly and the time and date of the referral are clearly stated in the risk assessment.

Referral

- The specific reason for the referral and the referral source are clearly identified in the risk assessment.
- The referral source is interviewed and his/her comments are included in the risk assessment.

Risk Factors

- A standardized risk assessment tool is used to guide the clinical interview and its use is documented in the risk assessment.
- Risk factors for suicide are identified and discussed in the risk assessment.
- If the potential of secondary gain is identified, secondary gain is not used to dismiss significant risk factors to rule out suicide risk.

Protective Factors

- Protective factors are identified, weighed in relation to risk factors, and documented in the risk assessment.
- The clinician weighs the risk factors against the protective factors and makes a clinical judgment.

Diagnosis

- The criteria supporting the diagnosis are clearly stated
- A mental status examination is conducted and findings are documented in the risk assessment.

Follow up Recommendations

- Follow up recommendations are clearly stated.
- The clinician's follow up recommendations are justified based upon the conclusions drawn in the risk assessment.
- Interventions in addition to constant/increased observation are considered and discussed. These interventions are focused on risk factors identified in the assessment, i.e. treatment is initiated.

Consultation

- The clinician consults with mental health clinicians, health care providers, custodial staff, and other staff knowledgeable of the offender.
- The consultation is documented in the risk assessment.

Collateral Information

- A review Collateral Information is conducted, to include mental and physical health records, as well as legal and custodial records.
- Relevant findings are noted in the risk assessment.

Development of Suicide Profiles

Based on the initial screening assessment, suicide profile can be developed that can be used to target high-risk groups and situations. For example, studies show that pre-trial inmates differ from sentenced prisoners with respect to certain key risk factors for suicide.

Profile 1: Pre-trial Inmates

Pre-trial inmates who commit suicide in custody are generally male, young (20-25 years), unmarried, and first time offenders who have been arrested for minor, usually substance related, offences. They are typically intoxicated at the time of their arrest and commit suicide at an early stage of their confinement, often within the first few hours (because of sudden isolation, shock of imprisonment, lack of information, insecurity about the future). A second period of risk for pre-trial inmates is near the time of a court appearance, especially when a guilty verdict and harsh sentencing may be anticipated. A great deal of all jail suicides occurred within three days of a court appearance.

According to a research¹⁰ conducted by Anju Gupta, N.K. Girdhar, Department of Psychiatry, Central Jail Hospital, Tihar, New Delhi, all inmates who committed suicide in these last ten years (2001-2010), were males and of younger age between 22 to 28 years of age except two patients who were 18 years and 38 years of age respectively. All were under-trial detainees, no one was sentenced. Reason might be on-going stress related to court proceedings and anticipation of unfavourable outcome of trial.

Profile 2: Sentenced Prisoners

Compared to pre-trial inmates, those who commit suicide in prison are generally older (30-35 years), violent offenders who commit suicide after

¹⁰Risk Factors of Suicide in Prisoners, an article published in Delhi Psychiatry Journal 2012; 15:(1) © Delhi Psychiatric Society

spending considerable time in custody (often four or five years). Their suicide may be precipitated by a conflict with other inmates or with the administration, a family conflict or breakup, or a negative legal disposition such as loss of an appeal or the denial of parole. Therefore, the suicide rate of long-term inmates seems to increase with length of stay. So called “lifeters” particularly seem to be at a high risk

Women

Women in custody are also at high risk of suicide. Female pre-trial inmates attempt suicide much more often than their female counterparts in the community and as their incarcerated male counterparts. Also the rates for completed suicides of women seem to be higher than those of men. For women, it may be that imprisonment itself has such dramatic effects on their outside relationships that ‘regime features are less directly relevant to the development of suicidal impulses. Thus, prison solutions need to be augmented by measures which reduce the stress placed on women prisoners’ outside relationships. As per data on suicide in prison in India, **the rate of suicide by women inmates are two times higher than their male counterpart.** The average suicidal rate of female inmate is 34.6 as compared to 16.12 in case of male inmates.

II. Staff training

The key to any suicide prevention program is properly trained prison staff, who form the backbone of any prison facility. Prison officers are often the only staff available 24 hours a day; thus, they form the front line of defence in preventing suicides. All prison staff should receive training in the “signs of suicide risk” and “suicide precautions,” along with training in the implementation of the suicide prevention program. All staff members who work with inmates should be trained to recognize verbal and behavioural cues that indicate potential suicide. Training should include:

1. Basic Training/ Induction training — All new employees should undergo classes in the identification, recognition, and mental health referral of suicidal and mentally-ill inmates. It should include instruction regarding staff attitudes about suicide and how negative attitudes impede suicide-prevention efforts, why prison's environments are conducive to suicidal behaviour, potential predisposing factors to suicide, high-risk suicide periods, warning signs and symptoms, how to identify suicidal inmates despite a denial of risk, components of the facility's suicide-prevention policy, and liability issues associated with inmate suicide.
2. Training in Emergency Medical Response- the prison staff should be adequately trained in emergency medical response such as cardiopulmonary resuscitation (CPR) procedures etc. so that in case of any eventuality, they can immediately provide medical aid before taking the victim to the hospital. To ensure an efficient emergency response to suicide attempts, mock drills should be incorporated into both the initial and refresher training for all staff.
3. In-Service Training— At least yearly, the prison staff should undertake advanced classes on suicide prevention to discuss the cases occurred in their prison and resultant lessons. The emphasis should be on sharing best practices and take corrective actions.

III. Communication

The screening and assessment process is one of several tools that can be used to identify suicide risk in inmates. This process, coupled with staff training, will be successful only if effective methods of communication are in place at the prison.

The inmate may exhibit certain behaviours that indicate a risk of suicide. If these behaviours are detected and communicated to others, the likelihood of suicide can be reduced. In addition, most suicides can be prevented by prison staffs who establish trust and rapport with inmates, gather pertinent information, and take action. Three levels of communication are important in preventing inmate suicides:

1. **Communication between the arresting and prison staff.** The scene of arrest is often the most volatile and emotional time for the individual, and the arresting officer should pay close attention to the arrestee during this time. Suicidal behaviour may occur because of the arrestee's feelings of anxiety or hopelessness, and previous suicidal behaviour can be confirmed by family members and/or friends. The arresting must communicate any pertinent information about the arrestee's wellbeing to prison staff. It is also critically important for prison staff to maintain open lines of communication with family members, who often have pertinent information about the inmate's mental health.
2. **Communication among prison staff (prison, medical and mental health personnel).** Effective management of suicidal inmates depends on communication between the prison personnel and other professional staff. Because inmates can become suicidal at any point during confinement, prison staff must maintain awareness, share information and make appropriate referrals to mental health and medical staff. At a minimum, the prison's shift supervisor should ensure that appropriate prison staffs are properly informed of the status of each inmate placed on suicide precautions. At the end of a shift, the shift supervisor should inform the incoming shift supervisor about the status of all inmates on suicide precautions. Multi-disciplinary team meetings that include prison, medical, and

mental health personnel should occur on a regular basis to discuss the status of inmates on suicide precautions. Finally, the authorization for suicide precautions, any changes in suicide precautions, and observation of inmates placed on precautions should be documented on designated forms and distributed to appropriate staff.

3. **Communication between prison staff and the suicidal inmate.**

Prison staff must use various communication skills with the suicidal inmate, including active listening, staying with the inmate if immediate danger is suspected and maintaining contact through conversation, eye contact, and body language. Prison staff should trust their own judgment and observation of risk behaviour and should not let other prison personnel (including mental health staff) convince them to ignore signs of suicidal behaviour. A lack of respect, personality conflicts, and boundary issues often lead to problems with communication. Simply stated, prisons that maintain a multi-disciplinary approach avoid preventable suicides.

A sample Suicide Precaution Protocol is annexed herewith at **Appendix E** delineating the referral process for psychological counselling if the inmate has exhibited some suicidal tendency, categorized as 'high risk' inmate or attempted to commit suicide or self-harm.

IV. Housing

1. Whenever possible, High risk probable suicidal inmates should be housed in the general population unit or mental health unit as the case may be, and should be located close to prison staff. Housing assignments should be based on the ability to maximize staff interaction with the inmate, not on decisions that heighten depersonalizing aspects of confinement.

2. 'Safe Cell' or 'suicide safe cell'- A suicide-safe cell would be a cell or dormitory that has eliminated or minimized hanging points and unsupervised access to lethal materials. All cells designated to house suicidal inmates should be as suicide resistant as possible, free of all obvious protrusions, and provide full visibility. These cells should contain tamperproof light fixtures along with smoke detectors and ceiling and/or wall air vents that are free of protrusions. In addition, the cells should not contain any live electrical switches or outlets, bunks with open bottoms, any type of clothing hook, towel racks on desks or sinks, radiator vents, or any other object that provides an easy anchoring device for hanging. Each cell door should contain a heavy-gauge Lexan (or equivalent grade) clear panel that is large enough to allow staff a full and unobstructed view of the cell interior. Finally, each housing unit in the facility should have an emergency response bag. The bag should contain emergency equipment, including a first aid kit, a pocketmask or face shield, a self-inflating resuscitator bag, and a rescue tool (to quickly cut through fibrous material). Prison staff should ensure that such equipment is in working order on a daily basis.

Suicide by hanging whilst in custody

Hanging accounts for a similarly high proportion of deaths in custody. The usual cause of death is asphyxia by hanging. Further, it could also be partial hanging wherein the height of the drop is less than the height of the person. Therefore, special attentions should be paid to identify ligature material used for hanging and the hanging points used as anchor. According to a research¹¹ based on Central Prison Tihar, Delhi, the method of committing suicide was hanging in all cases except one. This research

¹¹Risk Factors of Suicide in Prisoners-an article published in *Delhi Psychiatry Journal* 2012; 15:(1) © Delhi Psychiatric Society

analyzed custodial suicide occurred in Central Prison, Tihar Delhi during the year 2001-2010.

Ligature material:

The World Health Organization (WHO) in its guidelines¹² to Prison Officers regarding the prevention of suicide has advised to have inspections to identify potential ligature points. As per research on suicide in prison of England and Wales¹³, following ligature material are generally used for hanging:

Ligature Material	Ligature Points
▪ Shoe or boot-laces	▪ Hook or Handle
▪ Clothing or cord removed from clothing	▪ Pipe
▪ Bedding	▪ Bathroom fitting
▪ Belts/dressing gown cords	▪ Window iron grill
▪ Bed-sheet or towel	▪ Door
▪ Bag strap	▪ Light fixtures
▪ Head Scraf/Chunni/Ghamcha	▪ Wooden beam
▪ Pyjama/trouser	▪ Hanging rods
▪ Shirt	
▪ Material procured for suicide - rope	

However, in another study¹⁴ conducted in England, the most common forms of ligature used in prison suicides in England and Wales in 1999/2000 were bedding (56%) and shoe laces (13%). For this reason bedding made of fabric that is resistant to tearing is being piloted (*John Doohan, Safer Custody Group, HM Prisons, personal communication*). National suicide prevention strategies internationally and in England¹⁵

¹²Preventing Suicide A Resource for Prison Officers. Geneva: World Health Organisation, 2000, pp. 1-13.

¹³Safer Prisons: A National Study of Prison Studies 1999-2000 by the National Confidential Inquiry into Suicides and Homicides by People with Mental Illness, 2003- Shaw J, Appleby L, Baker D.

¹⁴Safer Prisons: A National Study of Prison Studies 1999-2000 by the National Confidential Inquiry into Suicides and Homicides by People with Mental Illness, 2003- Shaw J, Appleby L, Baker D.

¹⁵National suicide prevention strategy for England. London: Department of Health, 2002.



place emphasis restricting access to commonly used methods of suicide as a means of reducing suicide rates. The replacement of shoe laces with Velcro fastening has been recommended. Some forces now use replacement clothing and blankets that will not tear. However, modifying the availability of ligatures, particularly those utilizing clothing, is difficult to control while maintaining the dignity of the individual.

Further, majority of hanging were committed in the toilet or bathroom. Moreover, the fact that complete suspension is not required to successfully hang oneself needs to be understood and communicated to those reviewing potential ligature points in institutional settings.

Action Points

- Conducting environmental audits to identify ligature points to minimize the risk of hanging
- Introduction of collapsible material so that anchoring could not be done.
- Develop and disseminate information on appropriate modifications whenever new ligature points are identified and used.
- The development and introduction of safer bedding would limit acts of self-strangulation.

CHECKLIST FOR THE “SUICIDE-RESISTANT” DESIGN OF CORRECTIONAL FACILITIES¹⁶

The safe housing of suicidal inmates is an important component to a prison’s comprehensive suicide prevention policy. Although it is impossible to create a “suicide-proof” cell environment within any prison, given the fact that majority of suicides occur by hanging, but it is certainly reasonable to ensure that all cells utilized to house potentially suicidal inmates are free of all obvious protrusions. And while it is more common for ligatures to be affixed to air vents and window bars (or grates), all cell fixtures should be scrutinized, since bed frames/holes, shelves with clothing hooks, sprinkler heads, door hinge/knobs, towel racks, water faucet lips, and light fixtures have been used as anchoring devices in hanging attempts. As such, to ensure that inmates placed on suicide precautions are housed in “suicide-resistant” cells, prison officials are strongly encouraged to address the following architectural and environmental issues:

1. Cell doors should have large-vision panels of Lexan (or low-abrasion polycarbonate) to allow for unobstructed view of the entire cell interior at all times. If door sliders are not used, door interiors should not have handles/knobs; rather they should have recessed door pulls. Any door containing a food pass should be closed and locked. Interior door hinges should bevel down so as not to permit being used as an anchoring device. Door frames should be rounded and smooth on the top edges. The frame should be grouted into the wall with as little edge exposed as possible.
2. Vents, ducts, grilles, and light fixtures should be protrusion-free and covered with screening that has holes that are ideally 1/8

¹⁶Lindsay M. Hayes © National Center on Institutions and Alternatives, 2011, Deptt of Justice, USA

inches wide, and not more than 3/16 inches wide or 16-mesh per square inch;

3. Wall-mounted corded telephones should not be placed inside cells. Telephone cords of varying length have been utilized in hanging attempts;
4. Cells should not contain any clothing hooks. The traditional, pull-down or collapsible hook can easily be jammed and/or its side supports utilized as an anchor;
5. A stainless steel combo toilet-sink (with concealed plumbing and outside control valve) should be used.
6. Beds should ideally be either heavy moulded plastic or solid concrete slab with rounded edges, totally enclosed underneath. If metal bunks are utilized, they should be bolted flush to the wall with the frame constructed to prevent its use as an anchoring device.
7. Electricity should be turned off from wall outlets outside the cell;
8. Light fixtures should be recessed into the ceiling and tamper-proof. Some fixtures can be securely anchored into ceiling or wall corners when remodelling prohibits recessed lighting.
9. CCTV monitoring does not prevent a suicide; it only identifies a suicide attempt in progress. If utilized, CCTV monitoring should only supplement the physical observation by staff. The camera should obviously be enclosed in a box that is tamper-proof and does not contain anchoring points. It should be placed in a high corner location of the cell and all edges around the housing should be caulked or grouted. Cells containing CCTV monitoring should be painted in pastel colors to allow for better visibility. CCTV

cameras should provide a clear and unobstructed view of the entire cell interior, including all four corners of the room. Camera lens should have the capacity for both night and low light level vision;

10. Cells utilized for suicide precautions should be located as close as possible to a control desk to allow for additional audio and visual monitoring;
11. If modesty walls or shields are utilized, they should have triangular, rounded or sloping tops to prevent anchoring. The walls should allow visibility of both the head and feet;
12. Some inmates hang themselves under desks, benches, tables or stools/pull-out seats. Potential suicide-resistant remedies are: (a) Extending the bed slab for use as a seat; (b) Cylinder-shaped concrete seat anchored to floor, with rounded edges; (c) Triangular corner desk top anchored to the two walls; and (d) Rectangular desk top, with triangular end plates, anchored to the wall. Towel racks should also be removed from any desk area;
13. All shelf tops and exposed hinges should have solid, triangular end-plates which preclude a ligature being applied;
14. Cells should have security windows with an outside view. The ability to identify time of day via sunlight helps re-establish perception and natural thinking, while minimizing disorientation. If cell windows contain security bars that are not completely flush with window panel (thus allowing a gap between the glass and bar for use as an anchoring device), they should be covered with Lexan (or low-abrasion polycarbonate) paneling to prevent access to the bars, or the gap, should be closed with caulking, glazing tape, etc. If window screening or grating is used, covering should have holes

that are ideally 1/8 inches wide, and no more than 3/16 inches wide or 16-mesh per square inch;

15. The mattress should be fire retardant and does not produce toxic smoke. The seam should be tear-resistant so that it cannot be used as a ligature;
16. Mirrors should be of brushed, polished metal, attached with tamper-proof screws;
17. Ceiling and wall joints should be sealed with neoprene rubber gasket or sealed with tamper-resistant security grade caulking or grout for preventing the attachment of an anchoring device through the joints.

(Note : A portion of this checklist was originally derived from R. Atlas (1989), "Reducing the Opportunity for Inmate Suicide: A Design Guide," Psychiatric Quarterly, 60 (2): 161-171. Additions and modifications were made by Lindsay M. Hayes, and updated by Randall Atlas, Ph.D., a registered architect. See also Hayes, L.M. (2003), "Suicide Prevention and "Protrusion-Free Design of Correctional Facilities," Jail Suicide/Mental Health Update, 12 (3): 1-5. Last revised in March 2011)

V. Monitoring/Supervision

Adequate monitoring of suicidal inmates is crucial, particularly during the night shift (when staffing is low) and in facilities where staff may not be permanently assigned to an area (such as police lockups). The level of monitoring should match the level of risk.

Two levels of monitoring/observation are generally recommended for suicidal inmates:

Close observation is recommended for the inmate who is not actively suicidal but expresses suicidal ideation and/or has a recent history of self-harming behaviour. In addition, an inmate who denies suicidal ideation or does not threaten suicide, but demonstrates other behaviour (through actions, current circumstances, or recent history) that could indicate the potential for self-injury, should be placed under close observation. Staff should observe such an inmate in a protrusion-free cell at staggered intervals not to exceed every 10 minutes (e.g., at 5 minutes, 10 minutes, 7 minutes).

Constant observation is recommended for the inmate who is actively suicidal (i.e., either threatening or engaging in suicidal behaviour). Staff should observe such an inmate on a continuous, uninterrupted basis. Some jurisdictions also use an intermediate level of supervision, with observation at staggered intervals that do not exceed 5 minutes.

Other aids (e.g., closed-circuit television monitors, inmate companions, and cellmates) can be used as a supplement to, but never as a substitute for, these observation levels.

VI. Social Intervention

Social and physical isolation and lack of accessible supportive resources intensify the risk of suicide. Therefore, an important element in suicide prevention in correctional settings is meaningful social interaction. Social support is provided through the use of specially trained inmate “buddies” or “listeners”, which seems to have a good impact on the well being of potential suicidal inmates, as they may not trust prison officers but other inmates. Family visits may also be used as a means to foster social support, as well as a source of information about the risk for suicide of an inmate. All prisoners should be engaged in some constructive and recreation activities.

Action Points

- Minimize inactivity and boredom
- Increased recreation and schooling (involving more computer purchases and usage),
- Introduction of an anti-bullying policy,
- A streamlined prisoner grievance process,
- Improved notification of Parole decisions.
- Interaction with the outside world particularly with regard to family and friends including free access to Samaritan services, visiting welfare groups
- Participate in constructive activities such as employment, education and programs that build competency and address offending behaviour.

VII. Prison Administration

The duty of care owed by prison services requires that the prison environment should not be such that it drives prisoners to commit suicide. It appears from the literature that the discharge of the appropriate duty of care by prison services is not limited to preventing prisoners committing suicide. Duty of care extends to the creation and maintenance of a prison environment, which prevents suicidal ideation. Some of the systemic changes that need to be inculcated to secure a 'healthy prison' include:

- The emphasis of general measures designed to reduce stress and promote coping mechanisms rather than concentrate on the recognition of the suicidal behaviour;
- Direct efforts towards reducing stresses and increasing coping

mechanisms in the prison environment, rather than dealing with the issue in terms of some kind of illnesses;

- ❑ Changes in internal cultures and management - a properly managed and motivated service will deliver a high standard despite resource constraints and administrative barriers. This depends on appropriate behaviours being modelled by its leaders;
- ❑ Changing the physical and social environments of prisons and offering opportunities for staff development and training;
- ❑ Reducing the social isolation, segregation and boredom of prisoners, as these factors undermine coping mechanisms;
- ❑ Civilising the system through case management, the modelling of appropriate behaviour by staff, defining the prison officer role in broader terms than custody and security, and engaging prison officers in the treatment and rehabilitation of prisoners;
- ❑ Optimal staff allocation including staff rosters and position duties.

VIII. Administrative Review/ Mortality-Morbidity Review

An administrative review is the final critical component of a comprehensive suicide prevention program. Every completed suicide, as well as every serious suicide attempt, should be examined through a mortality-morbidity review process. If resources permit, a clinical review through a psychological autopsy is also recommended. National correctional standards¹⁷ recommend that such reviews include

1. A critical review of the circumstances surrounding the incident;

¹⁷National Correctional Standards for Health Services in Prison, formulated by US deptt. Of Justice- Source 'Prison Suicide: An Overview and Guide to Prevention' published by National Institute of Corrections, USA

2. Possible precipitating factors that led to the suicide or serious suicide attempt.
3. A critical review of prison procedures relevant to the incident;
4. A synopsis of all relevant training received by involved staff;
5. A review of pertinent medical and mental health services involving the victim; and
6. Any recommendations for changes in policy, training, physical plant, medical or mental health, and operational procedures.

It seeks to determine if there was a pattern of symptoms that might have resulted in earlier diagnosis and intervention. Additionally, the review examines events immediately surrounding a death to determine if appropriate interventions were undertaken. Each inmate death should be compared with other inmate deaths to determine if it is part of an emerging pattern. The focus of the review should be twofold: what happened in the case under review and what can be learned to help prevent future incidents.

IX. Standardized Record Keeping, Follow-Up, and Systematic Data Collection

Comprehensive documentation is critical to any effective suicide prevention program. Staff is required to use a series of standardized forms when initiating and terminating suicide watches, documenting and maintaining treatment procedures and referral decisions in a computerized data system, and compiling yearly statistics on all suicide evaluations and watches. The standardized record-keeping system forms the basis for effective clinical treatment and follow-up, and the availability of such statistical data is a valuable source of information to be used in training and policy development.

SECTION

V

Recommendations of National Human Rights Commission (NHRC)

NHRC Recommendations from the National Seminar on Prison Reforms held on 15 April, 2011¹⁸

1. A jail committee may be constituted, having representatives from the inmates, to assist the jail authorities in the cases of paroles, completion of bail documents, release of the inmates who have completed punishments and filing of the bail applications by the inmates in the court, etc.
2. The energies of the prisoners, who are behind bars for 24 hours, should be channelized into constructive work. The educational programmes could be upgraded for both male and female prisoners.
3. Vocational training should be enhanced by imparting computer skills, horticulture, agriculture, etc.
4. The model of skill training and campus placement of inmates, initiated by Tihar Jail Administration recently, may be replicated in other jails.
5. The health care system of jails should be improved. There should be medical examination of the prisoners at the time of their entry to the jail in the prescribed format and thereafter, a regular check-up may be undertaken by the jail authorities. The records of the prisoners may be maintained properly.

¹⁸Journal of NHRC Vol. 11, 2012 (pg 259-262)

6. The prison conditions should be made more humane for the women, the aged and the mentally ill prisoners, Regular medical check-ups should be ensured and provisions should be made that the mentally ill prisoners and high risk prisoners are kept separately.
7. Regular meditation and yoga may be conducted on a regular basis for the benefit of all prisoners. Assistance may be sought from NGOs in this regard.
8. Frequent opportunities may be provided for women prisoners to meet or unite with their families to address their concern.
9. Closing time for the prisoners may be advanced/increased, to allow them some time to spend in the open.
10. The Mulakat time may be fixed on phone, so that people may not have to come personally and wait for longer hours.
11. The family members of the prisoners should be allowed to meet on Sunday so that they do not have to take an off, on working days.
12. For an appropriate functioning of the prison administration and for the protection of the rights of the prisoners, it must be ensured that sanctioned posts (officers and medical staff) in the prison are filled up on priority.
13. Self-sustainability of prison should be encouraged by strengthening the prison industries. The model of Tihar Jail may be followed in this regard.
14. State Jail Manuals should be reviewed on a periodical basis to confront the new challenges.

15. Public private partnership model (in many countries) in prisons may be encouraged and followed in jails across the country. However, the experiment should be exercised with caution in view of their profit making objective.
16. Sharing of best practices should be encouraged, to learn and follow from each other, in terms of computerization of prison records, prison panchayats, mobility, infrastructure, education, connectivity, reorganization of jail industries, safety and security of prisoners, modernization and mechanization of kitchens and providing hygienic food, electronic surveillance, cultural programmes, fixing the mulakat time on phone, health care facilities etc.

SECTION

VI

Actionable Points for Suicide Prevention Program

The key recommendations are as follows:

1. The enhancement of constructive and supportive relationships between prison staff and inmates should be the major priority. Particular emphasis should be placed upon improvements to regimes, staff training and rostering arrangements to enhance these relationships.
2. Opportunities should be expanded for inmate's interaction with the outside world, particularly with regard to family and friends.
3. Each prisoner/inmate should be provided with the opportunity to participate in constructive activities such as employment, education and programs that build competency and address offending behaviour.
4. All aspects of prison operations and programs must recognise and be sensitive to the diversity of the prison population in terms of culture, ethnicity, gender and sentencing status.
5. Priority should be given to the provision of comprehensive mental health services to prisoners, including:
 - A multi-disciplinary model for screening and assessment;
 - Adequate mental health treatment and management resources and systems within prisons including qualified psychologist;
 - Sufficient provision of external hospital accommodation for the treatment and management of acute mental illness; and
 - Continuity of mental health care from specialist management

and treatment facilities, back into the mainstream prison environment, and ultimately into the community.

6. Suicide awareness training should be provided to prison officers and other prison staff.
7. Prison reception and induction processes should be reviewed to reduce uncertainty and stresses associated with suicide and self-harm, and should incorporate a detailed assessment of risk of self-harm or suicide.
8. A consistent and well-researched model of suicide treatment should be developed and implemented in prisons.
9. A thorough evaluation of the current suicide prevention strategy should be undertaken.
10. Conduct a thorough environmental audit to find out the probable places/area and items that are prone to be used while committing suicide. This will help in identifying and designing 'suicide resistant cells' with the use of collapsible material to replace potential hanging and anchoring points.
11. Use of CCTV cameras to keep constant surveillance on 'high risk prone' inmates.
12. Strengthening inmates grievance redressal system.
13. Rigorous and intensive review and follow up of suicide case to find out the particular reasons behind the suicide and improving the mitigating factors that could prevent such occurrence in future.
14. A longitudinal information system designed to identify behaviours indicative of suicide should be developed.
15. To have a detailed written suicide-prevention policy that addresses each of above stated critical components.



Conclusion

The success of efforts to prevent suicide in prisons depends on the ability and willingness to identify the vulnerability of each prisoner, provide the necessary supervision and support, and offer alternative ways of coping and reducing emotional distress. It is clear that any proposed piecemeal solution to the problem of suicide in prison will not achieve long-term improvement. An effective prevention program must accept the dynamic nature of suicide and, consequently, strive for continuous improvement through on-going review and vigilance. Prison suicide is a complex and dynamic phenomenon and approaches to its prevention should be multi-disciplinary, fluid, responsive, holistic and jurisdiction-specific. Prison suicide prevention programs need to be systemic but should be owned, supported and driven by prisoners, prison staff, prison services leadership and the general community. The report concludes that prison suicides are not simply a function of an individual's vulnerability and circumstance, but are also influenced by the quality of the prison regimes and staff responses – or the overall “health” of the prison or prison system. The essential theme of this report is “care for and awareness of others.” Future success in reducing prison suicides throughout the country will rely not only on progressive prison administrators’ developing comprehensive and operational suicide prevention policies, but also on the **attitude**. The prevention of future prison suicides might very well depend on the attitude displayed toward inmates.

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30. Prison Statistics India- Annual Report on prison published by NCRB for the year from 2007- 2011
31. Accident Deaths and Suicides in India- Annual Report published by NCRB for the year 2007- 2011

Internet Resources:

1. Jail/Custody Suicide: A Compendium of Suicide Prevention Standards and Resources
<http://www.suicidology.org/associations/1045/files/Jail.pdf>
This report from the Jail Suicide Task Force of the American Association of Suicidology reviews various operational standards designed to prevent suicide in U.S. detention and custody facilities.
2. Jail Suicide Prevention
<http://www.ncianet.org/suicideprevention/publications/index.asp>

This section of the National Center on Institutes and Alternatives (NCIA) website contains links to a number of resources on suicide prevention in jails and prisons, including Guiding Principles to Suicide Prevention in Correctional Facilities 2007 and Prison Suicide: An Overview and Guide to Prevention.

3. National Institute of Corrections Library

<http://nicic.org/Features/Library/>

This online library contains training curriculum and sample suicide prevention plans. Search “suicide” from the link above to find the appropriate materials.

4. NCCHC Standards: A Summary Guide to the Revisions

http://www.ncchc.org/resources/stds_summary/intro.html

This webpage contains summaries of recent revisions to the National Commission on Correctional Health Care’s standards for prisons, jails, and juvenile detention and confinement facilities.

5. Preventing Suicide: A Resource for Prison Officers

http://www.who.int/mental_health/media/en/60.pdf

A guide from the World Health Organization published in 2000.

6. Suicide Prevention Resource Center (SPRC)

<http://www.sprc.org/>

SPRC provides prevention support, training, and resources to strengthen suicide prevention efforts. Among the resources found on its website is the SPRC Library Catalogue (<http://library.sprc.org/>), a searchable database containing a wealth of information on suicide and suicide prevention,



including publications, peer-reviewed research studies, curricula, and web-based resources. Many of these items are available online.

7. American Association of Suicidology (AAS)

<http://www.suicidology.org/>

AAS is a non-profit organization dedicated to the understanding and prevention of suicide. It promotes research, public awareness programs, public education, and training for professionals and volunteers and serves as a national clearinghouse for information on suicide.

8. American Foundation for Suicide Prevention (AFSP)

<http://www.afsp.org>

AFSP is a non-profit organization dedicated to understanding and preventing suicide through research and education. AFSP supports research projects, provides information and education on depression and suicide to professionals, the media, and the public, and supports programs for those affected by suicide.

9. National Suicide Prevention Lifeline

<http://www.suicidepreventionlifeline.org/>

The Lifeline provides immediate assistance to individuals in suicidal crisis by connecting them to the nearest available suicide prevention and mental health service provider through a toll-free telephone number - 1-800-273-TALK (8255) that is available 24/7. Technical assistance, training, and other resources are available to crisis centers and mental health providers participating in the network of services linked to the Lifeline.

10. National Center for Injury Prevention and Control (NCIPC)

<http://www.cdc.gov/ncipc/>

The NCIPC, located at the Centers for Disease Control and Prevention, is a valuable source of information and statistics about suicide, suicide risk, and suicide prevention. For information on suicide and suicide prevention at this website, scroll down the left navigation bar and click on “Suicide” under the “Violence” heading.

11. Suicide Prevention Action Network USA (SPAN USA)

<http://www.spanusa.org>.

SPAN USA is the nation’s only suicide prevention organization dedicated to leveraging grassroots support among suicide survivors (those who have lost a loved one to suicide) and others to advance public policies that help prevent suicide.

12. Indian Kanoon- for legal citation

<http://www.indiankanoon.org>

Information Sheet for Morality Morbid Review

1. Number of inmate suicides between:

January 1, 20__ and December 31, 20__ _____

January 1, 20__ and December 31, 20__ _____

2. Which of the following categories best describes your facility?

(Please only check one category.)

a) Central Jail _____

b) District Jail _____

c) Women Jail _____

d) Open Jail _____

e) Sub-Jail _____

f) Juvenile Home/ Children Observation Home _____

g) Nari Niketan (Temp. Shelter for Women) _____

h) Other (Specify: _____) _____

NAME OF PRISON _____ STATE _____

PART A: PERSONAL CHARACTERISTICS OF VICTIM

1) Victim's Name : _____

2) Sex: (1) _____ Male (2) _____ Female

3) Date-of-birth _____/____/____ or _____ Years-Old

- 4) **Marital Status:** (1)___Single (5)___Widowed
 (2)___Married
 (3)___Separated
 (4)___Divorced (6)___Unknown

5) Please specify **Current Charge (s)** for which the victim was confined at time of suicide and whether victim was being **Detained** or had been **Sentenced** on those charge(s)-

CHARGE(S)	DETAINED	SENTENCED
_____	(1)_____	(1)_____
_____	(2)_____	(2)_____
_____	(3)_____	(3)_____

6a) Did the victim have a record of Prior Arrests?

(1)___Yes (2)___No (3)___Unknown

6b) If the victim had a prior arrest record, specify the **Most Recent Criminal Charges**.

Most Recent Criminal Charge(s)	Date
_____	_____
_____	_____
_____	_____



7) What was the total **Length of Confinement** that the victim had been in prison prior to their death? (If less than two days, indicate in hours.)

____Hours ____Days ____Months ____Years

8a) Did the victim have a history of **Substance Abuse**?

(1)____Yes (2)____No (3)____Unknown

8b) If the victim had a history of substance abuse, briefly **Describe Type of Substance Abuse.**_____

9a) Did the victim have a history of **Medical Problems**?

(1)____Yes (2)____No (3)____Unknown

9b) If the victim had a history of medical problems, briefly **Describe Type of Medical Problems.**_____

10a) Did the victim have a history of **Mental Illness**?

(1)____Yes (2)____No (3)____Unknown

10b) If the victim had a history of mental illness, briefly **Describe Type of Mental Illness.**_____

11a) Did the victim have a history of taking **Psychotropic Medication**?

(1)___Yes (2)___No (3)___Unknown

11b) If the victim had a history of taking psychotropic medication, briefly **Describe Type of Psychotropic Medication(s).**_____

11c) Was the victim receiving **Psychotropic Medication** during the most recent confinement?

(1)___Yes (2)___No (3)___Unknown

11d) If the victim was receiving psychotropic medication during the most recent confinement, briefly **Describe Type of Psychotropic Medication.**_____

12a) Did the victim have a history of **Suicidal Behaviour**?

(1)___Yes (2)___No (3)___Unknown



12b) If the victim had a history of suicidal behaviour, briefly **Describe Suicidal Behaviour.**_____

13a) Was the victim ever on **Suicide Watch** (see definition of page 8) in prison either during this confinement or a prior confinement?

(1)___Yes (2)___No (3)___Unknown

13b) If the victim had previously been on Suicide Watch at any time in prison, what was the **Time Span between Discharge from Suicide Watch and the Suicide, and Briefly Describe the Circumstances that resulted in Discharge from Suicide Watch.**

14a) Did the victim have a history of placement in **Isolation or Segregation** while in prison?

(1)___Yes (2)___No (3)___Unknown

- 14b) If the victim had a history of placement in isolation or segregation, briefly **Describe Type and Circumstances of Isolation or Segregation.**_____
- _____
- _____

PART B: SUICIDE INCIDENT CHARACTERISTICS

15. What was the **Date** and **Time** of the victim's suicide?

Date ___/___/___ **Time (Found):** _____am/_____pm

16. What was the **Method** of suicide and the **Instrument** used?

Method

- (1)___Hanging [from _____(bed, vent, etc.)]
- (2)___Overdose
- (3)___Cutting
- (4)___Shooting
- (5)___Jumping
- (6)___Ingestion of Foreign Object(s)
- (7)___Other



Instrument

- (1)___Clothing (specify type:_____)
- (2)___Belt
- (3)___Shoelace
- (4)___Bedding
- (5)___Telephone Cord
- (6)___Razor
- (7)___Other (Specify_____)
- (8)___Knife
- (9)___Glass
- (10)___Drugs

17. What was the **Time Span** between the suicide and finding the victim?

- | | |
|---------------------------------|-----------------------------|
| (1)___Less Than 15 Minutes | (4)___Between 1 and 3 Hours |
| (2)___Between 15 to 30 Minutes | (5)___Greater Than 3 Hours |
| (3)___Between 30 and 60 Minutes | (6)___Unknown |

18a) At the time of the suicide, was the victim **Under the Influence** of:

- | | |
|-------------------------|--------------------------------|
| (1)___Drugs | (4)___Neither Drugs or Alcohol |
| (2)___Alcohol | (5)___Unknown |
| (3)___Drugs and Alcohol | |



18b) If the victim was under the influence of drugs at the time of the suicide, briefly **Describe the Type(s) of Drugs:** _____

19a) At the time of the suicide, was the victim assigned to a **Single** or **Multiple Occupancy Cell**?

(1)___Single (2)___Multiple (3)___Unknown

19b) If the victim was assigned a multiple occupancy cell, **Were other Inmates in the Cell at the Time of the Suicide?**

(1)___Yes (2)___No (3)___Unknown

20a) Did correctional staff initiate **Cardiopulmonary Resuscitation** on the victim prior to the arrival of medical personnel?

(1)___Yes (2)___No (3)___Unknown

20b) If **Cardiopulmonary Resuscitation** was not provided on the victim prior to the arrival of medical personnel briefly **Describe Reasons why it was not provided?** _____



21a) Was the victim under any type of **Isolation or Segregation at the Time of the Suicide?**

(1)___Yes (2)___No (3)___Unknown

21b) If the victim was under **Isolation or Segregation** at the time of the suicide, what was **Time Span between placement in Isolation/Segregation and the suicide, and Briefly Type and Circumstances of Isolation or Segregation.** _____

22a) Was the victim under **Suicide Watch at the Time of the Suicide?**

(1)___Yes (2)___No (3)___Unknown

22b) If the victim was under suicide watch at the time of suicide, what was the **Frequency of Direct Visual Observation by Staff** (excluding any closed circuit television monitoring and/or inmate companion/inmate observation aide)?

(1)___Continuous (5)___Every 30 Minutes
(2)___Every 5 Minutes (6)___Every 60 Minutes
(3)___Every 10 Minutes (7)___Other (Specify_____)
(4)___Every 15 Minutes



22c) If the victim was under suicide watch at the time of the suicide, was **Closed Circuit Television Monitoring** utilized as a method of observation?

(1)___Yes (2)___No (3)___Unknown

22d) If the victim was under suicide watch at the time of the suicide, was an **Inmate Companion/Inmate Observation Aide** (see definition on page 6) utilized as a method of observation”

(1)___Yes (2)___No (3)___Unknown

23a) Did the victim attend a **Court Hearing or other Legal Proceeding** in close proximity to the suicide?

(1)___Yes (2)___No (3)___Unknown

23b) If the victim attended a court hearing or other legal proceeding in close proximity to the suicide, what was **Time Span between the Hearing/Legal Proceeding and the Suicide, and Briefly Describe the Circumstances of the Court Hearing/Legal Proceeding?** _____



24a) Did the victim have a **Visit or Telephone Call** in close proximity to the suicide?

(1)___Yes (2)___No (3)___Unknown

24b) If the victim had a visit or telephone call in close proximity to the suicide, what was **Time Span between the Visit/Telephone Call and the Suicide, and Briefly describe the Circumstances of the Visit/Telephone Call?** _____

25a) Was the victim ever **Assessed by a Qualified Mental Health Professional** (see definitions) prior to the suicide?

(1)___Yes (2)___No (3)___Unknown

25b) If the victim was assessed, specify the **Last Contact by a Qualified Mental Health Professional** prior to the suicide? (If less than two days, indicates in hours.)

___Hours ___Days ___Weeks ___Months

26a) If a mortality review was conducted, did the process offer any **Possible Precipitating Factors** (i.e., circumstances which may have caused the victim to commit suicide)? If yes, briefly list: _____

26b) If a mortality review was conducted, did the process offer any **Recommendation to Prevent Future Suicides?** If yes, briefly list:

PART C: JAIL CHARACTERISTICS

27. At the time of the suicide, what was the rated **Capacity** and **Population** of the facility?

(1)_____ Capacity

(2)_____ Population



28. At the time of the suicide, did the facility have a **Written Suicide Prevention Policy**?

(1)_____Yes

(2)_____No

29a) At the time of the suicide, did the facility have an **Intake Screening** process to **Identify Suicide Risk**?

(1)_____Yes

(2)_____No

29b) At the time of the suicide, did the **Intake Screening** process include the ability to verify whether the victim had been on **Suicide Watch During a Prior Confinement**?

(1)_____Yes

(2)_____No

30a) At the time of the suicide, had most (90% or more) correctional staff received **Suicide Prevention Training**?

(1)_____Yes

(2)_____No

30b) If most correctional staff had received suicide prevention training, what was the **Frequency and Duration of the Suicide Prevention Training** at the time of the suicide?

Frequency

Duration

(1)_____Yearly

(1)_____DAYS (Specify/Number)

(2)_____Other(Specify_____)

(2)_____HOURS (Specify/Number)

31. At the time of the suicide, had most (90% or more) correctional staff received **Certification in Cardiopulmonary Resuscitation?**

(1)_____Yes

(2)_____No

32. If the facility had a suicide watch process at the time of the suicide, what was the **Frequency Level(s) of Direct Visual Observation by Staff?** (Check all that apply.)

(1)_____Continuous

(5)_____Every 30 Minutes

(2)_____Every 5 Minutes

(6)_____Every 60 Minutes

(3)_____Every 10 Minutes

(7)_____Other (Specify_____)

(4)_____Every 15 Minutes

33. At the time of suicide, did the facility have a Housing process by which a suicidal inmate would be assigned to a safe, suicide-resistant, and protrusion-free cell?

(1)_____Yes

(2)_____No

DEFINITIONS

SUICIDE WATCH: The level(s) of direct visual observation by staff that is given to an inmate identified as being at risk of suicide. It excludes closed circuit television, inmate companion/inmate observation aide, or any other non-staff monitoring.

INMATE COMPANION/INMATE OBSERVATION AIDE: A designation by which another inmate is entrusted with the responsibility of providing observation to an inmate on suicide watch.

How to Prevent a Suicide Among Prison Inmates

Steps

Be alert for warnings signs, such as the following

A. Situational

1. Recent loss or separation from a loved one.
2. Long or life sentence.
3. Receiving a parole “hit”.
4. Receiving time in administrative segregation.
5. Chronic or terminal illness.
6. Family history of suicide.
7. History of previous suicide attempts.
8. Psychiatric diagnosis (“Special needs” inmate).
9. Absence of a support network (no letters or visits).
10. Suicide of a friend fellow inmate, or family member.

B. Cognitive/Emotional

1. Belief that one is a failure.
2. Feeling hopeless and helpless.
3. Extreme guilt about offence.

C. Behavioural.

1. Giving away personal possessions.
2. Change in previous patterns of behaviour.
3. Isolating oneself.
4. Hoarding medications.
5. Crying or other indication of depression.
6. Provoking attack from other inmates.

D. Use of Verbal Expressions such as the Following.

1. "I can't go on."
2. "I've nothing to live for."
3. "Nobody cares what happens to me."
4. "My life is over."

Determine whether additional risk factors are present.

In addition to the risk factors just mentioned, the three most important elements to look for in assessing suicidality are: ideation (Does the person have suicidal thoughts?), plan (Has the person decided on how to go about it?) and intent (Has the person taken any steps in implementing the plan, such as hoarding medication?)

Don't be afraid to ask the "S" question:

"Are you thinking of suicide?" or "Do you want to hurt yourself?" Most suicidal people are never free of mixed motives over what they are about to do, and most of them will tell you that they are thinking about suicide if you ask.



Get professional help:

Suicide ideation can be a symptom of many forms of mental illness. This information is not intended to turn you into an armchair psychologist but to help provide an essential link in the suicide prevention process. If you think that one or more risk factors for suicide are present, don't gamble with another person's life by attempting to talk the inmate out of it. You need to IMMEDIATELY relay this information to the prison mental health staff or to someone who will contact them. The mental health staff will assess all the relevant information and, if warranted, place the inmate on suicide watch and arrange for him or her to receive the necessary treatment.

Warnings

Every indication of suicidal tendencies must be taken seriously. Even so-called "suicidal gestures" which are obviously meant to gain more favourable housing, or more favourable treatment as a "special needs" inmate, should be regarded just as seriously as if they were a genuine suicide attempt. Those who do not seriously intend to kill themselves could always make a mistake and succeed when they did not intend to.

If you are an employee of a correctional institution and you are wondering, "Why should I care if an inmate commits suicide, or anyone for that matter?" the answer is very simple. If you get caught not doing everything, you can't prevent an inmate suicide, you could lose your job, and the inmate's family could sue you, so it would be best to not take the job in the first place if you can't handle this.

Jail Suicide Assessment Tool (JSAT)

Overview

The JSAT consists of twenty-four categories arranged in such a manner that the primary purpose of the interview is not immediately revealed, rapport building is facilitated, and essential information is obtained. Each category has cue words to prompt the clinician during the interview. Clinicians use professional judgement to rate each category as "+" (a positive indication of stability), "n" (a neutral finding), or "-" (a negative sign in the direction of potential suicide risk). Rating categories in this manner identifies areas of support and/or concern as related to suicide risk. The process lends itself well to topic-specific crisis counseling. It is also a vehicle whereby clinicians can conceptualize changes in functioning over time (e.g., during a suicide watch, post-crisis is follow up). Categories are not weighted nor are a score derived. *The primary benefit is the gathering of essential information so that an informed, clinical decision can be made.* The process of developing specific questions to get at an understanding of the prisoner's current status in relation to any given risk factor is entirely dependent upon the training, skill level, and personal preference of the clinician. The recommendation is that clinicians begin by asking general, open-ended questions and then follow up with specific, more pointed questions as appropriate.

Jail Suicide Assessment Tool

JSAT

David K. Carson, Psy. D. – Federal Bureau of Prisons

- A. Important relationships :** who, last contact, support, well-being, concerns, unresolved loss

B. Social Status: sudden change, culture shock, predator to victim, gang issues
C. Legal status: pre-trial, recently sentenced, 20+year sentence, new charges, high-risk group
D. Institutional adjustment: current adjustment, history of disciplinary actions, perceived safety
E. Physical health: perception of health, medical medication concern, life-threatening condition
F. Physical pain: pain, intensity, duration, ability to tolerate
G. Chemical abuse/use: History of substance abuse, signs of intoxication or Withdrawal
H. Psychiatric treatment: counseling, medication, compliance, hospitalization, diagnoses
I. Mental status: Orientation, mood, affect, thought content, agitation
J. Depression (Current signs): severity, obvious symptoms, subtle signs
K. Reality testing (current signs): hallucinations, content, delusions, negative signs
L. Character: antisocial, narcissistic, borderline, dependent, histrionic, etc
M. Hope: future orientation, life goals, reasons to live, supportive faith

N. Help self: perceived ability to solve presenting problems
O. Cognitive themes: optimism, pessimism, exaggeration, negativism, shame, self-loathing
P. Coping resources : History of coping, current level of distress, level of perceived self-control
Q. Measured reasoning: sudden destructive action toward self/others, impulsive, a ‘Hot-Head’
R. Self-harm history: thoughts, plans, actions, circumstances, how discovered, intentions
S. View of death: desire to survive, ideas and attitudes about dying
T. View of suicide: study of suicide of significant others, long history of thoughts/attempts
U. Recent suicide signs: self-harm action, preparations, notes/letters, changes noted by others
V. Suicidal intention: resolution to act, lethal plan with available means
W. Cooperation: rapport, therapeutic alliance, manipulative style, convincing contract
X. False presentation: secondary gain, factitious features, rare symptoms, unusual clustering

Prison Suicide Risk Assessment Checklist

Inmate Name _____ Reg. No. _____

Date of Assessment _____ Assessment completed by: _____

1. SOCIAL-RELATIONAL:

P¹⁹ N/S A. Significant Others(s) Status: Marital/other relationships; last contact; Recent / anticipated /feared change; informed of intent to end relationship; unresolved crisis; nearness to significant dates; etc.

P N/S B. Recent losses: Deaths; imminent loses; unusual aspects, etc.

P N/S C. Status Issues: Significant alteration of circumstances; unusual high risk groups; significant loss of status: Position of victim; gang issues; etc.

2. SITUATIONAL :

P N/S A. Criminal Justice Issues: Time in prison; 1st timer; status in rel. to Court; high risk group status; government witness etc.

P N/S B. Institutional Issues : Institutional adjustment; disciplinary issues; transfer concerns; problems with others; etc.

P N/S C. Safety Issues: Views prison environment as dangerous; identified conflict; level of fear; perception of ability to cope; etc

¹⁹P stands for Potential Problems Area Identified : and N/S stands for "Nothing Significant Noted".

3. MEDICAL

- P N/S A. Distressing illness; Significant medical concern, life threatening conditions; high risk groups such as cancer ; AIDS; etc.
- P N/S B. Pain (Physical): intensity and duration; ability to tolerate; strategies for dealing with; etc.
- P N/S Chemical Abuse/Use: History of abuse/use, current problems status such as withdrawal intoxication, etc.

4. PSYCHIATRIC:

- P N/S A. Treatment History : Type of treatment including conseling, medication, outpatient, medication, outpatient, hospitalization, etc.
- P N/S B. Current Status : Diagnosis (Axis 1, Axis II); medication compliance; command hallucinations; etc.

5. PSYCHOLOGICAL:

- P N/S A. General Mental Health Status : Current mental status; mind; acute perturbation, etc.
- P N/S B. Hopelessness- Helplessness; Absence of strong positive reasons to live; dependency issues, personal internal resource; unable or unwilling to continuing search for solution to personal problem; sees factors in current situation as uncontrollable and/or unchangeable current behaviours evidence of struggle for gaining or regaining control of life situations; etc.



- P N/S C. Depression: Obvious and subtle signs; severity; etc.
- P N/S D. Pain (Emotional): Heightened level of emotionality in relation to pain; low frustration intolerance level expressed in relations to pain; self-assessment of pain as intolerable; etc.
- P N/S E. Negative Cognitions (Emphasizing Self Concept): Shame; self-loathing; and or perceived humiliation; pessimistic world view; exaggeration of problems; inability to articulate; positive alternative(s); low self esteem, etc.
- P N/S F. Coping Resources: Inability to articulate cogent reasons for living; history of serious deficits in coping ; evidence for major deficits in basic living skills; presence of constriction (e.g. unable to see alternatives to present difficulties and distressing personal problem); etc.

6. HISTORICAL:

- P N/S A. Self Destructive: Past suicide attempt gestures; methods; lethality; intentions; how discovered circumstances; etc.
- P N/S B. Impulsivity :History of impulsive acting out; perceived level of self-content; frustration tolerance; violent acts; etc.
- P N/S C. Personal Awareness Issues : Significant others with history of suicide; any personal contact with suicidal individuals; other unusual factors such as fascination with suicide through reading, religious suicide cult ideology; etc.

7. BEHAVIOURAL:

- P N/S A. Self-Destructive : Recent self-inflicted injury or suicide attempt; type; lethality; etc.

- P N/S B. Withdrawal : Isolation; reduced interaction with others including inmates, staff, family; cessation of eating; etc.
- P N/S C. Changes: Evidence of significant changes on variety of fronts; interpersonal; eating, sleeping, hygiene; etc.
- P N/S D. Related Actions: Hoarding medications, stealing medications, buying drugs, collecting materials such as making a rope; writing a letter with death references; suicide note; making final arrangement; putting affairs “in order”; etc.

8. MOTIVATIONAL

- P N/S A. Intentionality : Desire to die, escape, effect change and solve problem through death; maligning, feigning, or factitious features; intent communicated; ambivalence; etc.
- P N/S B. Plan : Specific plan; lethality; means available; etc.
- P N/S C. Goals: Death as an escape; imagined scene of life after death in peaceful setting; no long or short range goals; unwillingness to work with clinician, no therapeutic alliance: unwillingness to convincingly contract to seek help to crisis, etc.

Note:

1. The “Prison Suicide Risk Assessment Checklist” was developed by the psychology services staff at the Federal Transfer Center, Oklahoma City, Oklahoma in 1997: David F. Wedeking, Ph.D., David K Carlson, Psy D., Theresa I Johnson Ph.D., Richard R. Ray M.S., and Knife N. Levins, M.A.
2. P stands for Potential Problems Area Identified : and N/S stands for “Nothing Significant Noted”.

Sample Suicide Precaution Protocols²⁰

If any staff suspects that an inmate is depressed and/or suicidal, the medical department should be notified. The physician and/or on-call psychiatrist should then be consulted. Any of the following levels of precaution may be recommended:

LEVEL 1

In most circumstances, this level will pertain to persons who have actually recently attempted suicide. The on-call psychiatrist will have been notified. Efforts will be in progress to have the inmate committed to a mental health facility. The inmate should be in a “safe room” or in the health clinic. Health staff should provide one-to-one constant attention while the person is awake, with visual checks every five to ten minutes while the inmate is asleep in a safe environment (described in Level 2). Toileting and bathing may or may not be visually supervised, depending on the inmate’s mood at the time; if visually unsupervised, staff should be standing close by with the door slightly ajar.

LEVEL 2

This level will pertain to inmates who are considered at high risk for suicide. The on-call psychiatrist will have been consulted. Efforts will probably be made to have the inmate committed to a mental health facility. The person should be either in a “safe room” or in the health clinic. Safety precautions should be observed. These should include searches of room and clothes for removal of all potentially harmful objects such as glass, pins, pencils, pens, and matches. Plastic bags should be removed. The room should be near the staff office, with no access to breakable glass and no

²⁰ Adopted from the National Commission on Correctional Health Care’s Standards For Health Services in Prison (1992)

electrical outlets (or outlets that can and should be turned off.) There should be no bed in the room if possible, and no pipes from which sheets could be hung. There may be a mattress and pillow on the floor. The person may have clothes (no belts), linen, and blankets. If the inmate verbalizes or demonstrates immediate intent to harm himself/herself, bedding should be removed and the health staff notified. The person should be checked at least every five minutes while awake and every ten minutes while asleep. He/she should have one-to-one attention when out of room, if potentially harmful objects (pencils, TV, etc.) are brought into room, or if he/she seems unusually distraught. Toileting and bathing: same as for Level 1.

LEVEL 3

This level will pertain to persons whom the physician or on-call psychiatrist feels are at moderate risk for suicide. They may be inmates who have previously been on Level 1 or 2 and whose mental status is improving. Safety precautions should be taken. These should include searches of room and clothes for removal of obviously potentially harmful objects, such as broken glass, pins and matches. Plastic bags should not be permitted. Bed and linen may be allowed in room. The person may have writing materials (and TV in the health clinic) at staff discretion, but they should be removed when not in use. Toileting and bathing may be done as in the normal routine. The person should be checked visually at least every ten minutes while awake, every one half hour while asleep.

LEVEL 4

This level will most often pertain to inmates who are at risk for becoming severely depressed /suicidal. This assumption may be based on past history. The person may be dealt with as in the normal unit routine; however staff should observe the inmate for symptoms of depression and signs of suicidal ideation, and should notify health staff if new signs or symptoms occur. The person should be checked visually at least every half



hour awake and asleep. The mental status of any given inmate may vary greatly from day-to-day and sometimes from hour-to-hour; therefore, it is imperative that staff have good observational skills and knowledge of signs and symptoms to look for. If any staff member has reason to feel that a person who is already on a precaution level should be moved to a higher level of precaution, the medical department should be notified, and the physician and/ or psychiatrist again consulted.



सर्वे
भवन्तु सुखिनः

National Human Rights Commission

Manav Adhikar Bhawan, C-Block, GPO Complex

INA, New Delhi-110023

Website : www.nhrc.nic.in