2024 Annual Report on Suicides

in the

California Department of Corrections and Rehabilitation

August 2026

CALIFORNIA DEPARTMENT of CORRECTIONS AND REHABILITATION

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

MENTAL HEALTH RECEIVER.

2024 Annual Report on Suicides in the California Department of Corrections and Rehabilitation

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List of Acronyms

APP	Acute Psychiatric Program
CAP	Corrective Action Plan
CCCMS	Correctional Clinical Case Management System
CDCR	California Department of Corrections and Rehabilitation
CPR	Cardiopulmonary Resuscitation
CTC	Correctional Treatment Center
DDP	Developmental Disabilities Placement Program
DOM	Department Operations Manual
DSM	Diagnostic and Statistical Manual of Mental Disorders
DSH	Department of State Hospitals
ECF	Electronic Court Filing
EOP	Enhanced Outpatient Program
GED	General Equivalency Diploma
GP	General Population
ICF	Intermediate Care Facility
IDTT	Interdisciplinary Treatment Team
ISUDT	Integrated Substance Use Disorder Treatment
KPI	Key Performance Indicator
LWP	Life with Possibility of Parole
LWOP	Life without Possibility of Parole
MHCB	Mental Health Crisis Bed
MHSDS	Mental Health Services Delivery System
NSSI	Non-Suicidal Self-Injury
PIP	Psychiatric Inpatient Program
PREA	Prison Rape Elimination Act
QIP	Quality Improvement Plan
R & R	Receiving and Release
RC	Reception Center
RHU	Restricted Housing Unit
RVR	Rules Violation Report
SPR FIT	Suicide Prevention and Response Focused Improvement Team
SRE	Suicide Risk Evaluation
SRMP	Suicide Risk Management Program

List of Institutions

ASP	Avenal State Prison
CAC	California City Correction Facility
CAL	Calipatria State Prison
CCC	California Correctional Center
CCHF	California Health Care Facility
CCI	California Correctional Institution
CCWF	Central California Women's Facility
CEN	California State Prison, Centinela
CIM	California Institution for Men
CIW	California Institution for Women
CMC	California Men's Colony
CMF	California Medical Facility
COR	California State Prison, Corcoran
CRC	California Rehabilitation Center
CTF	Correctional Training Facility
CVSP	Chuckawalla Valley State Prison
DVI	Deuel Vocational Institution
FSP	Folsom State Prison
HDSP	High Desert State Prison
ISP	Ironwood State Prison
KVSP	Kern Valley State Prison
LAC	California State Prison, Los Angeles County
MCSP	Mule Creek State Prison
NKSP	North Kern State Prison
PBSP	Pelican Bay State Prison
PVSP	Pleasant Valley State Prison
RJD	Richard J. Donovan Correctional Facility
SAC	California State Prison, Sacramento
SATF	Substance Abuse Treatment Facility and State Prison, Corcoran
SCC	Sierra Conservation Center
SOL	California State Prison, Solano
SQRC	San Quentin Rehabilitation Center
SVSP	Salinas Valley State Prison
VSP	Valley State Prison
WSP	Wasco State Prison

Executive Summary

Purpose

This report reviews the characteristics of adults who died by suicide while in the custody of CDCR and examines opportunities to improve its suicide prevention program.

Major Findings

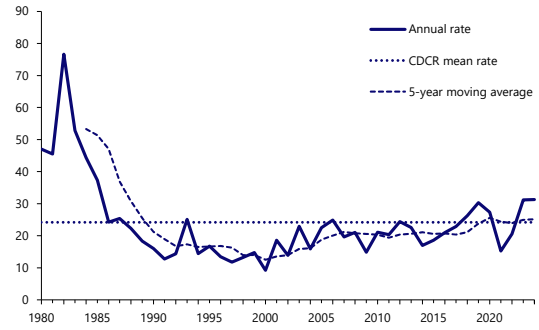
Suicides in 2024

- Of the 120,071 adults who spent at least one night in a CDCR facility during 2024, 29 died by suicide (28 males and one female), the equivalent of one death every 12.6 days.
- The rate of suicide was 31.3 per 100,000, which was similar to the rate in 2023 (31.2 per 100,000) but also the highest since 1985, when the rate was 37.3 per 100,000.
- Seventy-six percent of adults who died by suicide were receiving mental health care, compared to 37.5% of the overall population. Forty-one percent were receiving EOP care, compared with 8% of the overall population.
- The rate of suicide among all mental health patients was 63 per 100,000 but was nearly twice as high among EOP patients (116 per 100,000).
- Thirty-one percent of adults who died by suicide were housed in RHUs, compared to 3.4% of the overall population.
- Fifty-five percent of adults who died by suicide were at the highest security level, compared to 16.1% of the overall population.
- Eighty-three percent of adults who died by suicide were housed alone, compared to 26.4% of the population.
- About half of the decedents experienced an inter-facility transfer in the previous six months, compared to 26.1% of the population.
- About half of the decedents were issued an RVR in the previous six months, compared to 27.4% of the population.

Suicide Trends

- The number of annual deaths by suicide has fallen from its peak of 43 in 2006.
- In the past 10 years, 28 suicides have occurred per year on average.
- In the past 10 years, the average rate of suicide was 24.5 per 100,000. The annual rate of suicide has fluctuated year-to-year but has not appreciably changed (Figure 1).
- Although the RHU population has fallen dramatically, the rate of suicide in RHU has

Figure 1. Rates of Suicide per 100,000 in CDCR, 1980–2024



Note: CDCR mean rate = 24 per 100,000.

increased steadily from 147 per 100,000 in 2014 to 211 per 100,000 in 2019 to 303 per 100,000 in 2024.

- Adults receiving mental health care are consistently among the most vulnerable to suicide. In the past 10 years, mental health patients were five times more likely than non-mental health patients to die by suicide. Adults at the EOP level of care are particularly vulnerable.
- The rate of suicide following discharge from an inpatient unit was highest immediately after discharge and declined thereafter. Similarly, the rate following placement in RHU was highest immediately after placement and declined thereafter.

Improvement Opportunities

This report reviewed all deaths by suicide from 2022-2024 to identify opportunities to improve its suicide prevention program. Executive leaders from key departments reviewed the most significant quality concerns and then evaluated them in conjunction with other relevant information, including improvement initiatives from various divisions, other quality metrics, and available resources. As a result of this process, the use of cut-down kits was selected for a performance improvement project. A review of cases involving cut-down kits and their use showed that the most common issue involved officers retrieving the cut-down tool rather than bringing the entire kit to the scene. Cut-down kits contain a cut-down tool and other emergency devices (e.g., a bag valve mask and a disposable airway).

Overview of Suicides in 2024

29 Deaths by suicide

More males (28) than females (1) died by suicide

Half (51.7%) of decedents were transferred to another prison in the previous six months

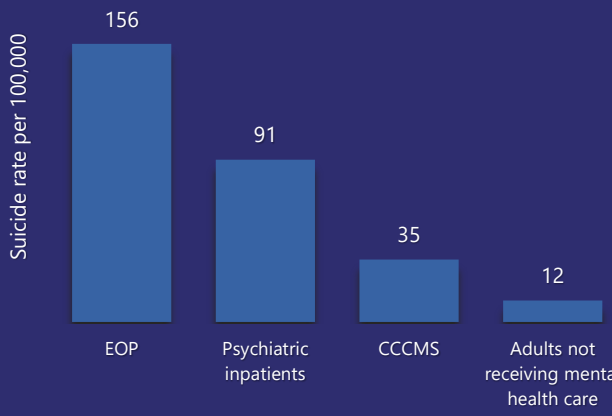
About half (55.2%) of decedents were issued an RVR in the previous six months

31.3 Suicides per 100,000

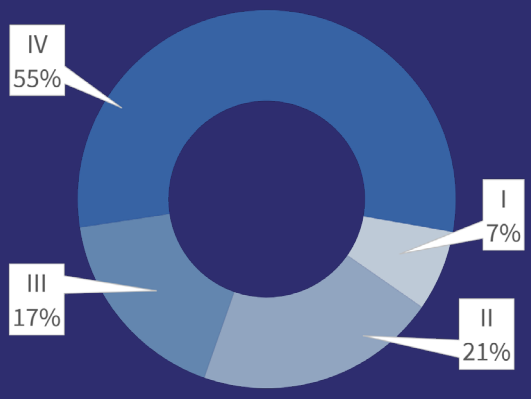
31% Of decedents lived in restricted housing units

76% Of decedents were mental health patients

83% Of decedents were housed alone



Suicide rates were higher in groups with more serious mental health concerns



The majority of decedents (55%) were classified at the highest security level

Note: These data are for descriptive purposes only. The information should not be used to draw conclusions about which characteristics elevate suicide risk. See the Introduction for details.

Introduction

Suicide is an unpredictable event, and its causes are complex. As a result, suicide prevention is a challenging endeavor. In an ongoing effort to reduce deaths by suicide among adults in its custody, CDCR completes an annual review of all suicides.[1]

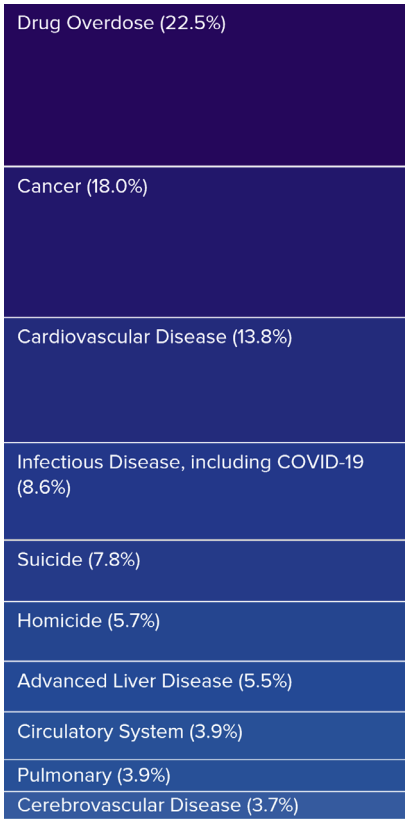
Purpose

This report has two aims:

1. To describe the characteristics of adults who died by suicide in CDCR custody[2] and monitor the trends in the prevalence of suicide
2. To identify opportunities to improve the department's suicide prevention program

This report also fulfills court-ordered obligations related to *Coleman v. Newsom.*[3]

Figure 2. Leading Causes of Death in CDCR, 2023



Source: Imai (2025). N = 383.

1. For a review of the department's initiatives to reduce suicide risk, see "2024 Annual Report on Suicide Prevention Efforts" (Obegi & Leidner, 2025) prepared for the California Legislature pursuant to Penal Code § 2064.1.
2. In 2024, CDCR custody or in-custody refers to all incarcerated persons placed in CDCR prisons, CDCR camps, in-state contract beds, Department of State Hospitals, and CDCR Pre-Release Community Programs. See Methodology for details.
3. ECF 7592, filed 7-25-2022; ECF 7681, filed 12-15-2022; ECF 8441, filed 10-25-2024, ECF 8890, filed 5-1-2026; ECF 8903, filed 6-5-2026.

Background

In CDCR, suicide has consistently ranked among the top 10 causes of death. For example, in 2023, suicide was the fifth leading cause (Figure 2). The number of suicides was comparable to the number of homicides and deaths due to infectious diseases.

Overview of CDCR's Suicide Prevention Program

The department's suicide prevention program began in 1990, and major developments are listed in Figure 3. CDCR's comprehensive approach to suicide prevention, referred to as the 4-Square Model of Suicide Prevention (Obegi, 2024a), comprises four sets of components, or squares: Prevention, Treatment, Preparedness, and Quality.

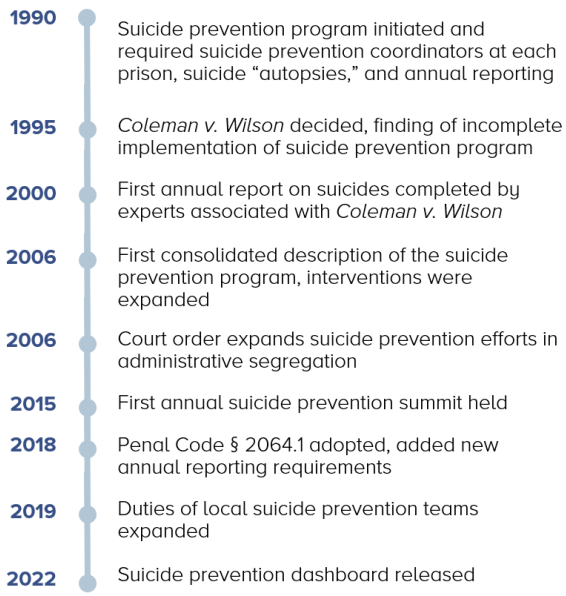
The Prevention square includes components designed to stop suicidal thoughts, feelings, and behavior (i.e., suicidality) from developing. Components in this square are meant to enhance the well-being of all incarcerated adults, support select groups who may be at elevated risk of experiencing suicidality, and respond to those who may be experiencing some signs of suicidality. The Treatment square is comprised of components meant to treat suicidality to avoid the outcome of suicide. The Preparedness square contains components that ensure staff are equipped to fulfill their suicide prevention roles and that the physical environment in treatment areas is safe. Finally, the Quality square has components designed to monitor how well the central components in the other squares are working. The resulting data is used to drive continuous improvement. This report is one of several components of the Quality square.

New Report Features

This report introduces five new features:

1. **Aggregation:** Whenever counts of deaths are small, it is difficult to reliably discern patterns in the characteristics of decedents from year-to-year. To mitigate this challenge, deaths were aggregated into multi-year periods (see Methodology).
2. **Trend Analysis:** Year-to-year differences in the number of deaths make it challenging to distinguish between random variation and actual trends. This report uses statistical process control charts, which are designed to detect nonrandom trends, to examine the suicide rate and other selected variables (see Methodology).
3. **Additional Circumstances:** Descriptive data were added for two new circumstances of death: Time since the last RVR and time since the last inter-facility transfer (Table 9).
4. **Additional Suicide Rates:** Rates of suicide following discharge from an inpatient psychiatric unit and following placement in an RHU were calculated to appreciate how quickly suicide risk changes over time (Figure 8 and Figure A1 in the Appendix).

Figure 3. Major Developments in CDCR's Suicide Prevention Program



Source: Adapted from Canning (2018).

5. **Assessment of Quality Problems:** The risk posed by quality problems identified in suicide reviews was rated according to the likelihood that the problem would cause harm (i.e., injury or death) and the scope of the problem (i.e., the prevalence of the problem across suicide reviews). This method supports the identification of improvement priorities (see Methodology).

Interpretive Caution

This report describes nearly 40 characteristics of incarcerated adults who died by suicide. The information should not be used to draw conclusions about which characteristics elevate suicide risk. For example, a characteristic common among decedents may also be common among all incarcerated individuals. Only research studies can establish whether certain characteristics qualify as risk factors for suicide.

This report also includes information about the rates of suicide among the total in-custody population as well as specific groups. However, suicide rates, by themselves, are not good indicators of a suicide prevention program's quality (Obegi, 2024b). Rather, quality is mainly judged by a program's comprehensiveness (Metzner & Hayes, 2020) and performance measures (Canning & Dvoskin, 2018).

Suicide Trends

Trends suggest how suicides may be changing over time. This section examines trends in the overall frequency and rate of suicide in the department over time. It also compares the overall suicide rate in the department to rates in other populations.

Trends Over Time

Figure 4 shows three ways to understand how suicide has changed in CDCR from 1980 to the present.

Panel A of the figure shows that the CDCR population grew rapidly in the 1980s and 1990s, eventually peaking at 173,312 in 2007. During the same period, the number of suicides also grew, with the highest number of deaths (43) occurring in 2006. Similarly, as the population declined after 2007, the number of suicides generally decreased. In the past 10 years, 28 suicides have occurred per year on average.

Panel B shows the rates of suicide from 1980 to the present. The highest rate (76.6 per 100,000) occurred in 1982 and the lowest (9.3 per 100,000) in 2000. From 1986 forward, the rate has been relatively stable, with evidence of an upward drift from 2000 forward. The rate in 2024 (31.3 per 100,000) was similar to the rate in 2023 (31.2 per 100,000). The 2024 rate was not unusual, although it was the highest rate since 1985, when the rate was 37.3 per 100,000. In the past 10 years, the average rate of suicide was 24.5 per 100,000. (Table A1 in the Appendix lists the counts and rates since 1980.)

Panel C is a moving average chart designed to detect unusual shifts in the suicide rate. The upward drift in Panel B is plainly evident in Panel C. Additionally, two years (2020 and 2024) exhibit unusual changes in the rate.

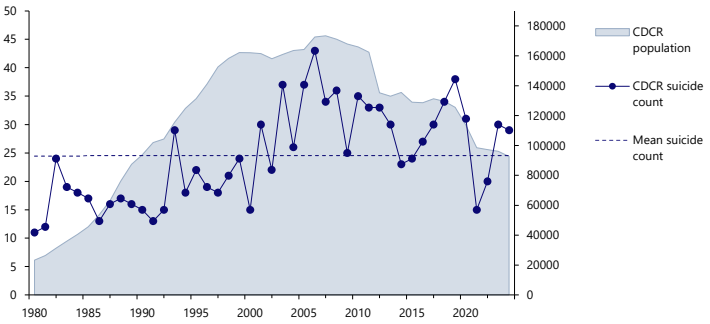
In CDCR, unusual changes in the rate occurred in the early 1980s and again between 1997 and 2002 as well in 2020 and 2024.

The COVID-19 pandemic coincided with a one-year decline in the suicide rate, from 31 per 100,000 in 2020 to 15 per 100,000 in 2021. However, historically speaking, this was not an unusual change. Panel C shows that while the rate of suicides decreased in 2021, the second year of the pandemic, it was not an unusual change from prior years.

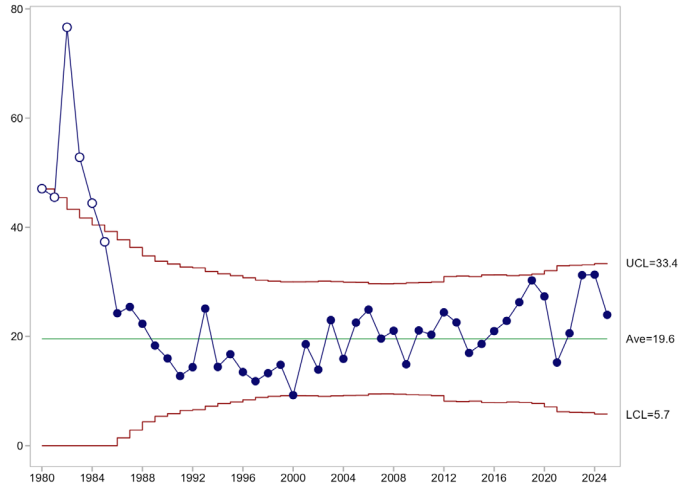
Comparative Trends

Another way to understand the suicide rate in CDCR is to compare it to the rates in related populations. However, comparing unadjusted rates across different populations requires caution (see Methodology).

Figure 4. Suicide Trends in CDCR, 1980–2024

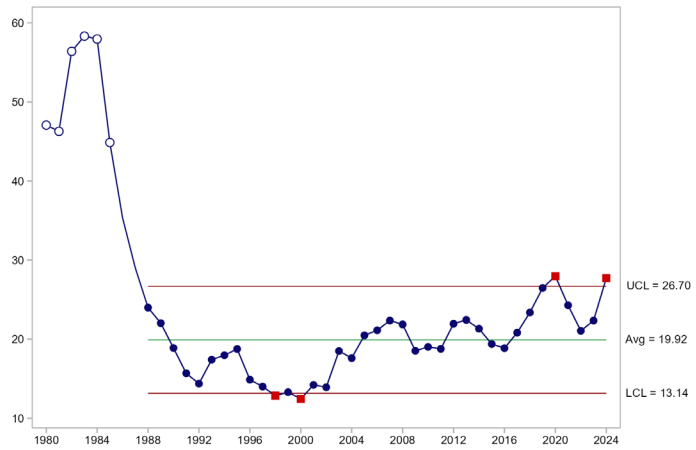


Panel A
Annual suicide counts and CDCR populations



Panel B
Annual suicides per 100,000

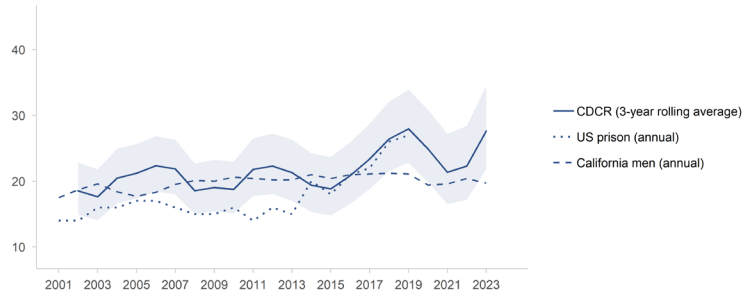
Note: UCL = upper control limit. Avg = overall average. LCL = lower control limit. UCL and LCL reflect three standard deviations from the overall average. To establish realistic parameters, the years 1980-1985 were excluded (open points) from the calculation of the UCL, Avg, and LCL. See Methodology.



Panel C
3-year moving average of suicides per 100,000

Note: UCL = upper control limit. Avg = overall average. LCL = lower control limit. UCL and LCL reflect three standard deviations from the overall average. See Methodology. To establish realistic parameters, the years 1980-1985 were excluded (open points) from the calculation of the UCL, Avg, and LCL.

Figure 5. Rates of Suicide per 100,000 in CDCR, U.S. Prisons, and Among California Men, 2001–2024



Note: The shaded area represents 95% confidence intervals for the CDCR rate. 2019 is the most recent data available for U.S. prisons (Carson et al., 2021). 2023 is the most recent data for California men (Center for Disease Control and Prevention, 2024).

Figure 5 compares the CDCR rate to the national rate in U.S. state prisons and the rate among California men. The CDCR rate was generally higher than the rate in U.S. state prisons until 2014, when both rates became similar through 2019. By contrast, the CDCR rate has been roughly similar to that of California men. From 2001 through all available years, the average rate was 21.9 per 100,000 for CDCR, 20.8 per 100,000 for California men, and 17.6 per 100,000 for U.S. state prisons.

Demographic and Social Characteristics

Both in the community and in correctional settings, suicide is not equally common in all groups. Describing the frequency of suicide in different demographic and social groups sheds some light on how suicide is distributed in CDCR.

Demographic Characteristics

Table 1 displays the percentage of suicides among various groups from 2019 to 2024. The overwhelming majority of deaths by suicide occurred among males. In general, more White and Hispanic adults died by suicide than Black or Other adults. In 2024, the percentage of suicides by Hispanic and Black adults was higher than in recent years. From 2019 to 2023, roughly 60% of adults who died by suicide were under the age of 45. In 2024, the figure was 72%.

Social Characteristics

Table 2 displays the percentage of suicides in additional groups from 2019 to 2024. The majority of deaths by suicide occurred among single adults and adults with less than a college education.

Among decedents with an employment history in the community, more deaths by suicide occurred among those who engaged in unskilled work. A history of juvenile offenses was common. English

Table 1. Percentage of Suicides and Total In-Custody by Demographic Characteristic

Characteristic	Suicides 2019–2023	Suicides 2024[a]	Total In-Custody 2024
Total	134	29	92,582
Gender Identity			
Male	96.3	96.6	94.9
Female	3	3.4	4.1
Non-binary[b]	.7	0	.9
Race/Ethnicity			
Hispanic	35.1	48.3	46.2
Black	17.2	24.1	27.4
White	38.8	24.1	20
Other	9	3.4	6.4
Age			
18–24	6.7	0	4.9
25–34	28.4	31	27.3
35–44	26.1	41.4	28.2
45–54	19.4	17.2	19.1
55–64	14.9	6.9	13.3
65 or older	4.5	3.4	7.1

Note: [a] Differences between 2024 and prior periods should be interpreted cautiously (see Methodology). [b] CDCR began tracking non-binary gender in late 2021. From 2019 to 2024, two suicides were by transgender adults.

Table 2. Percentage of Suicides by Social Characteristic

Characteristic	2019–2023[a]	2024
Total	134	29
Marital Status		
Single	63.4	58.6
Married	14.9	13.8
Divorced	16.4	24.1
Widowed	3.7	3.4
Unknown	1.5	0
Education		
< High school	41.8	41.4
High school	24.6	31
GED	26.9	17.2
College degree	3	6.9
Unknown	3.7	3.4
Employment		
Unskilled	61.2	48.3
Skilled	18.7	20.7
N/A or unknown	20.1	31
Juvenile Offenses		
Yes	59.7	58.6
No	37.3	31
Unknown	3	10.3
Primary Language		
English	88.8	89.7
Spanish	9	10.3
Other	2.2	0

Note: [a] Differences between 2024 and prior periods should be interpreted cautiously (see Methodology). Total in-custody data were unavailable for these characteristics.

was the primary language of the vast majority of decedents.

Health Conditions

From 2019 to 2023, 32.1% of adults who died by suicide were judged to have a serious, painful, or life-threatening medical condition. Similarly, in 2024, 7 or 24.1% had such a condition. The most common condition (6 of 7) was chronic pain. Other conditions included anemia, obesity, and hepatitis C.

Custodial and Criminal Justice Characteristics

Custodial characteristics generally refer to features of the correctional environment, whereas criminal justice characteristics refer to committing offenses and aspects of sentencing.

Custodial Characteristics

Table 3 shows the percentage of suicides by several custodial characteristics. From 2019 to 2023, about half of decedents were at Level IV, the highest security level in CDCR. About one in three decedents died in RHUs. Most of the remaining deaths by suicide occurred on general population yards (i.e., GP-non-designated) as opposed to yards designated for adults with safety concerns[1] (i.e., GP-designated). Suicides in hospital settings were rare. Roughly 81% of decedents were housed alone.[2] About half had an assigned job or were enrolled in an educational program. A disproportionate number of decedents were housed alone. The findings for 2024 were similar, with few exceptions (Table 3).

1. Safety concerns are "any documented and verified factor(s) or situation(s) that will cause a substantial risk of serious harm to any incarcerated person, staff, or other individual" (Cal. Code Regs. tit. 8, § 300, 2025).
2. Due to the age of some facilities, some cells are single occupancy by design. For a variety of reasons, some adults are housed alone in double-occupancy cells.

RHU Suicides

Since 2010, the number of suicides in RHU has declined. However, the RHU population also declined over the same period, albeit more dramatically (Figure 6, Panel A).

From 2010 to 2024, the average rate of suicide was 172.9 per 100,000. The rate in 2024 was 303 per 100,000. Because the decline in the number of suicides was not as substantial as the decline in the population over time, the suicide rate in RHU has gradually increased (Figure 6, Panel B). The upward shift in the RHU suicide rate beginning in 2017 (Figure 6, Panel B) may be attributable to the larger number of RHU suicides but a smaller RHU population compared to recent years. The higher suicide rate may also be due, for example, to a change in the composition of the RHU population.

From 2019 to 2024, 50 suicides occurred in RHU. Twenty-three percent occurred within 7 days of placement. The rate of suicide was highest immediately after placement and declined thereafter (Figure A1 in the Appendix).

Suicides by Facility

All in-custody suicides in 2024 occurred in CDCR prisons. Historically, some facilities have had more suicides than others (Table A2 in the Appendix),

Table 3. Percentage of Suicides and Total In-Custody by Custodial Characteristic

Characteristic	Suicides 2019–2023	Suicides 2024[a]	Total In-Custody 2024
Total	134	29	92,582
Security Level			
I	6	6.9	5.1
II	24.6	20.7	44.8
III	10.4	17.2	18.1
IV	53.0	55.2	16.1
Unclassified	6	0	5.2
Housing Type[b]			
RHU	30.6	31	3.4
Condemned	1.5	3.4	.6
CTC	.7	3.4	.9
Fire camp	.7	0	2
GP-designated	23.9	13.8	7.8
GP-non-designated	29.9	48.3	67.8
PIP	5.2	0	.7
DSH	0	0	.1
RC	7.5	0	5.3
Housing Arrangement			
Alone	81.3	82.8	26.4
With one person	9.7	10.3	34.8
With multiple persons	9	6.9	38.8
Job or Educational Assignment			
Yes	49.3	58.6	68.3
No	50.7	41.4	31.7

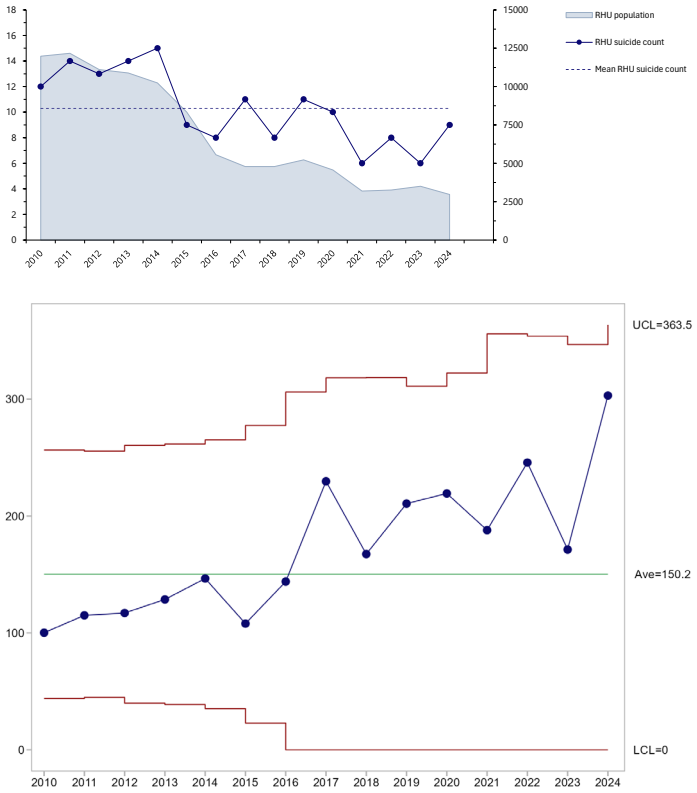
Note: [a] Differences between 2024 and prior periods should be interpreted cautiously (see Methodology). [b] "Total In-Custody 2024" percentages as of 12-31-2024. Percentages do not sum to 100% because CDCR has numerous housing codes, and only codes involving a suicide are listed.

Table 4. Percentage of Suicides by Criminal Justice Characteristic

Characteristic	Suicides 2019–2023	Suicides 2024[a]	Total In-Custody 2024
Total	134	29	92,582
Most Serious Offense[b]			
Person	91.8	93.1	83.3
Property	7.5	3.4	7
Drug	0	3.4	2.5
Other	.7	0	7.2
Sentence Length			
< 6 years	10.4	13.8	19
6–10 years	15.7	6.9	12.3
11–20 years	17.9	20.7	17.2
21+ years	19.4	13.8	12.8
LWP	26.1	37.9	32.3
LWOP	7.5	3.4	5.6
Condemned	3	3.4	.6
Time Served			
< 1 year	14.9	20.7	19.8
1–5 years	31.3	20.7	28.1
6–10 years	20.9	17.2	16.7
11–20 years	21.6	34.5	18.7
21+ years	11.2	6.9	16.8
Time Left to Serve			
< 1 year	13.4	13.8	6.4
1–5 years	32.8	37.9	41.4
6–10 years	9.7	10.3	8.3
11–15 years	9.7	6.9	3
16+ years	34.3	31	40.9[c]

Note: [a] Differences between 2024 and prior periods should be interpreted cautiously (see Methodology). [b] These categories differ from the ones used in previous annual reports (see Methodology). [c] Includes all indeterminate sentences (LWP, LWOP, and condemned).

Figure 6. Suicide Trends in RHUs, 2010–2024



Panel A
Annual suicide counts in RHUs and RHU populations

Note: Reliable housing data before 2010 are unavailable.

Panel B
Rates of suicide per 100,000 in RHUs

Note: UCL = upper control limit. Avg = overall average. LCL = lower control limit. UCL and LCL reflect three standard deviations from the overall average. See Methodology. Reliable housing data before 2010 are unavailable.

likely because facilities vary by the size and make-up of their populations (e.g., the number of adults receiving mental health care, housed in RHUs, or classified as Level IV security). From 2015 to 2024, eight facilities accounted for roughly 50% of all deaths. Over the same period, the number of suicides per facility ranged from none to 22.

Criminal Justice Characteristics

Table 4 shows the percentage of suicides by various criminal justice characteristics. From 2019 to 2023, the overwhelming majority of decedents (91.8%) committed offenses against a person, although this was also true of the total in-custody population in 2024. Decedents with sentences less than 20 years were roughly as common as those with sentences longer than 20 years (44 vs. 56%). Life with the possibility of parole was the most common sentence length (26.1%), although some of these were effectively life terms because the minimum sentence length was very long (i.e., more than 50 years). The patterns in 2024 were similar.

Mental Health Characteristics

Historically, adults receiving mental health care in CDCR have been overrepresented among those who died by suicide. This section examines characteristics of this population.

Mental Health Care

From 2019 to 2023, seven of every ten deaths by suicide were by adults receiving mental health services in CDCR. A history of mental health care in the community was also common. The pattern was similar in 2024 (Table 5).

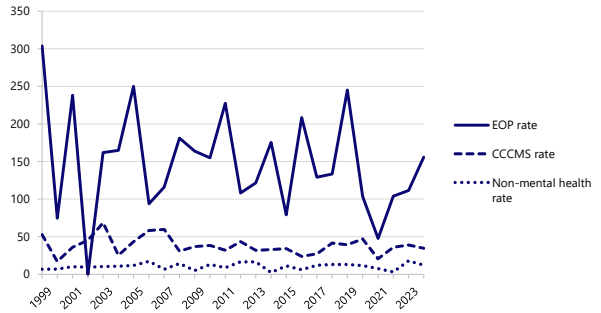
In 2024, as in previous years, a disproportionate number of mental health patients died by suicide. Although 37.5% of the total in-custody population received mental health care, 76% of decedents did so (Table 5). This discrepancy was especially pronounced among adults at the EOP level of care. Although EOP patients constituted 8.3% of the total in-custody population in 2024, they accounted for 41.4% of the suicides (Table 5). Similarly, EOP patients constituted 22.1% of the mental health population in 2024 (7,690 of 34,802) but accounted for just over half of the deaths among mental health patients.

The rate of suicide among mental health patients has been consistently higher than the rate among non-mental health patients. Over the past 10 years, the average rate of suicide among mental health patients was nearly six times higher: 57.8 versus 9.7 per 100,000. In 2024, the rate was 63 per 100,000 among mental health patients and 12.2 among non-mental health patients. No unusual changes in the suicide rate among mental health patients or non-mental health patients have occurred since 1999 (Figure A2 and Figure A3, respectively, in the Appendix).

Figure 7 shows the suicide rate from 1999 to 2024 by level of outpatient mental health care. In general, the rates among EOP patients were markedly higher than the rates among CCCMS patients or non-mental health patients. The average rate was 145.2 per 100,000 among EOP patients and 38 per 100,000 among CCCMS patients. For EOP patients, no unusual changes in the suicide rate occurred except in 2002 when no EOP patients died by suicide (Figure A4 in the Appendix). For CCCMS patients, no unusual changes in the suicide rate occurred (Figure A5 in the Appendix). For psychiatric inpatients or those referred to a psychiatric inpatient unit, no unusual changes in the suicide rate occurred except in 2007 when three such patients died by suicide (Figure A6 in the Appendix).

Finally, although the DDP classification is not a level of mental health care, the department tracks suicides among adults in DDP. From 2019 to

Figure 7. Rates of Suicide per 100,000 by Level of Outpatient Mental Health Care, 1999–2024



2024, five decedents were DDP. Three were EOP patients, and two were PIP patients. No adults classified as DDP died by suicide in 2024.

Psychiatric Medications

From 2019 to 2023, about half of decedents were prescribed medications by a psychiatrist at the time of their deaths (Table 5). The percentage in 2024 was somewhat lower (34.5%) but higher than the total in-custody population (25.7%).

About 8% of decedents from 2019 to 2023 had an active court order for involuntary psychiatric medication (Table 5). In 2024, the percentage was similar (about 10%).

Psychiatric Diagnoses

From 2019 to 2023, mood disorders and psychotic disorders were the most common diagnostic categories (Table 6). Thirty percent of decedents had diagnoses from two or more diagnostic categories, and 94% had a history of drug use. In 2024, substance use disorders were more common. In addition, 45% of decedents had diagnoses from two or more categories, and 86% had a history of drug use.

Suicide Risk Management Program

Mental health patients who meet certain criteria are enrolled in SRMP. The program involves augmented treatment plans designed to reduce suicide risk. In 2024, one decedent was enrolled in SRMP. In 2024, the number of patients enrolled in SRMP in any given month ranged from roughly 1,100 to 1,400.

Table 5. Percentage of Suicides and Total In-Custody by Mental Health Characteristic

Characteristic	Suicides 2019–2023	Suicides 2024[a]	Total In-Custody 2024
Total	134	29	92,582
Level of Mental Health Care			
Any	71.6	75.9	37.5
CCCMS	35.1	31	27.9
EOP	30.6	41.4	8.3
Inpatient[b]	6	3.4	1.3
Mental Health Care in the Community			
Yes	67.9	48.3	27.8[c]
No	26.9	41.4	26.8
Unknown	5.2	10.3	45.3
DDP			
Yes	3.7	0	1.2
No	96.3	100	98.8
Psychiatric Medications			
Yes	47.8	34.5	25.7
No	52.2	65.5	74.3
Involuntary Medications			
Yes	7.5	10.3	1.9
No	92.5	89.7	98.1

Note: [a] Differences between 2024 and prior periods should be interpreted cautiously (see Methodology). [b] Inpatient includes MHCB, PIP, and DSH. [c] In-custody counts based on available responses to mental health screening questions about prior treatment, when available.

Post-Discharge Suicides

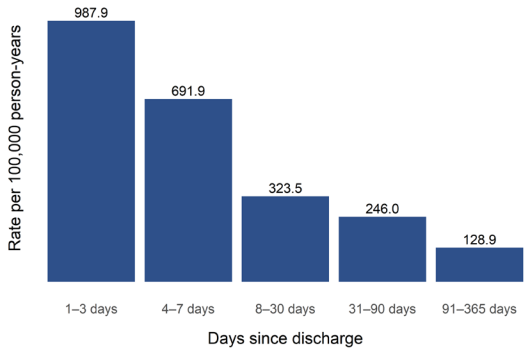
From 2015 to 2024, 30.6% (85 of 278) of decedents died by suicide in outpatient settings within one year of discharge from an inpatient psychiatric

Table 6. Percentage of Suicides by Diagnostic Category

Diagnostic Category	2019–2023	2024[a]
Total suicides[b]	134	29
Mood disorders	33.6	31
Psychotic disorders	30.6	20.7
Trauma- and Stressor Related Disorders	17.2	27.6
Substance-related disorders	15.7	48.3
Personality disorders	14.2	17.2
Anxiety disorders	6.7	17.2
Neurodevelopmental disorders	1.5	0
Gender dysphoria	.7	0
Paraphilic disorders	.7	0
No diagnosis	24.6	17.2

Note: [a] Differences between 2024 and prior periods should be interpreted cautiously (see Methodology). [b] The sum of percentages exceed 100% because many decedents carried multiple diagnoses. Diagnostic categories were drawn from the most recent version of the DSM (American Psychiatric Association, 2022).

Figure 8. Incidence of Suicide within 365 Days of Discharge from an Inpatient Psychiatric Unit, 2015–2024



Note: N=85 suicides. To obtain an adequate sample, a 10-year period was used.

unit (i.e., from MHCBs, PIPs, or DSH), or nine adults per year on average. Nearly half died within 60 days of discharge (47%), and most were at the EOP level of care (72.9%).

From 2015 to 2024, the average rate of suicide among adults in outpatient settings who were discharged from an inpatient psychiatric unit within the last 365 days was nearly 200 per 100,000 (Figure A7 in the Appendix). No unusual trends in the rate have occurred since 2015. The rate of suicide was highest immediately after discharge and declined thereafter (Figure 8).

History of Non-Fatal Self-Harm

From 2019 to 2023, over half of the adults who died by suicide (61.2%) had a history of suicide attempts (i.e., in CDCR, other custodial settings, or the community). About one in three (33.6%) had a history of suicide attempts while incarcerated in CDCR. About 19% had a history of NSSI in CDCR. About 17% had a history of both suicide attempts (in any setting) and NSSI (in CDCR).

Percentages in 2024 were similar. About 55% of adults who died by suicide had a history of suicide attempts, and 28% had a history of suicide attempts in CDCR. Six (20.7%) had a history of NSSI in CDCR, and the incidents involved lacerations, overdoses, asphyxiation, head banging, and ingestion. The severity of the resulting injuries ranged from none to moderate. Nearly 21% had a history of both suicide attempts (in any setting) and NSSI (in CDCR).

Circumstances

Although characteristics of individuals who die by suicide are important to describe (e.g., age, crime, diagnosis), so too are the circumstances of death. Circumstances refer to conditions that existed at the time of death and events that occurred near the time of death.

Method

Hanging is the most common method of suicide in CDCR, more than all other methods combined (Table 7). From 2019 to 2023, asphyxiation was used more often than in 2024.

Timing

In 2024, the number of deaths per month ranged from 0 to 6. The average was 2 to 3 deaths per month. Compared to previous years, no month in 2024 had an unusual suicide rate (Figure A8 in the Appendix).

Percentages of suicides by custody watch, time of day, and day of the week are presented in Table A3 in the Appendix. Percentages of suicides by month, season, and quarter are presented in Table A4 in the Appendix.

Suspected Precipitants

Recent and stressful life events (precipitants) may influence a person's decision to die by suicide. In each of the department's reports on suicide, the reviewer hypothesizes about the main precipitants. Table 8 presents the percentage of suspected precipitants among those who died by suicide.

From 2020 to 2023 and in 2024, the three most commonly suspected precipitants were mental health symptoms, custodial issues, and substance-related issues. In 2024, more than one precipitant was suspected in most cases (21).

Table 7. Percentage of Suicides by Method

Method	2019–2023	2024[a]
Total	134	29
Hanging	70.9	86.2
Asphyxiation	16.4	3.4
Laceration	6	10.3
Overdose	2.2	0
Insertion/Ingestion	2.2	0
Jumping	1.5	0
Other	.7	0

Note: [a] Differences between 2024 and prior periods should be interpreted cautiously (see Methodology).

Recent Inter-Facility Transfers

From 2019 to 2023, about 37% of adults who died by suicide did so less than six months after their most recent inter-facility transfer (Table 9). In 2024, the figure was about 52% and disproportionate to the in-custody population.

Recent RVRs

From 2019 to 2023, about half of the decedents had an RVR in the previous 6 months. The figure was similar in 2024 and disproportionate relative to the in-custody population (Table 9).

Suicide Notes

From 2019 to 2023, about one in every five decedents (22%) left a suicide note. In 2024, only two (7%) decedents left a suicide note.

Monitoring

The department has several levels of enhanced monitoring. In inpatient psychiatric units, mental health providers can order constant observation, 15-minute checks, or 30-minute checks. In RHUs, all adults are checked every 30 minutes by officers and daily by psychiatric technicians. Finally, patients discharged from an inpatient psychiatric unit are checked every 30 minutes by custody for the first 24 hours (and up to 72 hours) whenever the reason for their admission was danger to self. In 2024, 10 adults died while on some level of enhanced monitoring: nine in an RHU and one in an MHCB.

Postmortem Rigidity

Evidence of postmortem rigidity (i.e., rigor mortis) was noted in four decedents in 2024.[1] Two decedents were housed in RHUs, one in a condemned unit, and the remainder in mainline units. Since 2014, no unusual changes occurred in the percentage of decedents found with evidence of postmortem rigidity (Figure A9).

1. Estimating the time since death is the province of forensic experts, so no firm conclusions about the time since death should be drawn from this finding. In addition, postmortem rigidity is considered an unreliable method of estimating the time since death (Krompecher, 2023; Tsokos & Byard, 2016).

Table 8. Percentage of Suspected Precipitants Across Suicides

Precipitant	2020–2023[a]	2024[b]
Total precipitants[c]	198	69
Mental health symptoms	23.7	26.1
Custodial or legal issues	16.7	24.6
Substance-related issues	15.7	14.5
Safety concerns	15.2	11.6
Crises of despair	11.6	18.8
Medical concerns	10.1	2.9
History of childhood trauma	4	1.4
COVID-19 issues	2	0
Board of Parole Hearings issues	1	0

Note: [a] Individual level data for 2019 were unavailable. [b] Differences between 2024 and prior periods should be interpreted cautiously (see Methodology). [c] The total number of precipitants exceeds the number of suicides in a given year because many cases were judged as involving multiple precipitants.

Table 9. Percentage of Suicides with an Inter-Facility Transfer or RVR in the Previous 180 Days

Time	2019–2023	2024[a]	Total In-Custody 2024
Total	134	29	92,582
Inter-Facility Transfer			
Yes	37.3[b]	51.7	26.1
No	62.7	48.3	73.9
RVR			
Yes	48.5	55.2	27.4[c]
No	51.5	44.8	72.6[c]

Note: [a] Differences between 2024 and prior periods should be interpreted cautiously (see Methodology). [b] During the COVID-19 pandemic, inter-facility transfers were paused. [c] Includes administrative or serious RVRs only regardless of adjudication status.

Non-Fatal Self-Harm

Non-fatal self-harm refers to self-directed violence that does not result in death. CDCR tracks two broad types of non-fatal self-harm: behaviors without the intent to die (NSSI) and behaviors with the intent to die (suicide attempts).

Non-Fatal Self-Harm in 2024

Roughly 2,000 adults engaged in a total of 5,327 acts of non-fatal self-harm in 2024. Seventy-eight adults accounted for 25% of all incidents. The vast majority of non-fatal self-harm involved NSSI (Table 10), and nearly 90% involved no injury or minor injury. The most common methods of self-injury were laceration and ingestion/insertion.

Of the 382 suicide attempts, 8.1% involved serious injury. Although the MHCB and PIP settings are small populations, they accounted for nearly 50% of all non-fatal self-harm incidents. This may be due to the concentration of mental illness in inpatient units in combination with the heightened monitoring that occurs in those units.

Trends in Non-Fatal Self-harm

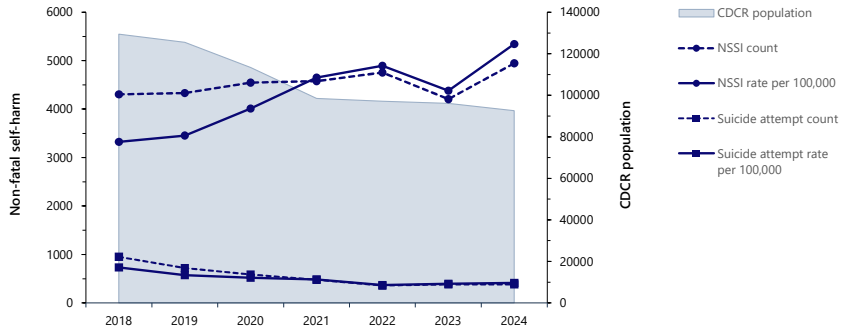
Figure 9 shows trends in non-fatal self-harm from 2018 to 2024. Over this period, the number of suicide attempts fell from 951 to 382. The rate of suicide attempts also fell, from 735 per 100,000 in 2018 to 413 per 100,000 in 2024. By contrast,

Table 10. Percentage of Non-Fatal Self-Harm Incidents by Characteristic

Characteristic	2019–2023	2024[a]
Total	24,946	5,327
Unique Individuals	10,432	2,090
Type		
NSSI	89.9	92.8
Suicide attempts	10.1	7.2
Injury Severity		
No injury	23.4	28.4
Minor	61.3	60.4
Moderate	13.3	10.5
Severe	2	1.1
Level of Mental Health Care		
GP	3.6	2.4
CCCMS	15.8	13.3
EOP	31.6	34.7
MHCB	17.3	25.6
PIP	31.5	23.9
Unclassified	.2	.2

Note: Excludes incidents of unknown intent (1,320 from 2019 to 2023 and 246 in 2024). [a] Differences between 2024 and prior periods should be interpreted cautiously (see Methodology).

Figure 9. Non-Fatal Self-Harm Incidents, 2018–2024



Note: Excludes events of unknown intent.

the number of NSSI incidents was relatively stable, but the NSSI rate trended upward. The latter may be attributable to (a) CDCR absorbing inpatients formerly treated by DSH between 2017 and 2018, and (b) gradually implementing the procedures for counting self-harm incidents among this population.

Suicide Reviews

CDCR completes a multidisciplinary review of each suicide. The reviews are a component of the department's overall approach to monitoring the quality of its suicide prevention program. The resulting reports identify opportunities to improve suicide prevention policies, clinical care, and emergency response procedures. This section reviews the department's compliance with review deadlines and the quality of its reports. It also analyzes the quality problems found by reviewers of suicide cases.

Reviews of Suicides

Compliance with Deadlines

The review process has multiple deadlines to ensure each step of the review process is completed on time. In 2024, three of the five deadlines were not consistently met (Table 11). Although compliance with the site-visit deadline was low, site visits were completed within nine days of death on average, and all occurred within 16 days of death. Deadlines for report drafts and review conferences were sometimes missed due to extenuating circumstances (e.g., reviewers' vacations or workloads, holidays, and departmental activities). Report drafts were completed on average within 33 days of death (range = 24–49 days). Review conferences were held on average within 50 days of death (range = 33–72 days).

Table 11. Percentage of Cases Compliant with Review Deadlines in 2024

Deadline (days)	Percent
1. Reviewer assigned *(within 5 business days)*	97
2. Site visit *(within 7 calendar days of no. 1)*	28
3. Facility's internal review *(within 10 business days)*	86
4. Draft suicide report *(within 30 calendar days)*	59
5. Review conference *(within 45 calendar days)*	45

Note: N = 29. Deadlines are based on the date of death unless otherwise noted.

Quality of Suicide Reports

The department uses a 15-item audit to assess report quality (Table A5). In 2024, all reports passed the audit (90% or better), and no areas of

weakness were identified. In 2022 and 2023, all reports also passed the audit.

Quality Problems

When warranted, reviewers identified quality problems.[1] In 2024, reviewers found quality problems in nearly all cases (27 of 29). The five most common types of problems were: meeting timelines for treatment, documentation quality, delays in 911 activation, safety planning quality, and policy violations of various types (Figure 10). Compared to previous years, no new types of problems were identified and fewer types occurred. (For trends in quality problems across years, see the section Trends in Quality Problems, below.)

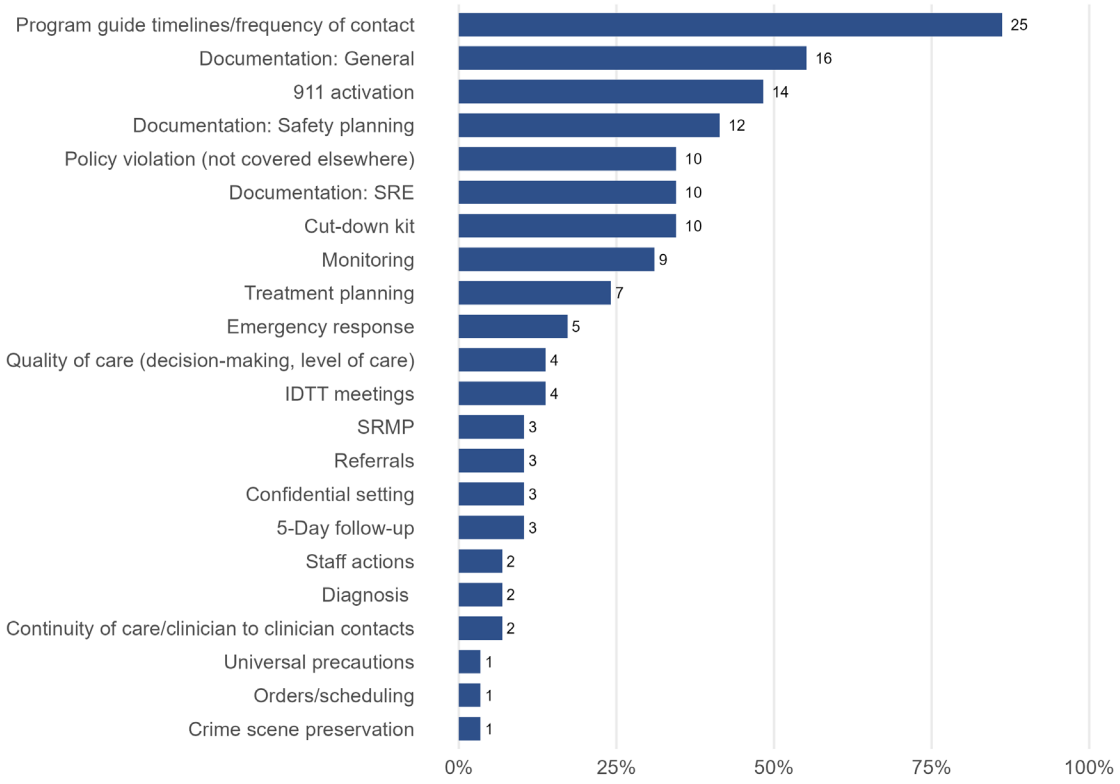
Emergency Response

In 2024, reviewers identified three problems with the emergency response to suicides: not immediately requesting emergency medical services (911), not responding with and properly using cut-down kits, and not implementing all aspects of the emergency response procedure.

Requests for emergency medical services (911) were not made immediately when indicated in

1. Quality problems are identified when they reflect administrative (e.g., policy violations, deviations from emergency response procedures) or clinical care issues. A nexus to the death is not required.

Figure 10. Prevalence of Quality Problems Identified in Suicide Reviews, 2024



Note: In 2024, there were 29 suicides. The label to right of each bar refers to the number of suicide reviews that identified the particular problem.

48.3% of cases. The average time to activation was 3.5 minutes (range = 1–6). In all cases, custody staff activated an alarm upon discovery and initiated life-saving measures. Additionally, medical staff arrived to assist in first aid and CPR.

Problems using cut-down kits were evident in 34.5% of cases. In all cases, officers retrieved the cut-down tool but did not retrieve the entire kit. In one case, the body was not supported before cutting the ligature. In another case, the ligature was not fully removed.

The quality of the emergency response was implicated in 17.2% of cases. Problems included beginning chest compressions without initially giving rescue breaths, momentarily leaving the scene unattended, and not immediately initiating life-saving measures.

Depending on the circumstances and custody factors, mechanical restraints may be applied during the emergency response. This occurred in 16 cases (55%). Seven of the cases (24%) occurred in an RHU, and the remainder in general population housing. In one case (3%), restraints were applied before life-saving measures. (Officers discovered the source of injury, a laceration, after restraints were applied). The timing of actions was unclear or occurred simultaneously in four cases.

By comparison, across 2022 and 2023, mechanical restraints were applied in 17 cases (34%, N=50). Eight (16%) occurred in an RHU or with a maximum custody patient. In seven cases (14%), restraints were applied before life-saving measures: Four took place in an RHU or with a maximum custody patient, and another two involved lacerations. Inappropriate use of mechanical restraints has not been identified as a quality problem since 2021.

Level of Mental Health Care

In 2024, reviewers did not identify problems with level-of-care decisions (i.e., failing to refer patients to a higher level of mental health care, failing to review the appropriateness of the current level of care, or inappropriately lowering the level of care).

Table 12. QIPs and Suicides by Facility, 2024

Facility	QIPs	Suicides
Total	188[a]	29
MCSP	27	4
LAC	24	3
SATF	22	1
SVSP	17	3
HDSP	15	2
CMF	16	1
KVSP	13	3
COR	11	2
CMC	8	2
CTF	5	2
SAC	5	0
FSP	5	2
PBSP	3	1
RJD	3	0
WSP	3	0
SQRC	3	1
CHCF	3	0
NKSP	2	0
VSP	1	0
CAL	1	0
CCI	1	1
CIW	0	1

Note: The review's scope is one year, so a facility may be issued a QIP even though the suicide occurred at a different facility. [a] In some cases, two facilities were named in a single QIP. Thus, the total number of QIPs by facility exceeded the total across reviews (182).

QIPs by Facility and Region

Whenever reviewers identified a quality problem, they issued a QIP. A QIP is a plan that reviewers recommend to facilities to address identified prob-

lems.[2] The QIP names the problem, recommends one or more actions, and lists the documents needed to confirm the action has been completed, and assigns responsibility for completing the action to the appropriate facility executive.

In 2024, reviewers issued QIPs in nearly all cases (27 of 29) and issued a total of 182 QIPs. On average, they issued six QIPs per suicide (range 0–15). Reviewers issued QIPs to 22 facilities (Table 12).[3] In general, facilities with more suicides were issued more QIPs. Across all suicides, the number of QIPs for each facility ranged from 0 to 27. Three facilities were issued more than 20 QIPs, and five were issued 11 to 19 QIPs. Together, these two groups accounted for 77% of all QIPs. The remaining facilities were issued eight or fewer QIPs. One QIP was assigned to headquarters (monitoring an institution's KPI on treatment hours offered) but was not completed.

A single facility with more than one suicide in 2024 sometimes exhibited the same problem in multiple cases:

- MCSP: Three of the four reviews identified problems with treatment timelines, all of which were attributed to critical levels of mental health staff.
- LAC: All three reviews identified delays in 911 activation and cut-down issues. Two of the three reviews identified (a) the use of non-confidential settings for mental health contacts and (b) untimely documentation of suicide watch.
- SVSP: Two of the three reviews identified problems with treatment timelines, treatment planning, and justification of suicide risk.
- KVSP: Two of the three reviews identified delays in 911 activation, cut-down issues, and timely nursing documentation of suicide precaution or suicide watch.
- HDSP: Both reviews identified problems with treatment timelines. Both were attributed to critical levels of mental health staff.
- COR: Both reviews identified problems with the quality of mental health documentation.
- CMC: There were no repeated problems.
- CTF: There were no repeated problems.
- FSP: There were no repeated problems

Table 13. QIPs and Suicides by Region and Status, 2024

Region	QIPs Opened	QIPs Closed	Suicides
Total	188[a]	188	29
Region I	74	74	11
Region II	34	34	7
Region III	76	76	10
Region IV	4	4	1

Note: In 2024, each region had eight facilities. [a] In some cases, two facilities were named in a single QIP. Thus, the total number of QIPs by region was larger than the total number of QIPs across reviews (182).

Table 13 shows the number of QIPs by region. Regions with more suicides were issued more QIPs.

Implementation of QIPs

All facilities must implement QIPs within 60 days of receiving a final suicide report. Of the 182 QIPs opened, all were completed within 60 days, indicating that no barriers to timely implementation were present (Table 13). In every case, facilities submitted evidence of implementation. The department also reviews and approves each facility's QIP implementation within 120 calendar days of the date of death. Review and approval were completed on time in all cases (N = 29).

2. Reviewers consider all quality problems. The identification of a problem does not mean that a nexus between the problem and the suicide existed.
3. Comparing the number of QIPs across facilities or regions requires caution. Facilities vary by size, complexity of mental health mission, security levels, and many other factors. Similarly, the facility makeup differs across regions.

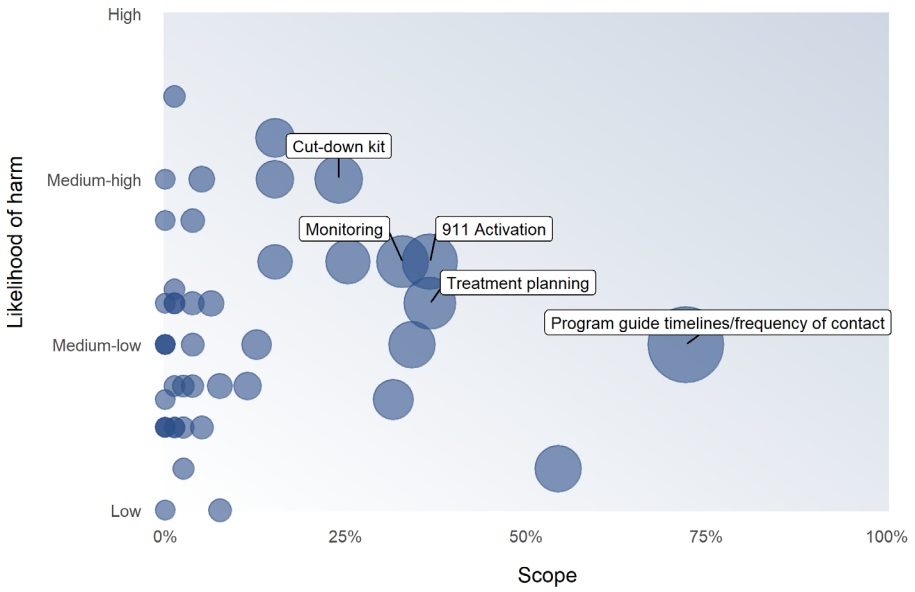
Facilities most often relied on training to address QIPs. Depending on the nature of the QIP, facilities trained individuals or groups of staff. The training content also varied depending on the nature of the QIP. Facilities used the following types of content as the basis of training: local policies, statewide memorandums, statewide training materials, and custom-developed training materials. Facilities submitted the training materials or the topical content of the training. Finally, facilities frequently submitted sign-in sheets to show that the training was completed.

Facilities also used a variety of other actions to implement QIPs. These included, but were not limited to:

- Auditing records to determine a problem's scope or confirm that a problem was corrected
- Revising local procedure
- Revising coverage plans when critical levels of mental health staffing exist
- Submitting evidence of improved compliance
- Re-mentoring staff in suicide risk assessment
- Issuing local memoranda clarifying expectations
- Terminating the employment of contract staff
- Initiating disciplinary procedures
- Creating new reference materials for staff
- Increasing the frequency of supervisory reviews
- Improving information technology capacity
- Requesting the Office of Internal Affairs to investigate possible misconduct

When staff misconduct is suspected, wardens submit investigatory requests to the Office of In-

Figure 11. Likelihood of Harm vs. Scope of Quality Problems, 2022–2024



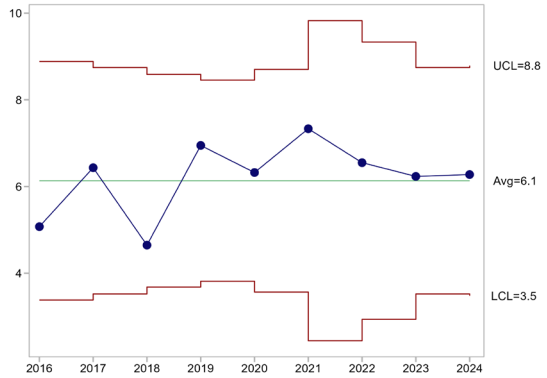
Note: Point sizes correspond to the value of the risk score (likelihood of harm multiplied by scope; see Methodology for details). Points with labels indicate the five types of problems with the highest risk scores. See Table A6 for a list of risk scores by problem type and Figure A10 for a graph of problem type by prevalence.

ternal Affairs. Five requests were submitted in 2022 and in 2023. All investigations were completed, and allegations were substantiated in all but one case. Eight requests were submitted in 2024. Two investigations are ongoing. In the remaining six requests, all allegations were substantiated. Requests were most often prompted by concerns regarding the quality of security/welfare checks in RHU and the emergency response.

Trends in Quality Problems

From 2022 to 2024, reviewers found quality problems in 97.5% of cases (77 of 79). (For a list of all problem types and their prevalence, see Figure A10.) Some problems were more severe or frequent depending on the year. To appreciate the differences, an approach modeled after the Joint Commission's (2016) Survey Analysis for Evaluating Risk (SAFER) was applied to each type of problem. The result was a risk score, which is the product of a problem's likelihood to cause harm and its prevalence (see Methodology for details). Figure 11 displays the results of this approach. The five problem types with the highest risk scores were:

Figure 12. Annual QIP Mean, 2016–2024



Note: UCL = upper control limit. Avg = overall average. LCL = lower control limit. UCL and LCL of this U' chart reflect three standard deviations from the overall average.

1. Meeting timelines for mental health contacts: Most instances involved tardy mental health contacts. Some cases involved missed contacts.
2. 911 activation: Problems reflected delays in calling 911 upon discovery, not failures to call 911 or failures to initiate medical alarms or life-saving interventions.
3. Quality of documented treatment plans: Problems involved plans that were missing clinically relevant information and, to a lesser extent, plans that were not completed.
4. Monitoring patients at risk of suicide: The department has several procedures for monitoring at-risk adults across different settings and circumstances (see p. 19 for details). A review of cases indicated that most instances involved low-quality security-welfare checks in RHU or missed nursing rounds in inpatient units or in RHU. Problems with nursing checks most often involve timeliness rather than quality. In addition, QIPs for nursing rounds were issued whenever timeliness fell below 100%.
5. Use of cut-down kits: The vast majority of instances involved retrieving the cut-down tool rather than the entire cut-down kit, which contains additional emergency equipment (e.g., a bag valve mask, a disposable airway).

Figure 12 displays the mean number of QIPs per suicide from 2016 to the present. No unusual changes in the mean occurred.

Improvement Opportunities

The department conducts continuous quality monitoring and improvement at the local, regional and statewide levels. Locally, facilities use more than 60 measures to monitor the health of their suicide prevention programs, and they take up local improvement projects as indicated. Regional suicide prevention coordinators and custody managers conduct multiple on-site audits each year, assigning corrective action plans to facilities when necessary. At the statewide level, the suicide prevention committee examines statewide trends and draws on multiple sources of data to improve processes and policies system-wide. Additionally, the department may undertake initiatives that have the potential to reduce suicide risk. A summary of the initiatives undertaken in 2024 can be found in Obegi & Leidner (2025).

The previous section of this report contributes another source of quality data: problems identified in reviews of suicide. To prioritize improvement opportunities in this area, executive leaders from key departments reviewed the most significant quality problems (p. 23) and then evaluated them in conjunction with other relevant information, including improvement initiatives from various divisions, other quality metrics, and available resources. As a result of this process, the use of cut-down kits was selected for a performance improvement project.

Use of Cut-Down Kits

In cases of hanging, the entire cut-down kit was not always retrieved.

Between 2022 and 2024, problems related to the use of cut-down kits ranked fifth in terms of risk among all problem types identified in suicide reviews. Most commonly, officers would bring only the cut-down tool instead of the complete kit to the scene. In addition to the cut-down tool, these kits contain other emergency equipment, such as a bag valve mask and a disposable airway. Having these items available may enhance the quality of the emergency response before medical staff arrive at the scene and paramedics arrive at the facility.

The department has taken two preemptive steps to mitigate problems with kit retrieval. First, the annual suicide prevention training has been revised to emphasize retrieval of the entire kit. Second, during quarterly on-site visits, regional custody staff test officer knowledge of proper kit retrieval.

Problems Not Selected

Four quality problems were not chosen as improvement opportunities.

Problems meeting timelines for mental health treatment were primarily linked to statewide staff-

ing shortages rather than shortcomings in the suicide prevention program's design. The department is actively working to enhance hiring and retention.[1] For these reasons, meeting timelines was not selected this report cycle.

Quality of treatment planning was not selected because existing processes are in place to address such concerns. Specifically, the statewide mental health program has two procedures in place to monitor plan quality: quarterly audits of treatment plans conducted by facility supervisors, and a continuous quality improvement tool, which is a comprehensive audit of facilities jointly conducted by headquarters staff and the Receiver's team. These tools offer more detailed assessments than the qualitative reviews from suicide case reviewers. Additionally, the Receiver's team and a statewide mental health quality subcommittee monitor the results of both audits.

Delay in 911 activation was not selected because revisions to training materials for cadets and line officers, focusing on emergency responses to suicidal behavior, are already underway. In addition, during on-site audits, regional custody staff now test officers' knowledge regarding when and how to activate 911.

The department has established procedures for monitoring adults at risk of suicide across various settings (see p. 19 for details). A review of cases indicated that most instances involved the quality of security/welfare checks in RHU and the timeliness of nursing rounds. Security/welfare checks were not selected because quality improvement efforts are underway. Specifically, regional custody staff are now conducting quarterly audits in which they directly observe the quality of the checks and give immediate feedback to officers and local managers. Additionally, the curriculum for the annual training on suicide prevention has been revised to emphasize the importance of check quality.

Finally, Nursing rounds were not selected as an improvement opportunity. Reviewers issued a QIP for nursing rounds whenever timeliness fell below 100%. In retrospect, this expectation was deemed too strict given the volume of completed rounds. Additionally, as of this writing, statewide performance for different types of nursing rounds typically exceeds 95% in any given month. These findings suggest that improving the timeliness of nursing rounds further is not a critical improvement opportunity.

1. Further details can be found in ECF 8722, filed 8-4-2025; ECF 8866, filed 3-11-2026; ECF 8889 filed 4-30-2026.

Methodology

Determinations of Suicide

The department generally relies on county coroners and medical examiners to determine the manner of death. Because reports from counties take several months or more to receive, the department makes a provisional finding regarding the manner of death. When a report from a county's coroner or medical examiner is received, the finding regarding the manner of death therein replaces the department's provisional finding unless the department has compelling evidence to the contrary. The procedure for arriving at preliminary findings is described in the Determination of Unknown Causes of Death section of CDCR's 2023 annual report (CDCR, 2024).

Data Sources

Characteristics of decedents were drawn from the department's suicide data sheets, which are completed after each suicide case review, and internal suicide tracking logs. Non-fatal self-harm data were drawn from the department's data warehouse. Each facility has procedures for notifying the local SPR FIT coordinator of a non-fatal self-harm incident. The coordinator documents the details of the incident in the electronic medical record.

Data regarding QIPs were drawn from the department's QIP logs. (For a review of the department's procedures for suicide case reviews and QIPs, see the Suicide Response Procedures section of CDCR's 2023 annual report, CDCR, 2024).

Suicide Rates

All rates of suicide are unadjusted rates. Rates were calculated using the in-custody population at midnight on June 30th for each year. Populations were drawn from the department's monthly population reports.

In-Custody Populations

In-custody populations were based on CDCR's Office of Research definition of in-custody. In 2024, in-custody referred to all incarcerated persons placed in CDCR prisons, CDCR camps, in-state contract beds, Department of State Hospitals, and CDCR Pre-Release Community Programs.

Unless otherwise noted, percentages of the total in-custody population for a given characteristic (e.g., security level) were based on the population at midnight on June 30, 2024. Some characteristics were based on a population size that was negligibly smaller or larger due to either missing data or differences in data sources.

Interpreting Differences

Interpreting year-to-year differences in the char-

acteristics of decedents requires caution (e.g., comparing the percentage of Hispanic individuals who died by suicide in 2023 to the percentage in 2024). Changes in suicide counts from year-to-year are expected due to randomness alone. This is especially true of low-frequency events like suicide. As a result, year-to-year differences in the characteristics of decedents are unreliable. To address this, suicide counts were aggregated, most often into five-year periods.

Interpreting rates across populations requires caution. Populations may differ in their distributions of age, ethnicity, gender, and other variables. As a result, one population may have characteristics that make it more vulnerable to suicide than another population (e.g., a larger percentage of adults with mental illness).

Interpreting rates among small populations also requires caution. Rates are unstable when they are based on a small number of cases because "it is almost impossible to distinguish random fluctuation from true changes in the underlying risk of disease or injury" (New York State Department of Health, 1999). As a result, treating unstable rates as accurate or comparing stable rates with unstable ones can lead to spurious conclusions. Relative standard error (RSE) was used to assess the stability of rates. Following the New York State Department of Health (1999), RSE was calculated as 1 divided by the square root of the case count. Rates followed by an '!' symbol indicate an RSE of 20% or more, a widely used threshold for identifying rates that are highly sensitive to random variation and therefore statistically unstable.

Trend Analysis

Statistical process control charts, also called Shewhart charts, were used to examine data for unusual changes and trends. Originally developed to monitor manufacturing defects, statistical process control charts have been used to monitor public health problems (Flowers, 2009) and, more recently, suicide rates (Spittal et al., 2023). Following convention (Provost & Murray, 2022), the upper and lower control limits for these charts were set at three standard deviations from the overall mean. Data points falling outside of control limits were described in the text as "unusual." All control charts are U charts, unless otherwise noted.

Offenses

This report adopts CDCR conventions for categories of offenses: person, property, drug, and other. When the decedent's term was based on multiple committing offenses, only the offense carrying the longest sentence was used. To facilitate comparisons with past years, past offense data were recoded accordingly.

Assessing Quality Problems

Quality problems identified over the last three years of suicide reviews were organized into like types. The types were then analyzed using an approach modeled after the Joint Commission's (2016) Survey Analysis for Evaluating Risk (SAFER). In that approach, surveyors place each problem within the SAFER matrix. The matrix has two axes, one describing the likelihood that the problem will cause harm and one describing the problem's prevalence. In this report, rather than making qualitative judgments about placement in the matrix, risk scores for each type of problem were calculated by multiplying the likelihood of harm by scope. The likelihood that a type of problem would cause harm to an incarcerated adult was determined by averaging the ratings of four departmental experts. Experts applied ratings of low, medium-low, medium-high, and high. Ratings were then converted to a 1 to 4 scale. The scope was calculated by dividing the number of cases exhibiting a type of problem by the total number of suicide cases.

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Appendix

Appendix content

Table A1. Frequency and Rate of Suicide per 100,000 by Gender, 1980–2024

Year	Male Count	Male Population	Male Rate	Female Count	Female Population	Female Rate	Total Count	Total Population	Total Rate
1980	--	--	--	--	--	--	11	23,371	47.1 !
1981	--	--	--	--	--	--	12	26,372	45.5 !
1982	--	--	--	--	--	--	24	31,319	76.6 !
1983	--	--	--	--	--	--	19	35,965	52.8 !
1984	--	--	--	--	--	--	18	40,524	44.4 !
1985	--	--	--	--	--	--	17	45,528	37.3 !
1986	--	--	--	--	--	--	13	53,620	24.2 !
1987	--	--	--	--	--	--	16	62,949	25.4 !
1988	--	--	--	--	--	--	17	76,171	22.3 !
1989	--	--	--	--	--	--	16	87,297	18.3 !
1990	15	87,435	17.2 !	0	6,375	0	15	93,810	16 !
1991	13	95,340	13.6 !	0	6,655	0	13	101,995	12.7 !
1992	15	98,008	15.3 !	0	6,344	0	15	104,352	14.4 !
1993	29	108,302	26.8	0	7,232	0	29	115,534	25.1
1994	18	116,879	15.4 !	0	7,934	0	18	124,813	14.4 !
1995	22	122,514	18 !	0	8,828	0	22	131,342	16.8 !
1996	19	131,273	14.5 !	0	9,744	0	19	141,017	13.5 !
1997	18	141,669	12.7 !	0	10,837	0	18	152,506	11.8 !
1998	21	147,001	14.3 !	0	11,206	0	21	158,207	13.3 !
1999	24	150,581	15.9 !	0	11,483	0	24	162,064	14.8 !
2000	15	150,793	9.9 !	0	11,207	0	15	162,000	9.3 !
2001	29	150,785	19.2	1	10,712	9.3 !	30	161,497	18.6
2002	22	148,153	14.8 !	0	9,826	0	22	157,979	13.9 !
2003	37	150,851	24.5	0	10,080	0	37	160,931	23
2004	23	152,859	15	3	10,641	28.2 !	26	163,500	15.9
2005	37	153,323	24.1	0	10,856	0	37	164,179	22.5
2006	39	160,812	24.3	4	11,749	34 !	43	172,561	24.9
2007	33	161,424	20.4	1	11,888	8.4 !	34	173,312	19.6
2008	36	159,581	22.6	0	11,392	0	36	170,973	21.1
2009	25	156,805	15.9 !	0	11,027	0	25	167,832	14.9 !
2010	34	155,721	21.8	1	10,096	9.9 !	35	165,817	21.1
2011	33	150,690	21.9	0	9,381	0	33	162,368	20.3
2012	32	130,189	23.8	1	6,594	15.2 !	33	135,238	24.4
2013	29	127,341	22.8	1	5,919	16.9 !	30	132,911	22.6
2014	21	129,484	16.2 !	2	6,216	32.2 !	23	135,484	17 !
2015	22	123,268	17.8 !	2	5,632	35.5 !	24	128,900	18.6 !
2016	24	128,643	18.7 !	3	5,769	52 !	27	128,643	21
2017	28	125,289	22.3	2	5,971	33.5 !	30	131,260	22.9
2018	33	123,511	26.7	1	5,906	16.9 !	34	129,417	26.3
2019	37	119,781	30.9	1	5,691	17.6 !	38	125,472	30.3
2020	31	108,682	28.5	0	4,721	0	31	113,403	27.3
2021	13	94,562	13.7 !	2	3,910	51.2	15	98,472	15.2 !
2022	20	93,510	21.4 !	0	3,669	0	20	97,179	20.6 !
2023[a]	28	92,271	31.4	1	3,762	26.6 !	30	96,033	31.2
2024	28	88,819	31.5	1	3,763	26.6 !	29	92,582	31.3

Note: Data prior to 1980 are unavailable. Gender data prior to 1990 are unavailable. ! Caution: standard error ≥20%. See Methodology for details. [a] One decedent identified as non-binary. Thus, the total count does not equal the sum of the male and female counts.

Table A2. Frequency of Suicide by Facility, 2015–2024

Facility	2015–2023	2024	Annual Average 2015–2024	Security Level	Mental Health Programs
Total suicides	246[a]	29			
SAC	22	0	2.2	II, III, IV	CCCMS, EOP, MHCB, RHU CCCMS, RHU EOP, DDP
KVSP	17	3	2	I, IV	CCCMS, EOP, MHCB, RHU CCCMS
LAC	16	3	1.9	I, III, IV	CCCMS, EOP, MHCB, RHU CCCMS, RHU EOP
COR	15	2	1.7	I, II, III, IV	CCCMS, EOP, MHCB, RHU CCCMS, RHU EOP
SVSP	15	3	1.8	I, III, IV	CCCMS, EOP, MHCB, RHU CCCMS, DDP, ICF
CCI	14	1	1.5	II, III, IV	CCCMS, EOP
MCSP	13	4	1.7	I, II, III, IV	CCCMS, EOP, MHCB, RHU EOP, DDP
CMC	12	2	1.4	I, II, III	CCCMS, EOP, MHCB, RHU EOP, DDP
SQRC	12	1	1.3	II[b]	CCCMS, EOP, MHCB, APP, ICF
DVIC	11	--	1.8	--	--
RJD	11	0	1.1	I, II, III, IV	CCCMS, EOP, MHCB. RHU EOP, DDP
WSP	11	0	1.1	I, III	RC, CCCMS, MHCB
CMF	10	1	1.1	I, II, III	CCCMS, EOP, MHCB, RHU EOP, DDP, APP, ICF
CIW	7	1	.8	N/A, I	CCCMS, EOP, MHCB, RHU CCCMS, RHU EOP, APP, ICF
CTF	7	2	.9	II	CCCMS
HDSP	7	2	.9	I, II, III, IV	CCCMS, EOP, MHCB, RHU CCCMS
CHCF	6	0	.6	N/A, II	CCCMS, EOP, MHCB, RHU EOP, DDP, APP, ICF
CIM	6	0	1	II	CCCMS, EOP, MHCB, DDP
NKSP	6	0	.6	I, II	RC, CCCMS, MHCB
FSP	4	2	.6	I, II, III	CCCMS
SATF	4	1	.5	II, III, IV	CCCMS, EOP, MHCB, RHU CCCMS, DDP
VSP	4	0	.4	II	CCCMS, EOP
CCC[c]	3	--	.4	--	--
CCWF	3	0	.3	N/A	RC, CCCMS, EOP, MHCB, RHU EOP, DDP
PVSP	3	0	.3	I, III	CCCMS, EOP, MHCB, RHU CCCMS
PBSP	2	1	.3	I, II, III, IV	CCCMS, EOP, MHCB, RHU CCCMS
SOL	2	0	.2	II, III	CCCMS, MHCB
CAL	1	0	.1	I, II, IV	--
CRC	1	0	.1	II	CCCMS, EOP
ISP	1	0	.1	I, II, III	--
SCC	0	0	--	I, I, III	CCCMS
ASP	0	0	--	I, II	CCCMS
CEN	0	0	--	I, III, IV	--
CVSP[c]	0	0	--	I, II	--
CAC[c]	0	--	--	--	--

Note: [a] Suicides at fire camps and non-CDCR facilities were excluded. Data for years prior to 2015 are available in previous annual reports. [b] SQRC held condemned adults until 2024. [c] Closed facilities. Averages were based on full years of operation. Security levels and mental health programs reflect only the 2024 composition because compositions have changed over time.

Table A3. Percentage of Suicides by Custody Watch, Time of Day, and Day

Characteristic	2019–2023	2024[a]
Total suicides	134	29
Custody Watch		
1st Watch (2200–0600)	27.6	24.1
2nd Watch (0600–1400)	31.3	34.5
3rd Watch (1400–2200)	41	41.4
Time of Day		
Morning (0600–1200)	25.4	20.7
Afternoon (1200–1800)	29.9	51.7
Evening (1800–2400)	20.1	13.8
Overnight (000–0600)	24.6	13.8
Day		
Sunday	8.2	24.1
Monday	20.1	3.4
Tuesday	10.4	6.9
Wednesday	14.2	20.7
Thursday	16.4	20.7
Friday	12.7	13.8
Saturday	17.9	10.3

Note: [a] Differences between 2024 and prior periods should be interpreted cautiously (see Methodology).

Table A4. Percentage of Suicides by Month, Season, and Quarter

Characteristic	2019–2023	2024[a]
Total suicides	134	29
Month		
January	11.2	10.3
February	5.2	6.9
March	9	6.9
April	7.5	6.9
May	9.7	0
June	6.7	13.8
July	4.5	3.4
August	11.9	0
September	8.2	17.2
October	7.5	6.9
November	7.5	13.8
December	11.2	13.8
Season		
Winter	27.6	31
Spring	26.1	13.8
Summer	23.1	17.2
Fall	23.1	37.9
Quarter		
Quarter 1	25.4	24.1
Quarter 2	23.9	20.7
Quarter 3	24.6	20.7
Quarter 4	26.1	34.5

Note: [a] Differences between 2024 and prior periods should be interpreted cautiously (see Methodology).

Table A5. Audit Criteria for Suicide Reports

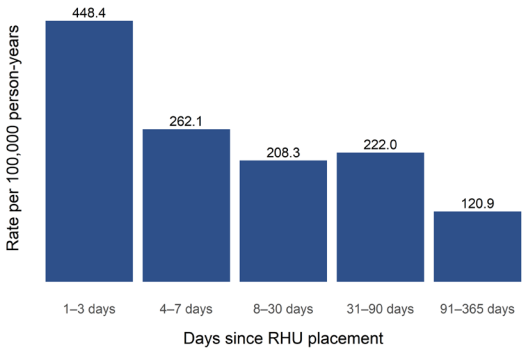
1. Does the Executive Summary describe the means of death, the emergency response taken, and the mental health level of care of the patient?
2. Are the sources for the report identified?
3. Are substance abuse issues reported, if applicable?
4. Does the Institutional Functioning section include information on institutional behavior, including disciplinary history?
5. Does the Mental Health History review the adequacy of mental health care and screening?
6. Are medical concerns discussed?
7. Is the quality of the most recent suicide risk evaluations (past year) reviewed, with comment on risk level, safety planning, and risk and protective factors?
8. Does the Suicide History section review all prior attempts, as applicable?
9. Are significant pre-suicide events discussed?
10. Was a risk formulation offered specific as to why the person was vulnerable to suicide?
11. Does the review comment on the adequacy of the emergency response?
12. Are all violations of policy and breaches of standards of care in mental health, medical, and nursing addressed in the reviewer's concerns, if applicable?
13. Were custody policies followed? If not, were violations noted in the report?
14. Were all concerns raised by reviewers (custody, nursing, and mental health) represented in Quality Improvement Plan recommendations?
15. Were the Quality Improvement Plan recommendations adequate to address the concerns?

Table A6. Likelihood of Harm, Scope, and Risk Scores for Quality Problems, 2022–2024

Problem	Likelihood of Harm	Scope (N)	Risk Score
Program guide timelines/frequency of contact	2.00	72.2%	1.44
911 activation	2.50	36.7%	0.92
Treatment planning	2.25	36.7%	0.83
Monitoring/observation (suicide watch, security/welfare checks, etc.)	2.50	32.9%	0.82
Cut down (kit and use)	3.00	24.1%	0.72
Documentation: SRE	2.00	34.2%	0.68
Documentation: General	1.25	54.4%	0.68
Policy violation (not covered elsewhere)	2.50	25.3%	0.63
Documentation: Safety planning	1.67	31.6%	0.53
Emergency response	3.25	15.2%	0.49
Quality of care (decision-making, level of care)	3.00	15.2%	0.46
Referrals	2.50	15.2%	0.38
Continuity of care/clinician to clinician contacts	2.00	12.7%	0.25
Confidential setting	1.75	11.4%	0.20
5-Day follow-up	3.00	5.1%	0.15
Staff actions	2.25	6.3%	0.14
IDTT meetings	1.75	7.6%	0.13
Self-harm, nonfatal (recording)	2.75	3.8%	0.10
SRMP	2.25	3.8%	0.09
7362 processing	2.00	3.8%	0.08
Training	1.50	5.1%	0.08
Universal precautions	1.00	7.6%	0.08
Issue (clothing, materials, etc.)	1.75	3.8%	0.07
Crisis intervention	3.50	1.3%	0.04
DDP	1.75	2.5%	0.04
Diagnosis	1.50	2.5%	0.04
Crime scene preservation	1.25	2.5%	0.03
Orders/scheduling	2.33	1.3%	0.03
Administration of Narcan	2.25	1.3%	0.03
RVRs	2.25	1.3%	0.03
Programming (yard, privileges, groups, etc.)	1.75	1.3%	0.02
Classification Committee	1.50	1.3%	0.02
Records review/requests/missing records	1.50	1.3%	0.02
Board of Parole Hearings	1.67	0.0%	0.00
Housing review recommendation	1.50	0.0%	0.00
Hunger strike	2.00	0.0%	0.00
ISUDT	1.50	0.0%	0.00
Mechanical restraint (during emergency response)	1.50	0.0%	0.00
Medication	2.25	0.0%	0.00
PC 2602	2.75	0.0%	0.00
PREA	2.00	0.0%	0.00
R & R	2.00	0.0%	0.00
ROI (release of information line)	1.00	0.0%	0.00
Visibility of the Cell	3.00	0.0%	0.00

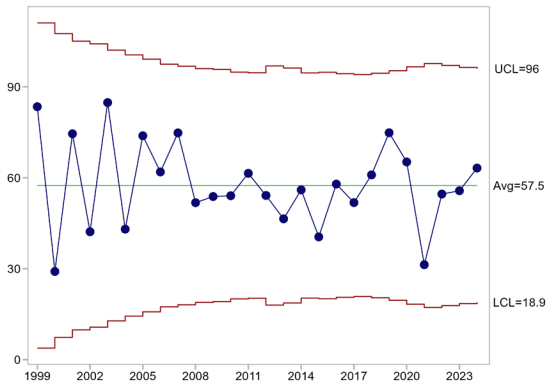
Note: See Methodology for details on how scores were calculated for Likelihood of Harm, Scope, and Risk Score.

Figure A1. Incidence of Suicide within 365 Days of RHU Placement, 2015–2024



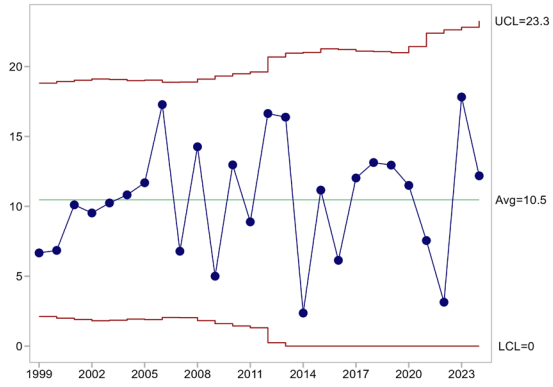
Note: N = 80 suicides. To obtain an adequate sample of suicides, a 10-year period was used.

Figure A2. Rates of Suicide per 100,000 among Mental Health Patients, 1999–2024



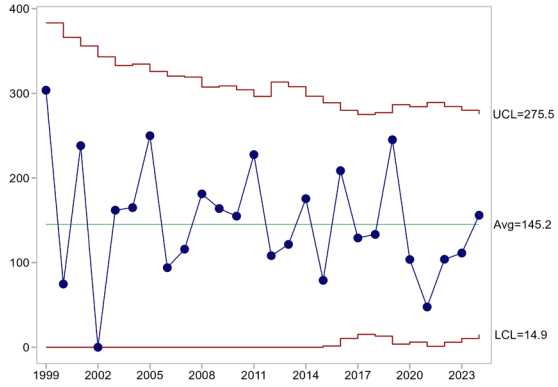
Note: UCL = upper control limit. Avg = overall average. LCL = lower control limit. UCL and LCL reflect three standard deviations from the overall average.

Figure A3. Rates of Suicide per 100,000 among Non-Mental Health Adults, 1999–2024



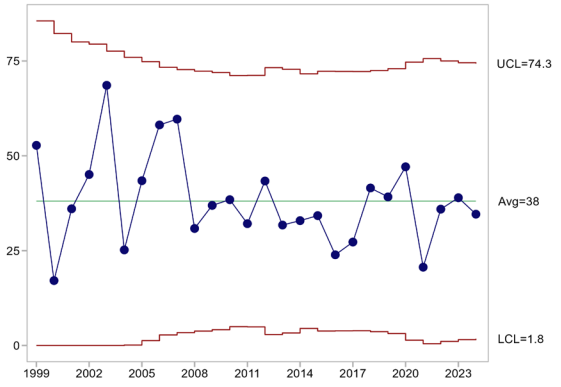
Note: UCL = upper control limit. Avg = overall average. LCL = lower control limit. UCL and LCL reflect three standard deviations from the overall average.

Figure A4. Rates of Suicide per 100,000 among EOP Patients, 1999–2024



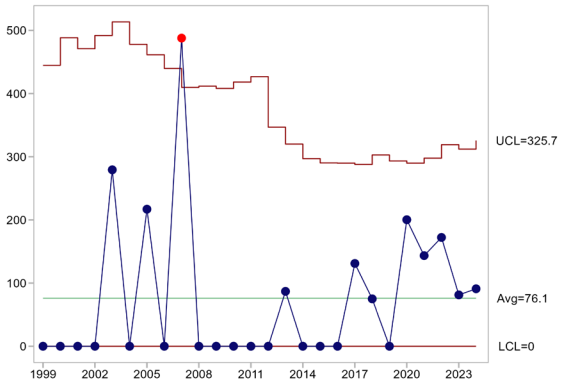
Note: UCL = upper control limit. Avg = overall average. LCL = lower control limit. UCL and LCL reflect three standard deviations from the overall average.

Figure A5. Rates of Suicide per 100,000 among CCCMS Patients, 1999–2024



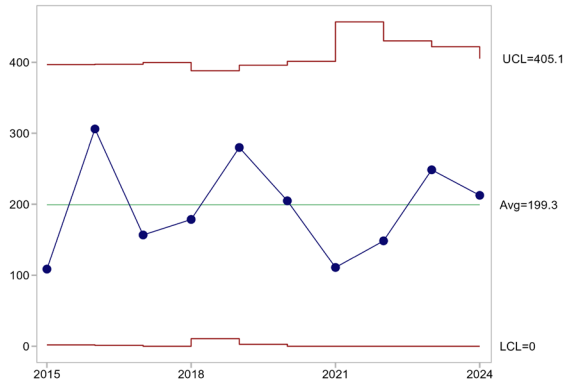
Note: UCL = upper control limit. Avg = overall average. LCL = lower control limit. UCL and LCL reflect three standard deviations from the overall average.

Figure A6. Rates of Suicide per 100,000 among Psychiatric Inpatients and Adults Referred to a Psychiatric Inpatient Unit, 1999–2024



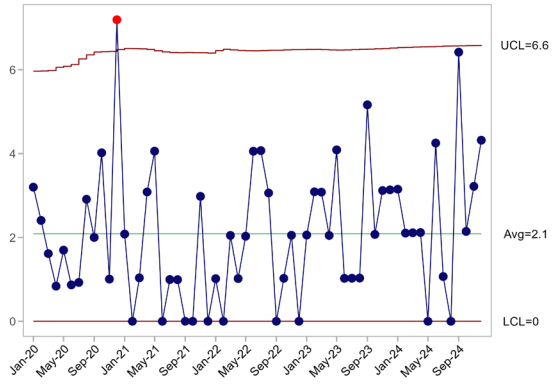
Note: UCL = upper control limit. Avg = overall average. LCL = lower control limit. UCL and LCL reflect three standard deviations from the overall average.

Figure A7. Rates of Suicide per 100,000 among Adults Discharged from an Inpatient Psychiatric Unit within the Last 365 days, 2015–2024



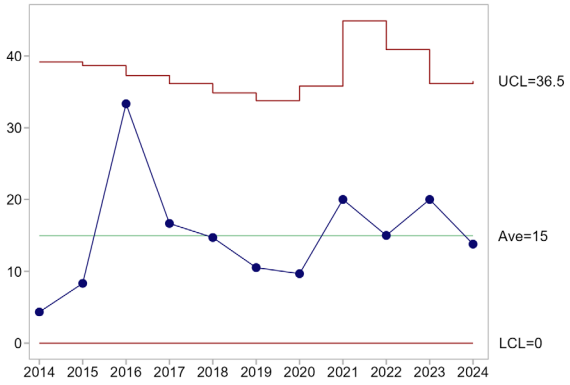
Note: UCL = upper control limit. Avg = overall average. LCL = lower control limit. UCL and LCL reflect three standard deviations from the overall average. Only discharges to outpatient settings (i.e., mainline, RC, and RHU locations) were included.

Figure A8. Monthly Rates of Suicide per 100,000, 2020–2024



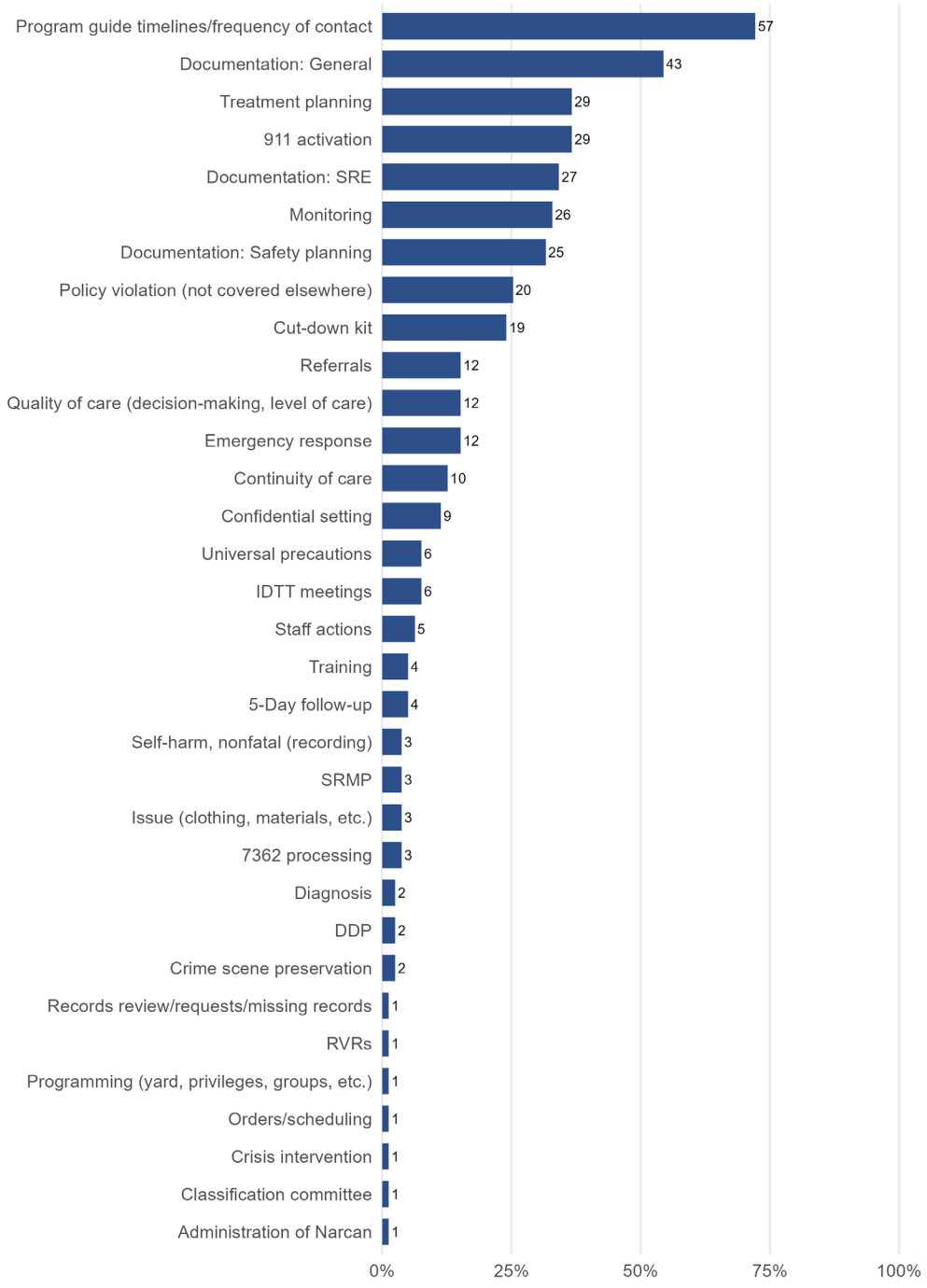
Note: UCL = upper control limit. Avg = overall average. LCL = lower control limit. UCL and LCL reflect three standard deviations from the overall average. See Methodology.

Figure A9. Percentage of Suicides with Evidence of Postmortem Rigidity, 2014–2024



Note: UCL = upper control limit. Avg = overall average. LCL = lower control limit. UCL and LCL reflect three standard deviations from the overall average.

Figure A10. Prevalence of Quality Problems Identified in Suicide Reviews, 2022–2024



Note: From 2022 to 2024 there were 79 suicides. The label to right of each bar refers to the number of suicide reviews that identified the particular problem.

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