

## Clarification Sheet

Analysis of 2018 Mortality Reviews in the California Correctional Healthcare System  
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This Clarification Sheet explains the discrepancy in the reported number of suicides in 2018 between the California Correctional Health Care Services (CCHCS) "Analysis of 2018 Mortality Reviews in the California Correctional Healthcare System" by Kent Imai, MD and the 2018 annual report to the Legislature entitled, "Report on Suicide Prevention and Response within the California Department of Corrections and Rehabilitation" compiled by the California Department of Corrections and Rehabilitation (CDCR) Mental Health program. The CCHCS analysis reported 30 suicides in 2018 which differed from the 34 suicides reported in the Mental Health program's report to the Legislature.

All inmate deaths which occur within CDCR custody are reviewed by Medical Services. The Medical Services review focuses on the medical care the patient received prior to the death and are categorized by Death Type and Death Category. All suicide deaths are also reviewed separately by the Mental Health program. The Mental Health review focuses on the mental health care provided to the patient.

Death Types are broad classifications of deaths that include natural-expected, natural-unexpected, accidental injury to self, accidental injury by others, homicide (by other), homicide (by inmate), drug overdose (suicide), drug overdose (accidental), suicide, and unknown. Most deaths from disease fall into the natural-expected or natural-unexpected death types. Drug overdoses can be classified as either accidental or suicide.

Death Categories are selected by the physician reviewer and relate to the immediate cause of the death, i.e., what disease or action caused the death of the patient. Death category examples include cancer, cardiovascular disease, cerebrovascular disease, liver disease, homicide, drug overdose, suicide, etc.

In the case of the four conflicting reviews, the CCHCS report documented three of these deaths as having a primary cause of drug overdose while the mental health report to the Legislature listed them as suicides. While neither report is incorrect, the CCHCS review focused on the immediate cause of the deaths, which was drug overdose, and the Mental Health report focused on the manner, or category, of death, which was suicide. The fourth case was listed as a suicide by Mental Health based solely on a coroner's report, but CCHCS medical review determined the death was caused by renal disease.

Going forward, CCHCS and Mental Health will validate the number of suicides prior to publication of their respective reports. Any discrepancy related to the type or category of the death will be clarified in each report to explain any differences in reporting.

With regards to the CCHCS review of deaths in 2018, if the three suicides by drug overdose deaths are counted as suicides, this correction would result in suicide being the sixth most common manner of death in 2018 and homicide as the seventh.