

Annual Report on Suicide

in the California Department of Corrections and Rehabilitation

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List of Acronyms

APP	Acute Psychiatric Program	RC	Reception Center
CAP	Corrective Action Plan	RHU	Restricted Housing Unit
CCCMS	Correctional Clinical Case Management System	RVR	Rules Violation Report
CDCR	California Department of Corrections and Rehabilitation	SPR FIT	Suicide Prevention and Response Focused Improvement Team
CPR	Cardiopulmonary Resuscitation	SRE	Suicide Risk Evaluation
CTC	Correctional Treatment Center	SRMP	Suicide Risk Management Program
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		

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, describes trends, and examines opportunities to improve the department's suicide prevention program.

Major Findings

Suicides in 2025

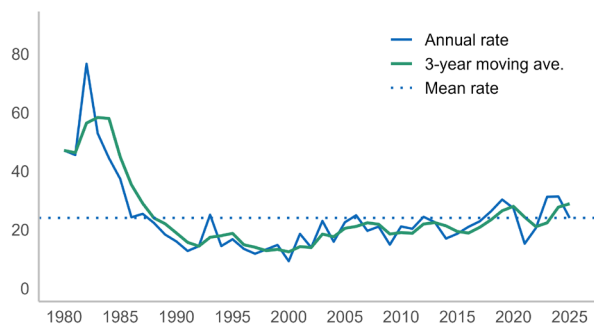
- Of the 117,384 adults who spent at least one night in a CDCR facility during 2025, 22 died by suicide (all males), the equivalent of one death every 17 days.
- The rate of suicide was 24 per 100,000, which was the lowest rate since 2022 (20.6 per 100,000).
- Seventy-seven percent of decedents were receiving mental health care, whereas 40% of the overall population was receiving mental health care. Eighteen percent of decedents were receiving EOP care, whereas 9% of the overall population was receiving EOP care.
- The rate of suicide among all mental health patients was 46.1 per 100,000. The rates among CCCMS patients and EOP patients were 47 and 49.8 per 100,000, respectively.

- About 23% of decedents were housed in RHUs, whereas only 4% of the overall population was housed in RHUs.
- Forty-one percent of decedents were at the highest security level, whereas 24% of the overall population were at the highest security level.
- Seventy-seven percent of decedents were housed alone, whereas 27% of the overall population was housed alone.
- Two-thirds of the decedents were issued an RVR in the previous six months, whereas 29% of the overall population was issued an RVR in the previous six months.

Suicide Trends

- The number of annual deaths by suicide has trended downward 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 25 per 100,000, and the annual rate of suicide has trended upward ([Figure 1](#)).
- Although the RHU population has fallen dramatically, the rate of suicide in RHU has increased steadily from 137 per 100,000 in

Figure 1. Rates of Suicide per 100,000 in CDCR, 1980–2025



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

2014 to 211 per 100,000 in 2019 to 303 per 100,000 in 2024. The rate in 2025 was lower (148 per 100,000).

- 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.
- The increasing suicide rate in CDCR is likely driven by the changing composition of the in-custody population. The percentage of adults enrolled in the mental health program has grown dramatically, from 12% in 1999 to 40% in 2025. Because mental health problems increase suicide risk, a growing mental health population can increase CDCR's overall suicide rate.

Improvement Efforts

This report reviewed all deaths by suicide from

2023–2025 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 quality of security-welfare checks was selected for a performance improvement project. Of the cases identified as having problems with monitoring, nearly half involved the quality of security-welfare checks.

Overview of Suicides in 2025

2025 Annual Report on Suicides in the California Department of Corrections and Rehabilitation

22 DEATHS BY SUICIDE
24 per 100,000

GENDER
100% were male

LIVING ARRANGEMENT
77% were housed alone

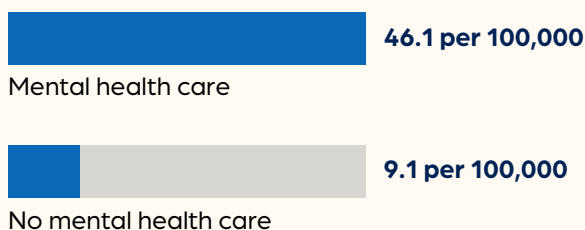
HOUSING TYPE
23% lived in restricted housing units

TRANSFERS
36% were transferred from another prison in the previous six months

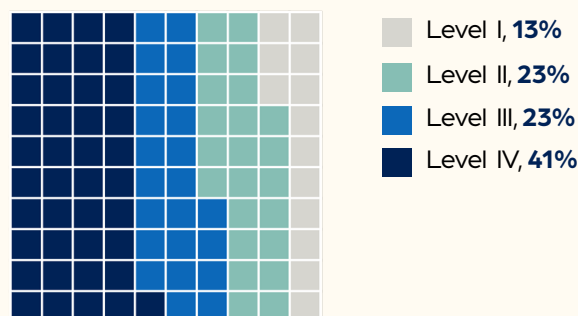
MENTAL HEALTH CARE STATUS
77% were mental health patients

DISCIPLINARY HISTORY
68% were issued an RVR in the previous six months

SUICIDE RATE BY MENTAL HEALTH STATUS



DECEDENTS BY 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. To inform its 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 custody² and monitor the trends in the prevalence of suicide
2. To identify opportunities to improve the department's suicide prevention program based on findings from reviews of suicide

This report also fulfills court-ordered obligations specified in *Coleman v. Newsom*.³

1. For a review of the department's initiatives to reduce suicide risk, see "2025 Annual Report on Suicide Prevention Efforts" (Obegi & Leidner, 2026) prepared for the California Legislature pursuant to Penal Code § 2064.1.

2. 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

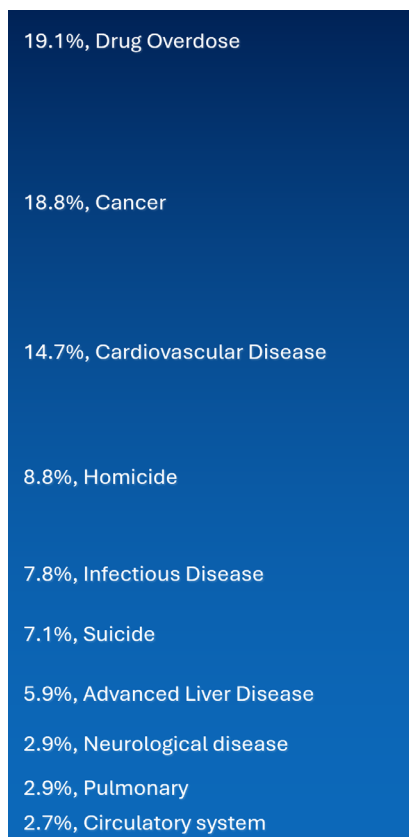
In CDCR, suicide has consistently ranked among the top 10 causes of death. For example, in 2024, suicide was the sixth leading cause ([Figure 2](#)). The number of suicides was comparable to the number of deaths due to infectious diseases and deaths due to advanced liver disease.

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), consists of 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 people, 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 con-

Figure 2. Leading Causes of Death in CDCR, 2024



Note: N = 409. Imai (2025).

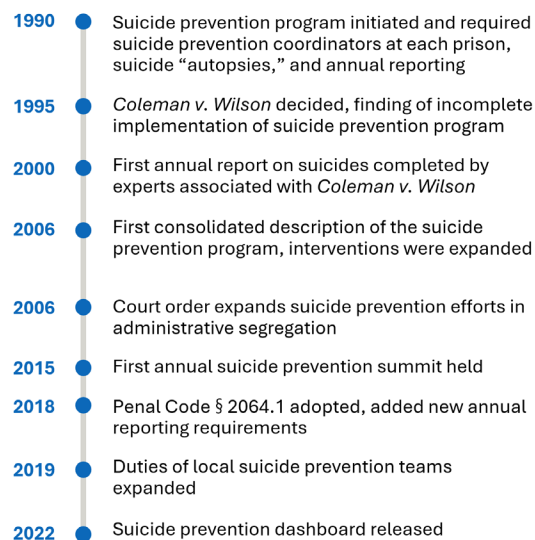
tains components that ensure staff are equipped to fulfill their suicide prevention roles and that the physical environment in treatment areas is safe. Finally, the Quality square has components designed to monitor how well central components in the other squares are working. The resulting data is used to drive continuous improvement. This report is one of several components of the Quality square.

New Report Features

This report introduces four new features:

- 1. Age-Adjusted Rates:** Appreciating how CDCR's suicide rates among men compare to the rates of California men requires statis-

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



Note: Adapted from Canning (2018).

tically adjusting rates for age (see [Methodology](#)). Age-adjusted rates are presented in [Figure 5](#), Panel B.

- 2. Additional Suicide Rates:** Rates of suicide were calculated for adults in RHU enrolled and not enrolled in the mental health program ([Figure A5 in the Appendix](#)).
- 3. Physical Disabilities:** This report adds the percentage of decedents who had a physical disability (p. 11).
- 4. Diagnostic categories:** Previous reports described the percentage of decedents by diagnostic category. This report adds the prevalence of diagnostic categories in the total in-custody population ([Table 6](#)).

Interpretive Caution

This report describes many 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 suicide may be changing over time. This chapter 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 through 2015, the rate was relatively stable. However, beginning in 2016, rates were generally above the historical average of 19.6 per 100,000. This trend indicates a changing

suicide rate. (See Table A1 in the Appendix for the suicide counts and rates since 1980.)

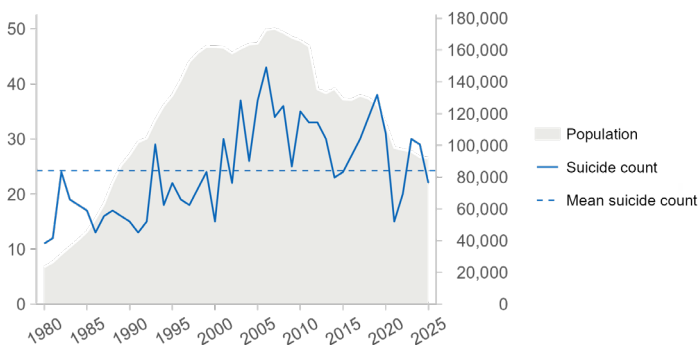
To further examine this trend, Panel C presents a moving average chart, which is designed to detect changes over time. In CDCR, unusually low rates occurred in the early 1980s and again in 1998 and 2000. Several unusually high rates have also occurred since 2020. These recent changes suggest that the overall suicide rate has increased.

Population Trends

The suicide rate is heavily influenced by the composition of a population. For example, because males die by suicide at a higher rate than females, populations with more males are likely to have higher overall suicide rates than populations with fewer males. Thus, whenever the size of a group at increased risk of suicide grows relative to other groups, the overall suicide rate of the population is also likely to grow. This phenomenon is known as a composition effect.

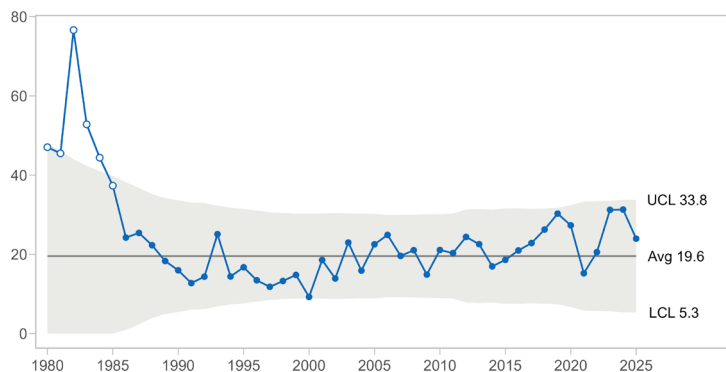
The steady increase in CDCR's overall suicide rate is likely driven by a change in the mental health composition of its incarcerated population. The proportion of the mental health population has grown steadily for the past 26 years. In 2000, less than 14% of the population was enrolled in men-

Figure 4. Suicide Trends in CDCR, 1980–2025



Panel A

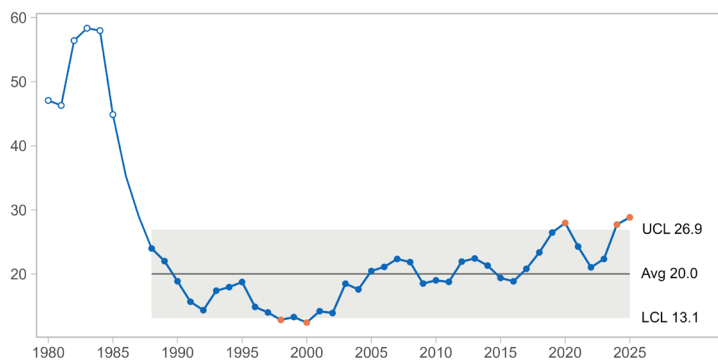
Annual suicide counts and CDCR populations



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 from calculation of the UCL, Avg, and LCL (hollow points). See [Methodology](#).

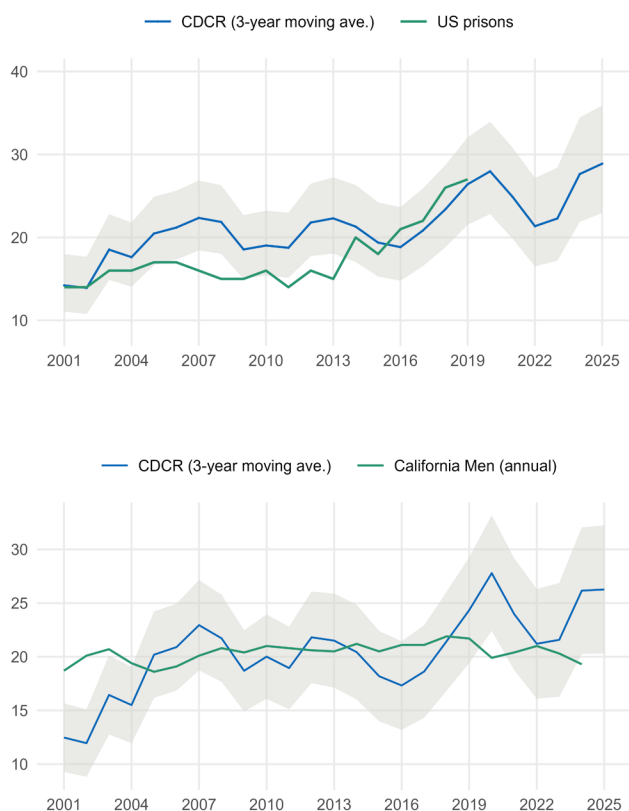


Panel C

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 from calculation of the UCL, Avg, and LCL (hollow points). Orange dots mark rates that exceeded the control limits.

Figure 5. Rates of Suicide in CDCR versus Other Populations



Panel A

Rates of Suicide per 100,000 in CDCR and U.S. Prisons, 2001–2025

Note: The shaded band is the 95% confidence interval for the CDCR rate. 2019 is the most recent data available for U.S. prisons (Carson et al., 2021).

Panel B

Age-Adjusted Suicide Rates per 100,000 among CDCR Men and California Men, 2001–2025

Note: The shaded band is the 95% confidence interval of the age-adjusted moving average for CDCR men. 2024 is the most recent data for California men (Center for Disease Control and Prevention, 2026).

tal health services. In 2025, it was 40%. Because mental health problems increase suicide risk, a growing mental health population is likely to increase CDCR's overall suicide rate. Importantly, the increase in the overall rate is occurring even though the suicide rates in the mental health and non-mental health populations have been statistically stable (Figure A5 in the Appendix).

Comparative Trends

Another way to understand the suicide rate in CDCR is to compare it to the rates in related populations. Panel A in Figure 5 compares the CDCR rate to the national rate in U.S. state prisons. The CDCR rate was generally higher than the rate in

U.S. state prisons until 2014, when both rates became similar through 2019.¹

Nearly all suicides in CDCR are by men, so it is also useful to compare the age-adjusted CDCR rate for men to that of Californian men. Panel B in Figure 5 shows that CDCR's age-adjusted rate hovered at or below the California rate up until 2019 and has since moved above it in most years. Across all available years, the average age-adjusted rate was 20.8 per 100,000 for CDCR men and 20.4 for California men.

1. Comparing the unadjusted rates of different populations requires caution (see Methodology).

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 2020 to 2025. 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. Compared to recent years, the percentage of suicides in 2025 among Hispanics was lower and the percentage among Whites was higher. From 2020 to 2024, roughly 62% of adults who died by suicide were under the age of 45. In 2025, the figure was 73%.

Social Characteristics

Table 2 displays the percentage of suicides in additional groups from 2020 to 2025. 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 2020–24	Suicides 2025 ^a	Total In-Custody 2025
Total	125	22	91,805
Gender Identity			
Male	96	100	94.6
Female	3.2	0	4.3
Non-binary	.8	0	1.1
Unknown	0	0	>.1
Race/Ethnicity			
Hispanic	40	27.3	46.7
Black	17.6	13.6	27.4
White	36	54.5	19.5
Other	6.4	4.5	6.5
Age			
18–24	6.4	0	3.8
25–34	29.6	36.4	25.2
35–44	25.6	36.4	29.1
45–64	33.6	18.2	33.7
65 or older	4.8	9.1	8.2

Note: ^a Differences between 2025 and prior periods should be interpreted cautiously (see [Methodology](#)). Since 2020, two transgender adults died by suicide.

Table 2. Percentage of Suicides by Social Characteristic

Characteristic	2020–2024 ^a	2025
Total suicides	125	22
Marital Status		
Single	60	50
Married	16.8	31.8
Divorced	17.6	13.6
Widowed	4	4.5
Unknown	1.6	0
Education		
< High school	43.2	40.9
High school	25.6	22.7
GED	24	36.4
College degree	4	0
Unknown	3.2	0
Employment		
Unskilled	61.6	59.1
Skilled	16.8	13.6
N/A or unknown	20.8	27.3
Juvenile Offenses		
Yes	60	68.2
No	34.4	27.3
Unknown	5.6	4.5
Primary Language		
English	88	86.4
Spanish	11.2	13.6
Other	.8	0

Note: ^a Differences between 2025 and prior periods should be interpreted cautiously (see [Methodology](#)). Except for primary language, total in-custody data is unavailable for these characteristics.

was the primary language of the vast majority of decedents.

Health Conditions

From 2020 to 2024, 34.4% of adults who died by suicide were judged to have a serious, painful,

or life-threatening medical condition. Similarly, in 2025, five or 22.7% had such a condition. The most common condition (4 of 5) was chronic pain.

Regarding physical disabilities, from 2020 to 2024, 11% of decedents had a physical disability compared to 11% of the population over the same period. In 2025, 23% of decedents had a physical disability compared to 16% of the population.

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 2020 to 2024, 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). Suicides in hospital settings were rare. A disproportionate number of decedents were housed on yards designated for adults with safety concerns¹ (i.e., GP-designated). Similarly, a disproportionate number of decedents were housed alone: 82% compared to 26% in the total population.² About half had an assigned job or were enrolled in an educational program. The findings for 2025 were largely similar ([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 2025, the average rate of suicide in RHU was 171 per 100,000. The rate in 2025 was 148 per 100,000. The suicide rate in RHU has trended upwards ([Figure 6](#), Panel B). The upward trend may be due to the composition effect discussed earlier ([p. 7](#)). The proportion of mental health patients in RHU roughly doubled from 2010 to 2025 (33% versus 61%). Because mental health patients are at greater risk for suicide generally, increases in the size of the mental population in RHU will elevate the overall suicide rate in RHU. This effect will occur even though the suicide rates among mental health patients and non-mental health adults in RHU are statistically stable (see [Figure A5](#) in the Appendix).

From 2016 to 2025, twenty-five percent of suicides occurred within 7 days of placement. The rate of suicide was highest during the first 3 days of placement ([Figure A1](#) in the Appendix).

Suicides by Facility

All in-custody suicides in 2025 occurred in CDCR prisons. Historically, some facilities have had

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

Characteristic	Suicides 2020–2024	Suicides 2025 ^a	Total In-Custody 2025
Total	125	22	91,805
Security Level			
I	7.2	13.6	9.6
II	27.2	22.7	49.8
III	11.2	22.7	15.7
IV	50.4	40.9	23.7
Unclassified	4	0	1.2
Housing Type^b			
Condemned	1.6	0	.6
CTC	1.6	0	.9
DSH	0	0	>.1
Fire camp	.8	0	2.1
GP–designated	21.6	18.2	6.4
GP–non–designated	33.6	59.1	69.4
PIP	4.8	0	.8
RC	4.8	0	5.2
RHU	31.2	22.7	3.6
Housing Arrangement			
Alone	82.4	77.3	26.4
With one person	8	13.6	40.9
With multiple persons	9.6	9.1	32.8
Job or Educational Assignment			
Yes	52	54.5	70.1

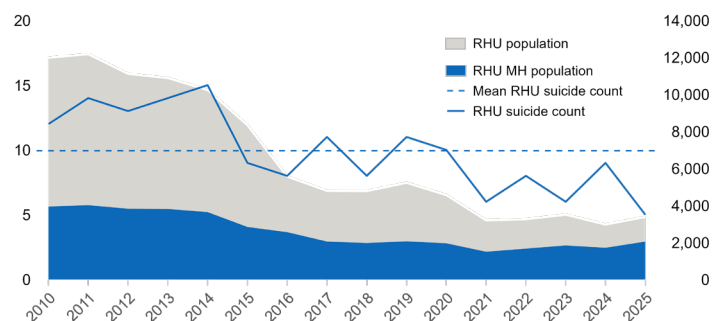
Note: ^a Differences between 2025 and prior periods should be interpreted cautiously (see [Methodology](#)). ^b “Total In-Custody 2025” percentages do not sum to 100% because CDCR has numerous housing codes, and only codes involving a suicide are listed.

Table 4. Percentage of Suicides by Criminal Justice Characteristic

Characteristic	Suicides 2020–2024	Suicides 2025 ^a	Total In-Custody 2025
Total	125	22	91,805
Most Serious Offense			
Person	92	90.9	83.6
Property	6.4	9.1	6.9
Drug	.8	0	2.4
Other	.8	0	7.1
Sentence Length			
< 6 years	13.6	18.2	18.7
6–10 years	14.4	13.6	12.6
11–20 years	20	13.6	16.7
21+ years	16	4.5	13
LWP	28.8	36.4	32.7
LWOP	4	9.1	5.8
Condemned	3.2	4.5	.6
Time Served			
< 1 year	16.8	13.6	28.8
1–5 years	28.8	22.7	16.1
6–10 years	20.8	22.7	18.6
11–20 years	23.2	36.4	19.8
21+ years	10.4	4.5	16.8
Time Left to Serve			
< 1 year	13.6	22.7	12.7
1–5 years	37.6	27.3	34.9
6–10 years	8.8	4.5	8.1
11–15 years	8	13.6	2.9
16+ years	32	31.8	41.2 ^b

Note: ^a Differences between 2025 and prior periods should be interpreted cautiously (see [Methodology](#)). ^b Includes all indeterminate sentences (LWP, LWOP, and condemned).

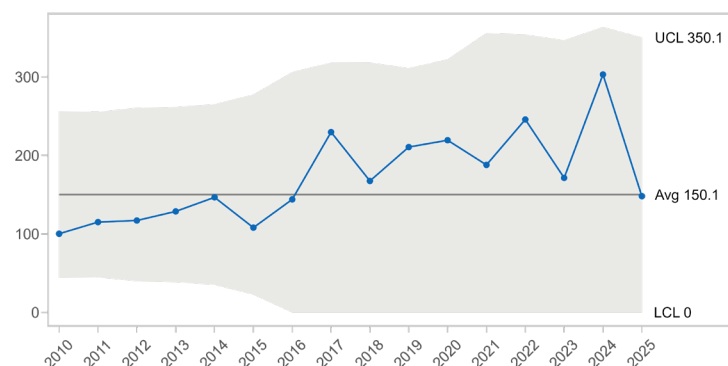
Figure 6. Suicide Trends in RHUs, 2010–2025



Panel A

Annual suicide counts in RHUs and RHU populations

Note: Reliable housing data before 2010 are unavailable.



Panel B

Rate 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.

more suicides than others ([Table A2](#) in the Appendix), 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 2016 to 2025, eight facilities accounted for roughly 50% of all deaths. Over the same period, the number of suicides per facility ranged from none to 23.

Criminal Justice Characteristics

[Table 4](#) shows the percentage of suicides by various criminal justice characteristics. From 2020 to 2024, the overwhelming majority of de-

cedents (92%) committed offenses against a person. Decedents with sentences 20 years or less were roughly as common as those with sentences longer than 20 years (48 vs. 52%). Life with the possibility of parole was the most common sentence length (28.8%), 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 2025 were largely similar.

Mental Health Characteristics

In the community, people with mental health disorders are at greater risk for suicide, and more serious disorders generally carry greater risk. This chapter examines the mental health characteristics of in-custody adults who died by suicide.

Mental Health Care

From 2020 to 2024, seven of every ten deaths by suicide were by adults receiving mental health services in CDCR. Similarly, in 2025, a disproportionate number of mental health patients died by suicide. Although 40% of the total in-custody population received mental health care, 77% of decedents in 2025 did so ([Table 5](#)). A history of mental health care in the community was also common ([Table 5](#)).

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 over five times higher: 56.2 versus 10.5 per 100,000. In 2025, the rate was 46.1 per 100,000 among mental health patients and 9.1 among non-mental health patients. No unusual changes in the suicide rate among mental health patients or non-mental health adults have occurred since 2000 ([Figure A5](#) in the Appendix).

[Figure 7](#) shows the suicide rate from 2000 to

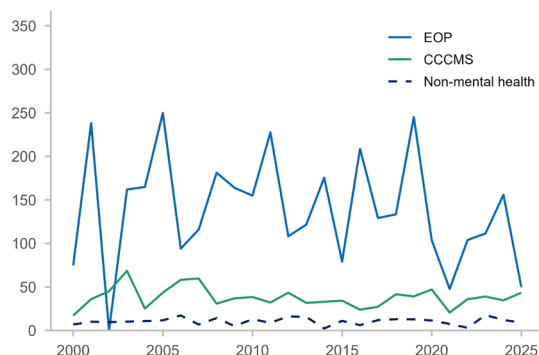
2025 by level of outpatient mental health care. In general, the rates among EOP patients were markedly higher than the rates among CCCMS patients or non-mental health patients. The average rate was 138.5 per 100,000 among EOP patients and 38.1 per 100,000 among CCCMS patients. For EOP and CCCMS patients, no unusual changes in the suicide rate have occurred ([Figure A5](#)). For psychiatric inpatients or those referred to a psychiatric inpatient unit, no unusual changes in the suicide rate have occurred except in 2007 when three such patients died by suicide ([Figure A2](#) 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 2020 to 2024, three decedents (2.4%) were DDP, compared with 1.2% of the 2024 total in-custody population. One was an EOP patient, and two were PIP patients. No adults classified as DDP died by suicide in 2025.

Psychiatric Medications

From 2020 to 2024, about half of decedents were prescribed medications by a psychiatrist at the time of their deaths ([Table 5](#)). The percentage in 2025 was similar (50%) but higher than the total in-custody population (27.7%).

Figure 7. Rates of Suicide per 100,000 by Level of Outpatient Mental Health Care, 2000–2025



About 6% of decedents from 2020 to 2024 had an active court order for involuntary psychiatric medication (Table 5). In 2025, the percentage was higher (9.1%).

Psychiatric Diagnoses

From 2020 to 2024, mood disorders, psychotic disorders, and personality disorders were over-represented among decedents (Table 6). In 2025, these disorders were also over-represented as were trauma- and stressor-related disorders (Table 6). Decedents often had diagnoses in more than one diagnostic category. From 2020 to 2024, 43% of decedents had diagnoses in more than one category. In 2025, 71% did.

From 2020 to 2024, 92% of decedents had a history of drug use. In 2025, 86% had a history of drug use.

Suicide Risk Management Program

Mental health patients who meet certain criteria are enrolled in the Suicide Risk Management Program (SRMP). The program involves augmented treatment plans designed to further reduce suicide risk. In 2025, four decedents were enrolled in SRMP. In addition, the number of patients enrolled in SRMP grew from 1,688 at the end of Q1 to 1,832 at the end of Q4.

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

Characteristic	Suicides 2020–2024	Suicides 2025 ^a	Total In-Custody 2025
Total	125	22	91,805
Level of Mental Health Care			
Any	72.8	77.3	40.2
CCCMS	36	59.1	30.1
EOP	29.6	18.2	8.8
Inpatient ^b	7.2	0	1.3
Mental Health Care in the Community^c			
Yes	65.9	50	51.9
DDP			
Yes	2.4	0	1.2
Psychiatric Medications			
Yes	54.4	50	27.7
Involuntary Medications			
Yes	6.4	9.1	2

Note: ^a Differences between 2025 and prior periods should be interpreted cautiously (see [Methodology](#)). ^b Inpatient includes MHCB, PIP, and DSH. ^c In-custody counts based on responses to mental health screening questions about prior treatment, when available.

Post-Discharge Suicides

From 2016 to 2025, 29% (80 of 276) of decedents died by suicide in outpatient settings within one year of discharge from an inpatient psychiatric unit (i.e., from MHCBs, PIPs, or DSH), or eight adults per year on average. Nearly half died within 60 days of discharge (46%), and most were at the EOP level of care (74%).

From 2015 to 2025, 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 A3 in the Appendix). No unusual trends in the rate have occurred since 2015. The

Table 6. Percentage of Suicides by Diagnostic Category

Diagnostic Category ^a	Suicides 2020–2024	Suicides 2025	Total In-Custody 2025
Total	125	22	91,805
Mood disorders	35.2	50	17.1
Psychotic disorders	26.4	18.2	8.8
Substance-related disorders	24.8	31.8	24.1
Trauma-and-stressor-related disorders	21.6	36.4	15.9
Personality disorders	15.2	13.6	6.5
Anxiety disorders	10.4	0	10.7
Gender dysphoria	.8	0	1.1
Neurodevelopmental disorders	.8	9.1	1.3
No diagnosis	21.6	22.7	55.6

Note: Only diagnostic categories that occurred among decedents are listed. Diagnostic categories were drawn from the most recent version of the DSM (American Psychiatric Association, 2022). Mood disorders include depressive and bipolar disorders. Total in-custody percentages reflect any adult who carried a diagnosis, not just those enrolled in the mental health program. The sum of percentages exceeds 100% because many decedents carried multiple diagnoses.

^a Differences between 2025 and prior periods should be interpreted cautiously (see [Methodology](#)).

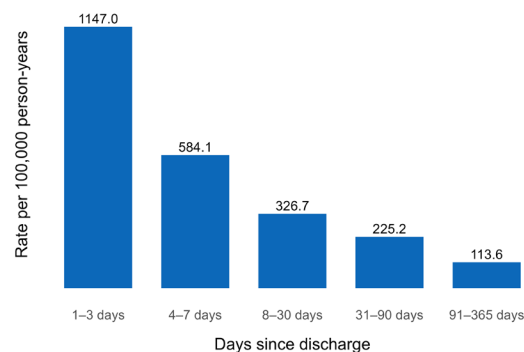
rate of suicide was highest immediately after discharge and declined thereafter ([Figure 8](#)).

History of Non-Fatal Self-Harm

From 2020 to 2024, over half of the adults who died by suicide (60%) had a history of suicide attempts (i.e., in CDCR, other custodial settings, or the community). About one in three (34%) had a history of suicide attempts while incarcerated in CDCR. About 19% had a history of NSSI in CDCR. Nineteen percent had a history of both suicide attempts (in any setting) and NSSI (in CDCR).

Percentages in 2025 were similar. About 64% of adults who died by suicide had a history of sui-

Figure 8. Rate of Suicide within 365 Days of Discharge from an Inpatient Psychiatric Unit, 2016–2025



Note: To obtain adequate sample sizes for each of the post-discharge timeframes (e.g., 0–7 days), a 10-year period was used. Person-years are comparable to annual rates of suicide.

cide attempts, and 36% had a history of suicide attempts in CDCR. Three (14%) had a history of NSSI in CDCR. About 14% 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](#)).

Timing

In 2025, the number of deaths per month ranged from 1 to 3. The average was two deaths per month. Compared to previous years, no month in 2025 had an unusual suicide rate ([Figure A4](#) 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

Table 7. Percentage of Suicides by Method

Method	2020–2024	2025 ^a
Total suicides	125	22
Hanging	72.8	77.3
Asphyxiation	13.6	9.1
Laceration	7.2	9.1
Overdose	2.4	4.5
Insertion/Ingestion	2.4	0
Jumping	.8	0
Other	.8	0

Note: ^a Differences between 2025 and prior periods should be interpreted cautiously (see [Methodology](#)).

precipitants. [Table 8](#) presents the percentage of suspected precipitants among those who died by suicide.

From 2020 to 2024 and in 2025, the three most commonly suspected precipitants were mental health symptoms, custodial and legal issues, and substance-related issues. In 2025, more than one precipitant was suspected in nearly all cases (22).

Recent Inter-Facility Transfers

From 2020 to 2024, 36% of adults who died by suicide did so less than six months after their most recent inter-facility transfer (Table 9). In 2025, the figure was similar and disproportionate to the in-custody population.

Recent RVRs

From 2020 to 2024, half of the decedents had an RVR in the previous 6 months. The figure was higher in 2025 and disproportionate to the in-custody population (Table 9).

Suicide Notes

From 2020 to 2024, about one in every five decedents (18%) left a suicide note. Similarly, in 2025, 23% of 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. 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 included danger to self. In 2025, six adults died while on some level of enhanced monitoring, all of whom were housed in an RHU.

Postmortem Rigidity

Evidence of postmortem rigidity (i.e., rigor mortis) was noted in four decedents in 2025.¹ One decedent was housed in an RHU and the remainder in mainline units. Since 2014, no unusual changes occurred in the percentage of decedents found with evidence of postmortem rigidity (Figure A6 in the Appendix).

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	2020–2024	2025 ^a
Total precipitants^b	267	53
Mental health symptoms	24.3	22.6
Custodial or legal issues	18.7	20.8
Substance-related issues	15.4	18.9
Safety concerns	14.2	5.7
Crises of despair	13.5	22.6
Medical concerns	8.2	5.7
History of childhood trauma	3.4	0
COVID-19	31.5	0
Board of Parole Hearings	.7	1.9
Other	0	1.9

Note: ^a Differences between 2025 and prior periods should be interpreted cautiously (see [Methodology](#)). ^b 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	Suicides 2020–2024	Suicides 2025 ^a	Total In-Custody 2025
Total	125	22	91,805
Inter-Facility Transfer^b			
Yes	36	36.4	24.7
RVR^c			
Yes	50.4	68.2	28.9

Note: ^a Differences between 2025 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, referred to as non-suicidal self-injury (NSSI), and behaviors with the intent to die (suicide attempts).

Non-Fatal Self-Harm in 2025

Nearly 2,200 adults engaged in a total of 5,679 acts of non-fatal self-harm in 2025. Seventy-two adults accounted for 25% of all incidents. The vast majority of non-fatal self-harm was NSSI (Table 10), and nearly 90% involved no injury or minor injury. The three common methods of self-injury were laceration, ingestion/insertion, and self-inflicted blows (e.g., head banging).

Of the 308 suicide attempts, 10.1% 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

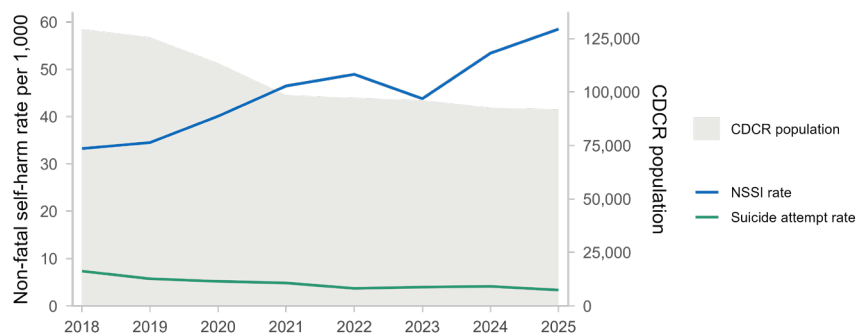
Figure 9 shows trends in non-fatal self-harm from 2018 to 2025. Over this period, the rate of suicide attempts declined, from 7.4 per 1,000 in 2018 to

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

Characteristic	2020–2024	2025 ^a
Total incidents	25,221	5,679
Unique Individuals	9,985	2,157
Type		
NSSI	91.3	94.6
Suicide attempts	8.7	5.4
Injury Severity^b		
No injury	23.3	30.9
Minor	63.1	58.2
Moderate	12.1	9.8
Severe	1.5	1.1
Level of Mental Health Care		
GP	2.7	2.1
CCCMS	12.8	15
EOP	30.9	35.5
MHCB	19.5	25.3
PIP	33.9	22
Unclassified	.2	.1

Note: Excludes incidents of unknown intent (1,349 from 2020 to 2024 and 239 in 2025). ^a Differences between 2025 and prior periods should be interpreted cautiously (see [Methodology](#)). For definitions, see [Methodology](#).

Figure 9. Rate of Non-Fatal Self-Harm, 2018–2025



Note: Excludes events of unknown intent. Data prior to 2018 was unavailable or unreliable.

3.4 per 1,000 in 2025. By contrast, the NSSI rate trended upward. The latter may be at least partly 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 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 identified by reviewers of suicide cases.

Reviews of Suicides

Compliance with Deadlines

The review process has multiple deadlines to ensure that each step of the review process is completed timely. In 2025, four of the five deadlines were not consistently met (Table 11). Although compliance with the site visit deadline was low, site visits were completed within 10 days of the death on average, and all site visits occurred within 20 days of the death. Deadlines for report drafts and review conferences were sometimes missed due to extenuating circumstances (i.e., reviewer vacations, reviewer workload, holidays, and departmental activities). Report drafts were completed on average within 31 days of the death (range = 22–50). Review conferences were held on average within 46 days of the death (range = 35–57).

Table 11. Percentage of Cases Compliant with Review Deadlines in 2025

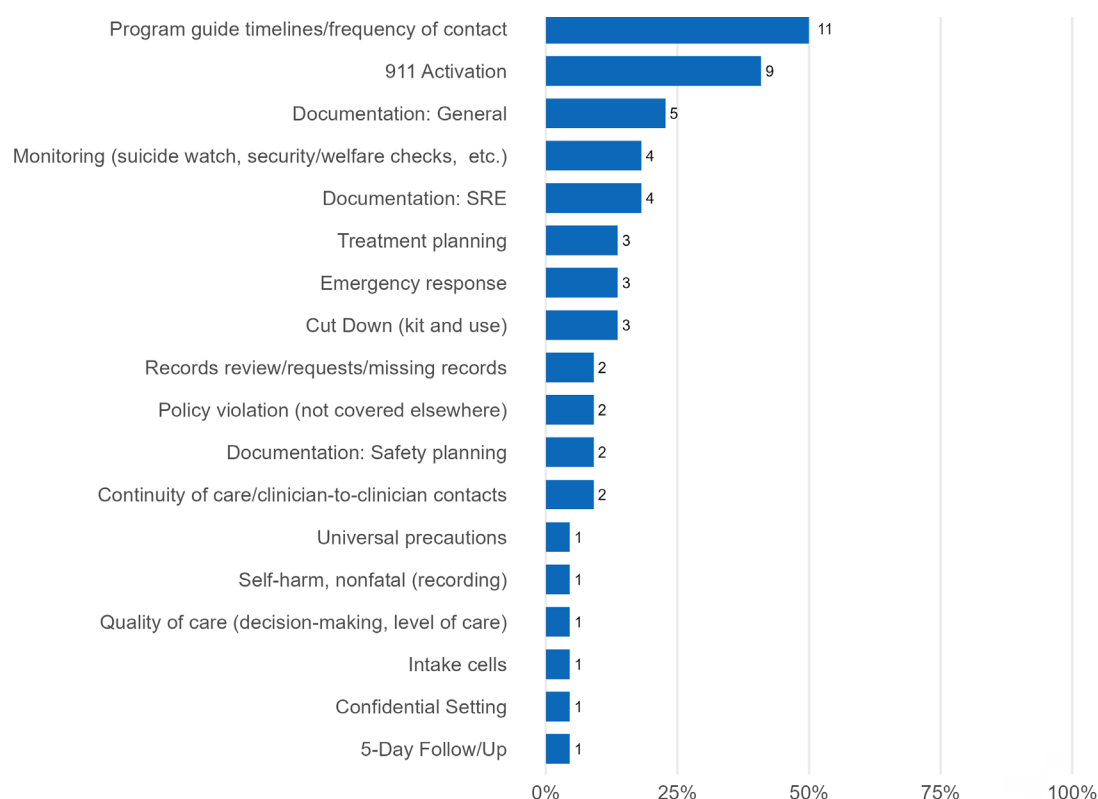
Deadline (days)	Percent
1. Reviewer assigned (within 5 business days)	96
2. Site visit (within 7 calendar days of no. 1)	46
3. Facility's internal review (within 10 business days)	68
4. Draft suicide report (within 30 calendar days)	68
5. Review conference (within 45 calendar days)	73

Note: N = 22. In 21 cases, deadlines were based on the date of death. Due to a belated determination of suicide, one case relied on the date of death and the date of determination, as applicable.

Quality of Suicide Reports

The department uses a 15-item audit to check report quality (Table A5 in the Appendix). In 2025, all reports passed the audit (90% or better).

Figure 10. Prevalence of Quality Problems Identified in Suicide Reviews, 2025



Note: In 2025, there were 22 suicides. Each bar's label indicates how many suicide reviews identified the problem.

Quality Problems

When warranted, reviewers identified quality problems.¹ In 2025, reviewers found quality problems in most cases (18 of 22). The five most common types of problems were: meeting timelines for treatment, delays in 911 activation, documentation quality, monitoring, and SREs (Figure 10). Compared to previous years, one new type

of problem was identified (intake cells²), fewer types occurred, and fewer quality problems per death were found. (For trends in quality problems across years, see the section [Trends in Quality Problems](#), below.)

Emergency Response

In 2025, reviewers identified three problems with the emergency response to suicides: not immediately requesting emergency medical services (911), not responding with or properly using cut-

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.

2. Intake cells refer to failures to place new RHU arrivals in cells retrofitted to be suicide-resistant and/or retaining new arrivals in those cells for 72 hours.

down kits, and not implementing all aspects of the emergency response procedures.

Requests for emergency medical services (911) were not made immediately when indicated in nine cases (40.9%). In all but one case, requests were made after the initial emergency response (e.g., removal of a ligature and moving the body outside of the cell to perform CPR). The average time to activation was 3.1 minutes (range = 1–6).

Problems using cut-down kits were evident in three cases (13.6%). Officers retrieved the cut-down tool but not the entire kit, retrieved the kit without the tool, or cut the ligature without fully removing the noose.

The quality of the emergency response was implicated in three cases (13.6%). In two cases, staff did not immediately activate their personal alarm. In the third case, paramedics were delayed at the prison's sally port.

Depending on the circumstances and custody factors, mechanical restraints may be applied during the emergency response. This occurred in 11 cases (50%). Four of the cases (11%) occurred in an RHU, and the remainder in general population housing. In two cases (9.1%), restraints were applied before life-saving measures; one occurred in an RHU and in the other, an officer suspected a ruse. The application of mechanical restraints and life-saving measures occurred simultaneously in one case.

By comparison, from 2022 to 2024, mechanical restraints were applied in 41% of cases (33 of 79). Of these, 45% occurred in an RHU or with a maximum custody patient. In eight cases (24%), restraints were applied before life-saving measures: Four took place in an RHU or with a maximum custody patient, and another two involved lacerations.

Level of Mental Health Care

In 2025, reviewers identified one case in which staff did not sufficiently justify a decision to lower the level of care. Reviewers did not find other

problems related to level-of-care decisions (i.e., failing to refer patients to a higher level of mental health care or failing to review the appropriateness of the current level of care).

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 problems.³ The QIP names the problem, recommends one or more actions, lists the documents needed to confirm the action has been completed, and assigns responsibility for completing the action to the appropriate facility executive.

In 2025, reviewers issued a total of 76 QIPs, or two QIPs per suicide on average (range 0–11). Reviewers issued QIPs to 17 facilities (Table 12). In general, facilities with more suicides were issued more QIPs. Across all suicides, the number of QIPs for each facility ranged from zero to 16. Two facilities were issued 11 or more QIPs, and four were issued six to 10 QIPs. The remaining facilities were issued five or fewer QIPs.

A single facility with more than one suicide in 2025 sometimes exhibited the same problem in multiple cases:

- SVSP: Three of the four reviews identified problems with treatment timelines, all of which were attributed to critical levels of mental health staff. Two cases involved delays in 911 activation, and another two cases involved collaboration or communication regarding care needs.
- KVSP: There were no repeated problems.
- CMC: In both reviews, delays in 911 activation were identified.
- VSP: There were no repeated problems.
- CIM: There were no repeated problems.

3. Reviewers flag all quality problems. Identifying a problem does not mean a connection to the suicide existed.

Table 12. QIPs and Suicides by Facility, 2025

Facility	QIPs	Suicides
Total	76	22
SVSP	17	4
KVSP	14	3
CMC	8	2
CHCF	6	1
LAC	6	1
VSP	5	2
PVSP	4	1
SATF	4	1
ISP	3	0
RJD	2	1
WSP	2	0
CIM	1	2
COR	1	1
FSP	1	1
MCSP	1	1
SCC	1	0
CTF	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.

Table 13 presents QIPs by region. Regions with more suicides were issued more QIPs.⁴

Implementation of QIPs

All facilities must implement QIPs within 60 days of receiving a final suicide report. Of the 17 applicable cases,⁵ 76.5% had their associated QIPs completed within 60 days. The four cases not meeting the deadline were overdue by one day.

4. 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.

5. Five cases were not applicable. Four had no QIPs. One case had a belated determination. As a result, QIP timelines ran past the due date for this report.

Table 13. QIPs and Suicides by Region, 2025

Region	QIPs Opened	QIPs Closed	Suicides
Total	76	74	22
Region I	3	3	2
Region II	28	26 ^a	8
Region III	33	33	8
Region IV	12	12	4

Note: In 2025, Regions I, III, and IV had eight facilities. Region II had seven facilities. ^a One suicide had a belated determination. As a result, QIP timelines ran past the due date for this report.

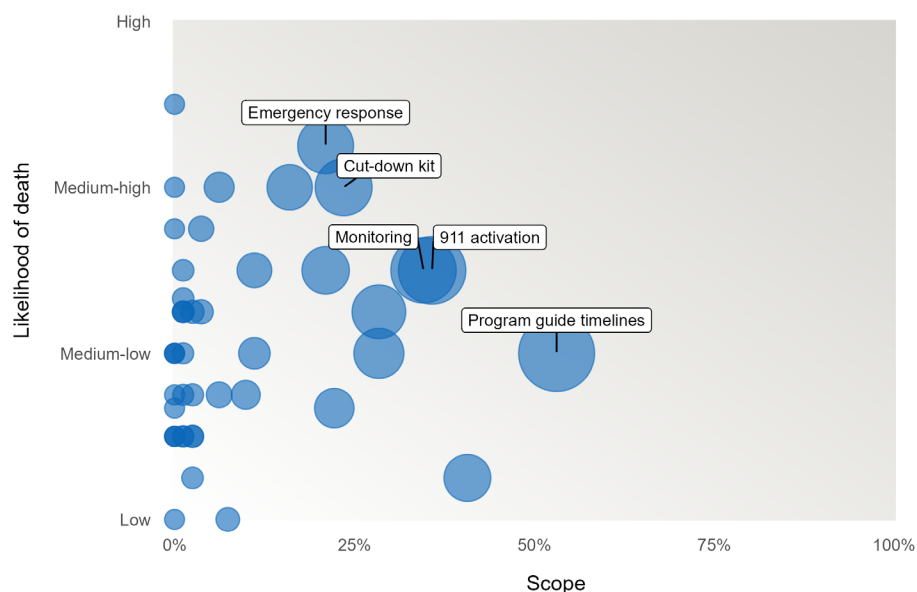
One facility had open QIPs (Table 13). Two QIPs were assigned to headquarters, one of which remains in process.

Depending on the nature of the QIP, discipline-specific managers at headquarters review the quality of each facility's QIP implementation and, when indicated, direct facilities to revise their implementations. In 2025, all QIP response were reviewed and approved.

In every case, facilities submitted a response to QIPs assigned to them and, where indicated, included evidence of implementation. 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 submitted sign-in sheets in nearly all cases 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:

Figure 11. Likelihood of Death vs. Scope of Quality Problems, 2023–2025



Note: Point sizes correspond to the value of the risk score (likelihood of death 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 A7](#) for a graph of problem types by prevalence.

- Auditing records to determine a problem's scope or confirm that a problem was corrected
- Reviewing relevant performance measures
- Revising local procedure
- Revising coverage plans when critical levels of mental health staffing exist
- Submitting evidence of improved compliance
- Issuing local memoranda clarifying expectations
- Augmenting staffing
- Creating new reference materials for staff
- Implementing a supervisory action plan
- Requesting the Office of Internal Affairs to investigate possible misconduct

When staff misconduct is suspected, wardens

submit investigatory requests to the Office of Internal Affairs. Two requests were carried over from 2024. Investigations were completed, and allegations were substantiated on both cases. In 2025, wardens made four requests, and all involved the quality of security/welfare checks. Investigations for these are ongoing.

Trends in Quality Problems

From 2023 to 2025, reviewers found quality problems in 91.4% of cases (74 of 81). (For a list of all problem types and their prevalence, see [Figure A7](#) in the Appendix.) 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 death and its prevalence (see [Methodolo-](#)

gy for details). [Figure 11](#) displays the results of this approach. The five problem types with the highest risk scores were:

1. Meeting timelines for mental health contacts: Most instances involved either missed or tardy contacts for individual meetings and treatment team meetings.
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. 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). Cases with monitoring problems (28) involved either security-welfare checks in RHU or missed nursing rounds in inpatient units. Security-welfare checks comprised 46% (13 of 28) of cases, and most of these involved check quality⁶ (11 cases) rather than check timeliness (2 cases). Nursing rounds comprised 54% (15 of 28) of cases. However,

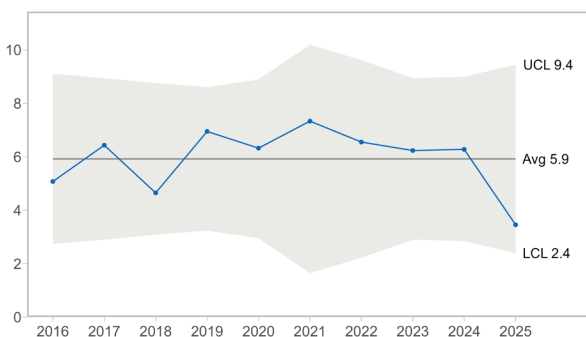
problems with nursing checks often involved timeliness rather than quality. In addition, in 2023 and 2024, QIPs for nursing rounds were issued whenever timeliness fell below 100%. In 2025, QIPs were only issued when timeliness was less than 90%.

4. Emergency response: Problems were diverse with no clear pattern. All but two occurred in only one or two cases; the exceptions were applying a cervical collar (four cases in 2023) and delayed alarm activation (four cases across 2023 and 2024).
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). In several cases, the ligature was cut, but the noose was not immediately removed.

[Figure 12](#) displays the mean number of QIPs per suicide from 2016 to the present. No unusual changes in the mean occurred. Fewer QIPs per suicide were issued in 2025.

6. Quality of security-welfare checks in RHU refers to the visual verification of an adult's well-being by a correctional officer.

Figure 12. Annual QIP Mean, 2016–2025



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. See [Methodology](#).

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. The department may also 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). Finally, the Receiver, appointed by the court in 2025,¹ is actively implementing court-ordered improvements.

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. 26) and then evaluated them in conjunction with other relevant in-

formation, including improvement initiatives from various divisions, other quality metrics, and available resources.

Quality of Security-Welfare Checks

Upon review of this report's data, the quality of security-welfare checks was selected for an improvement project.

Between 2023 and 2025, problems monitoring patients at risk of suicide ranked third among all problem types identified in suicide reviews. Of the cases identified as having problems with monitoring, nearly half involved the quality of security-welfare checks. A similar trend was noted in the 2024 version of this report, which examined quality problems from 2022 through 2024.

Problems Not Selected

Four quality problems were not chosen as improvement opportunities.

Use of cut-down kits was selected for an improvement project in the 2024 version of this report. Because the current report was finalized soon after the 2024 report, no project update was available.

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

1. ECF 8753, dated 8-27-2025.

staffing shortages rather than shortcomings in the suicide prevention program's design. The department is actively working to enhance hiring and retention.² For these reasons, meeting time-lines was not selected this report cycle.

Delay in 911 activation was not selected because the department revised its annual suicide prevention training in January 2025. The revisions included special emphasis on immediate 911 activation. Similar changes have been made to the training for cadets. All staff will receive the updated training during the 2025 calendar year. Regional custody staff, during their on-site visits, continue to test officers' knowledge regarding when and how to activate 911 without delay.

Although problems with aspects of emergency response were identified, the problems were judged to be diverse and infrequent and, thus, not indicative of a system-level deficiency.

Projects Underway

In the previous year's annual report, the use of cut-down kits was selected for a performance improvement project. Because the previous year's report and the current report were released in close succession, no project update was available.

2. Further details can be found in ECF 8722, filed 8-4-2025; ECF 8866, filed 3-11-2026; ECF 8889 filed 4-30-2026; ECF 8936, filed July 31, 2026.

Methodology

Surveillance

Healthcare staff are required to record all deaths of incarcerated adults, including suspected suicides, in the medical record and to alert headquarters staff within two business days of the death. All suspected suicides are logged. 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 within 72 hours of the incident. Annually, suicide and non-fatal self-harm data are analyzed, and the results are presented in a report.

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](#)).

Determinations of Non-Fatal Self-Harm

Local SPR FIT coordinators review each incident of non-fatal self-harm to determine whether the incident involved at least some intent to die. They also assessed injury severity. Injury severity was rated as mild, moderate, or severe. Mild injuries are superficial (e.g., scratches, bruises, scrapes). Moderate injuries require some skilled treatment (e.g., sutures, medical intervention to remove objects). Severe injuries require intensive medical or surgical management (e.g., surgery to close wounds, hospital admission for stabilization).

Data Sources

Characteristics of decedents were drawn from the department's suicide data sheets, which are completed after each suicide case review, and stored in a central database. Non-fatal self-harm data were drawn from the department's data warehouse.

Beginning in 2025, counts of the in-custody population were expanded to include previously overlooked groups. In-custody populations include all incarcerated persons placed in CDCR prisons, CDCR camps, in-state and out-of-state contract

beds, the Department of State Hospitals, CDCR Pre-Release Community Programs, community hospitals, and outside correctional facilities for court dates.

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, and drawn from CDCR's data warehouse. Some characteristics were based on a population size that was negligibly smaller or larger due to either missing data or differences in data sources.

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

Unless otherwise noted, rates of suicide are unadjusted rates. Rates were calculated using the in-custody population at midnight on June 30th for each year. Until 2024, populations were drawn from the department's monthly population reports. Beginning with this report, the in-custody population was drawn from the data warehouse to achieve a more precise count.

Age-adjusted rates were calculated using distribution 9 described in Klein and Schoenborn ([2001](#)).

Interpreting Differences

Interpreting year-to-year differences in the characteristics 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 based on 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 in [Table A1](#) in the Appendix. 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 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. Additionally, we used the rules developed by Anhøj and Olesen (2014) to identify statistically significant shifts in suicide rates.

Offenses

This report uses CDCR conventions for categor-

ries of committing 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.

Assessing and Responding to Quality Problems

Quality problems identified over the last three years of suicide reviews were grouped into similar types and analyzed using an approach modeled after the Joint Commission's (2016) Survey Analysis for Evaluating Risk (SAFER). In that approach, surveyors place each problem on the SAFER matrix, which scores problems along two axes: the likelihood that the problem will cause death, and its prevalence. Rather than making qualitative judgments about placement on the matrix, this report calculated a risk score for each problem type by multiplying likelihood of death by scope. Likelihood of death was determined by averaging ratings from four departmental experts, who rated each problem as low, medium-low, medium-high, or high; these ratings were then converted to a 1–4 scale. Scope was calculated by dividing the number of cases exhibiting a given problem type by the total number of suicide cases.

Quality problems selected for an improvement project are taken up by the headquarters suicide prevention committee. Following departmental quality management procedures, the committee assigns the problem a priority level, initiates an improvement project, and monitors the project until completion.

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Table A1. Frequency and Rate of Suicide per 100,000 by Gender, 1980–2025

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	29	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
2025 ^b	22	88,256	24	0	3,549	0	22	91,805	24 !

Note: Data prior to 1980 are unavailable. Gender data prior to 1990 are unavailable. ! Caution: Relative standard error $\geq 20\%$. 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. ^b Beginning in 2025, population counts were expanded to include previously overlooked groups. See [Methodology](#) for details.

Table A2. Frequency of Suicide by Facility, 2016–2025

Facility	2016–2024	2025	Annual Average 2016–2025	Security Level	Mental Health Programs
Total suicides	252 ^a	22			
KVSP	20	3	2.3	I, IV	CCCMS, EOP, MHCBC, RHU CCCMS
LAC	19	1	2	I, III, IV	CCCMS, EOP, MHCBC, RHU CCCMS, RHU EOP
SAC	19	0	1.9	II, III, IV	CCCMS, EOP, MHCBC, RHU CCCMS, RHU EOP, DDP
SVSP	18	4	2.2	I, III, IV	CCCMS, EOP, MHCBC, RHU CCCMS, DDP, ICF
MCSP	17	1	1.8	I, II, III, IV	CCCMS, EOP, MHCBC, RHU EOP, DDP
COR	15	1	1.6	I, II, III, IV	CCCMS, EOP, MHCBC, RHU CCCMS, RHU EOP
CCI	14	0	1.4	II, III, IV	CCCMS, EOP
CMC	11	2	1.3	I, II, III	CCCMS, EOP, MHCBC, RHU EOP, DDP
WSP	11	0	1.1	I, III	RC, CCCMS, MHCBC
CMF	10	0	1	I, II, III	CCCMS, EOP, MHCBC, RHU EOP, DDP, APP, ICF
SQRC	10	0	1	II ^b	CCCMS, EOP, MHCBC, APP, ICF
CTF	9	1	1	II	CCCMS
HDSP	9	0	.9	I, II, III, IV	CCCMS, EOP, MHCBC, RHU CCCMS
RJD	9	1	1	I, II, III, IV	CCCMS, EOP, MHCBC, RHU EOP, DDP
DVI ^c	8	--	1.3	--	--
CIW	6	0	.6	N/A, I	CCCMS, EOP, MHCBC, RHU CCCMS, RHU EOP, APP, ICF
NKSP	6	0	.6	I, II	RC, CCCMS, MHCBC
CHCF	5	1	.6	N/A, II	CCCMS, EOP, MHCBC, RHU EOP, DDP, APP, ICF
CIM	5	2	1.2	II	CCCMS, EOP, MHCBC, DDP
FSP	5	1	.6	I, II, III	CCCMS
SATF	5	1	.6	II, III, IV	CCCMS, EOP, MHCBC, RHU CCCMS, DDP
VSP	4	2	.6	II	CCCMS, EOP
CCC ^c	3	--	.4	--	--
CCWF	3	0	.3	N/A	RC, CCCMS, EOP, MHCBC, RHU EOP, DDP
PBSP	3	0	.3	I, II, III, IV	CCCMS, EOP, MHCBC, RHU CCCMS
PVSP	3	1	.4	I, III	CCCMS, EOP, MHCBC, RHU CCCMS
SOL	2	0	.2	II, III	CCCMS, MHCBC
CAL	1	0	.1	I, II, IV	--
CRC	1	0	.1	II	CCCMS, EOP
ISP	1	0	.1	I, II, III	--
ASP	0	0	0	I, II	CCCMS
CAC ^c	0	--	0	--	--
CEN	0	0	0	I, III, IV	--
CVSP ^c	0	--	0	--	--
SCC	0	0	0	I, II, III	CCCMS

Note: ^a Suicides at fire camps and non-CDCR facilities were excluded. Data for years prior to 2016 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 2025 composition because compositions have changed over time.

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

Characteristic	2020–2024	2025 ^a
Total suicides	125	22
Custody Watch		
1st Watch (2200–0600)	28.8	22.7
2nd Watch (0600–1400)	30.4	36.4
3rd Watch (1400–2200)	40.8	40.9
Time of Day		
Morning (0600–1200)	23.2	27.3
Afternoon (1200–1800)	35.2	36.4
Evening (1800–2400)	18.4	13.6
Overnight (000–0600)	23.2	23.7
Day		
Sunday	12.8	0
Monday	14.4	27.3
Tuesday	8.8	13.6
Wednesday	15.2	36.4
Thursday	19.2	0
Friday	11.2	13.6
Saturday	18.4	9.1

Note: ^a Differences between 2025 and prior periods should be interpreted cautiously (see [Methodology](#)).

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

Characteristic	2020–2024	2025 ^a
Total suicides	125	22
Month		
January	10.4	13.6
February	6.4	0
March	8.8	9.1
April	7.2	4.5
May	9.6	13.6
June	8	9.1
July	5.6	9.1
August	5.6	4.5
September	10.4	4.5
October	6.4	13.6
November	9.6	9.1
December	12	9.1
Season		
Winter	28.8	22.7
Spring	25.6	27.3
Summer	19.2	22.7
Fall	26.4	27.3
Quarter		
Quarter 1	25.6	22.7
Quarter 2	24.8	27.3
Quarter 3	21.6	18.2
Quarter 4	28	31.8

Note: ^a Differences between 2025 and prior periods should be interpreted cautiously (see [Methodology](#)).

Table A5. Audit Criteria for Suicide Reports

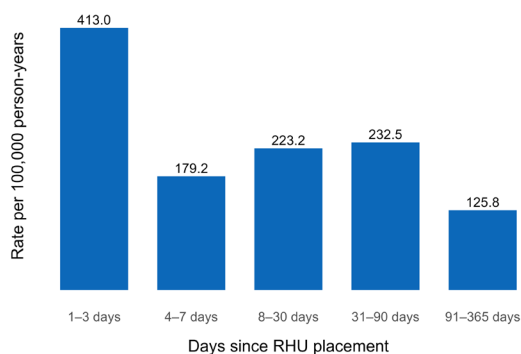
1. Does the Executive Summary describe the means of death, the emergency response taken, and the mental health level of care of the patient?
 2. Are the sources for the report identified?
 3. Are substance abuse issues reported, if applicable?
 4. Does the Institutional Functioning section include information 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 Death, Scope, and Risk Scores for Quality Problems, 2023–2025

Problem	Likelihood of Death	Scope	Risk Score
Program guide timelines/frequency of contact	.531	2.00	1.06
911 Activation	.358	2.50	.90
Monitoring	.346	2.50	.86
Emergency response	.210	3.25	.68
Cut-down kit	.235	3.00	.70
Treatment planning	.284	2.25	.64
Documentation: SRE	.284	2.00	.57
Policy violation (not covered elsewhere)	.210	2.50	.52
Documentation: General	.407	1.25	.51
Quality of care (decision-making, level of care)	.160	3.00	.48
Documentation: Safety planning	.222	1.67	.37
Referrals	.111	2.50	.28
Continuity of care	.111	2.00	.22
5-Day follow-up	.062	3.00	.19
Confidential setting	.099	1.75	.17
IDTT meetings	.062	1.75	.11
Self-harm, nonfatal (recording)	.037	2.75	.10
Staff actions	.037	2.25	.08
Universal precautions	.074	1.00	.07
SRMP	.025	2.25	.06
Issue (clothing, materials, etc.)	.025	1.75	.04
Diagnosis	.025	1.50	.04
Training	.025	1.50	.04
Crime scene preservation	.025	1.25	.03
Intake cells	.012	2.50	.03
Orders/scheduling	.012	2.33	.03
Administration of Narcan	.012	2.25	.03
Medication	.012	2.25	.03
RVRs	.012	2.25	.03
7362 processing	.012	2.00	.02
DDP	.012	1.75	.02
Mechanical restraint (during emergency response)	.012	1.50	.02
Records review/requests/missing records	.012	1.50	.02
Board of Parole Hearing	0	1.67	0
Crisis intervention	0	3.50	0
Housing review recommendation	0	1.50	0
Hunger strike	0	2.00	0
Classification committee	0	1.50	0
ISUDT	0	1.50	0
PC 2602	0	2.75	0
PREA	0	2.00	0
Programming (yard, privileges, groups, etc.)	0	1.75	0
R & R	0	2.00	0
ROI (release of information line)	0	1.00	0
Visibility of the cell	0	3.00	0

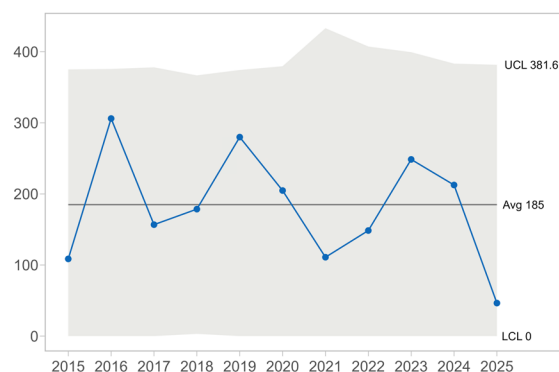
Note: From 2023 to 2025 there were 81 suicides. See [Methodology](#) for details on how scores were calculated for Likelihood of Death, Scope, and Risk Score.

Figure A1. Rate of Suicide within 365 Days of RHU Placement, 2016–2025



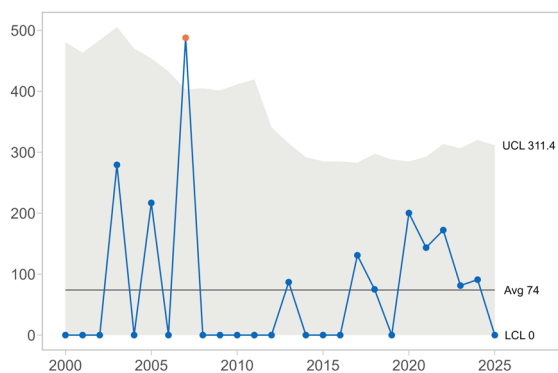
Note: To obtain adequate sample sizes for each length of stay post-placement (e.g., ≤ 3 days), a 10-year period was used. Person-years are comparable to annual rates of suicide.

Figure A3. Rates of Suicide per 100,000 among Adults Discharged from an Inpatient Psychiatric Unit within the Last 365 days, 2015–2025



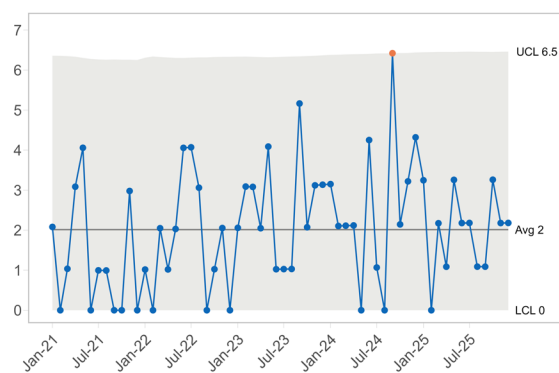
Note: Run chart of rates. Only discharges to outpatient settings (i.e., mainline, RC, and RHU locations) were included.

Figure A2. Rates of Suicide per 100,000 among Psychiatric Inpatients and Adults Referred to a Psychiatric Inpatient Unit, 2000–2025



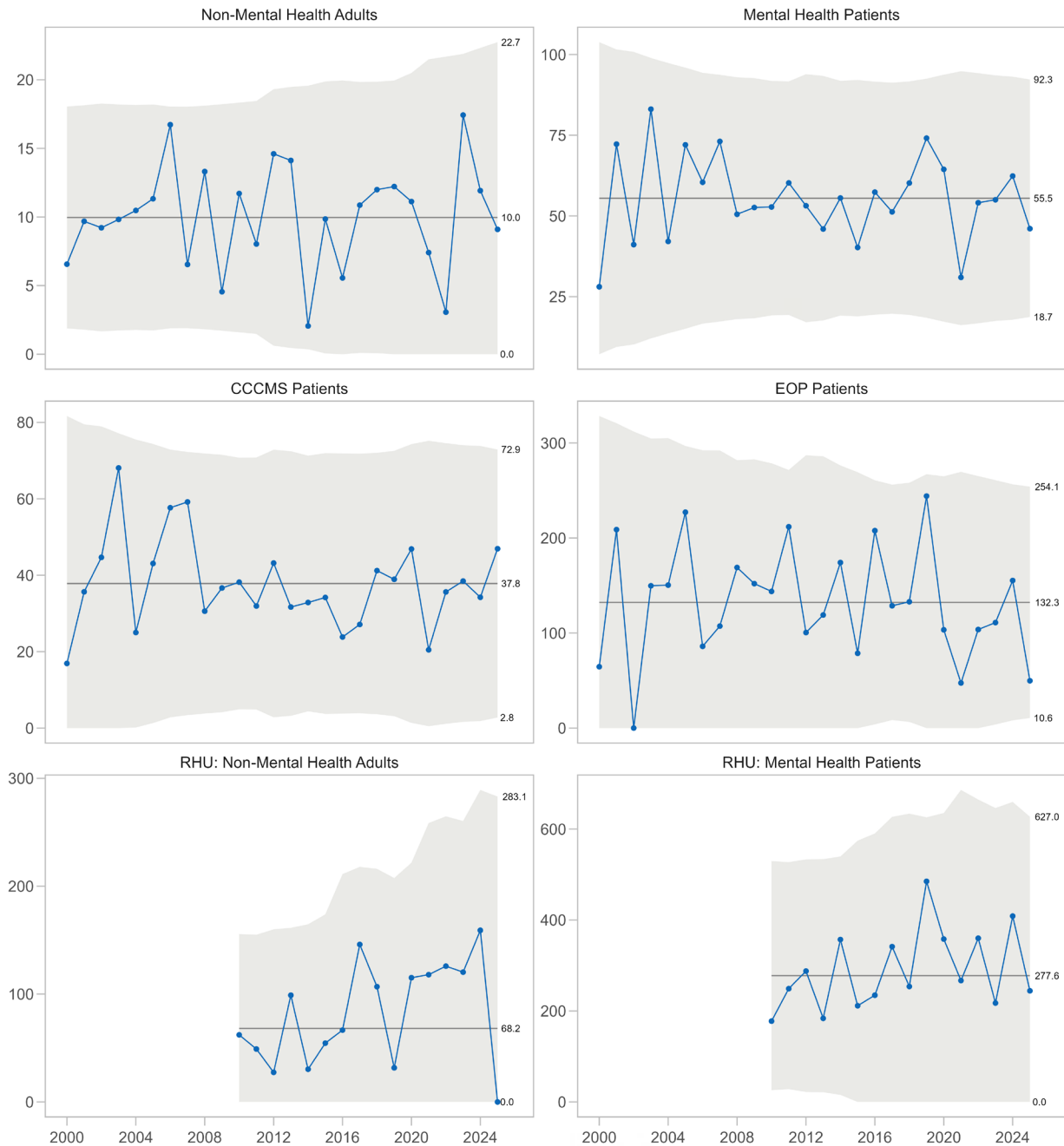
Note: UCL = upper control limit. Avg = overall average. LCL = lower control limit. UCL and LCL reflect three standard deviations from the overall average.

Figure A4. Monthly Rates of Suicide per 100,000, 2021–2025



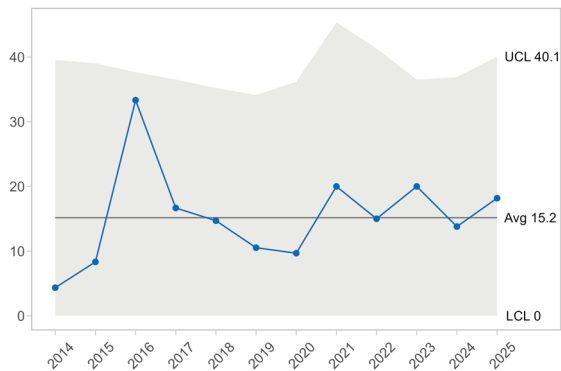
Note: UCL = upper control limit. Avg = overall average. LCL = lower control limit. UCL and LCL reflect three standard deviations from the overall average. See [Methodology](#).

Figure A5. Rate of Suicide by Population Groups, 2000–2025



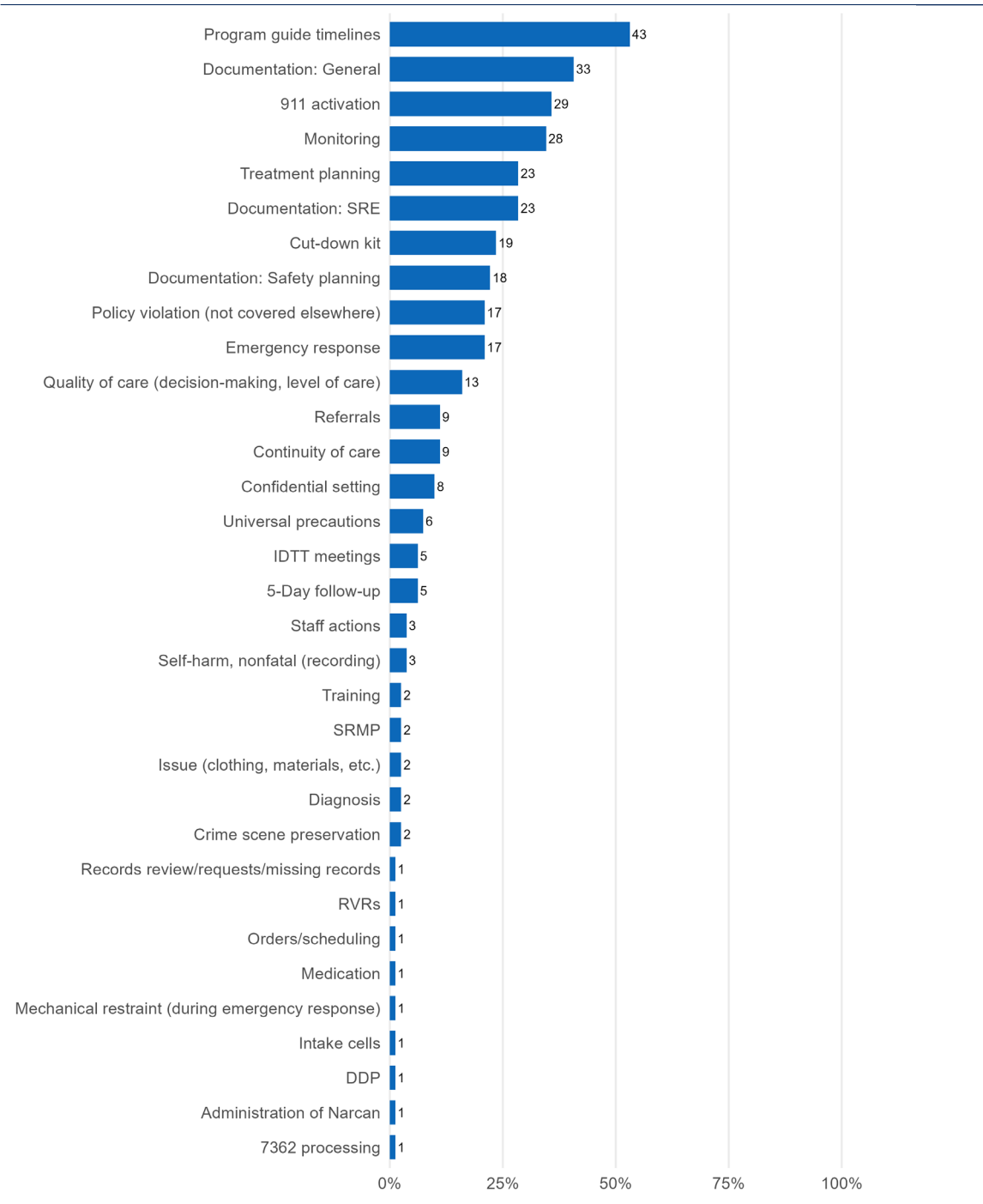
Note: The numbers on the right side of each panel correspond to the upper control limit, overall average, and lower control limit. Upper and lower control limits reflect three standard deviations from the overall average. For the RHU groups, reliable housing data were unavailable before 2010.

Figure A6. Percentage of Suicides with Evidence of Postmortem Rigidity, 2014–2025



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. Prevalence of Quality Problems Identified in Suicide Reviews, 2023–2025



Note: From 2023 to 2025, there were 81 suicides. Each bar's label indicates how many suicide reviews identified the problem.

