ALBERTA

Report to the Minister of Justice and Solicitor General
Public Fatality Inquiry

Fatality Inquiries Act

WHEREAS a Public Inquiry was held at the Edmonton Law Courts

in the City (City, Town or Village) of Edmonton (Name of City, Town, Village), in the Province of Alberta,

on the 7th and 8th day of May, 2015 (year), and by adjournment to

on the 10th day of May, 2016 (year)

before D.M. Groves, a Provincial Court Judge,

into the death of Mehari Wodaje (Name in Full) 46 (Age)

of Federal serving prisoner – in transit at Edmonton Institution (Residence) and the following findings were made:

Date and Time of Death: October 11, 2012 at 11:45 a.m.

Place: Royal Alexandra Hospital, Edmonton, Alberta

Medical Cause of Death:
("cause of death" means the medical cause of death according to the International Statistical Classification of Diseases, Injuries and Causes of Death as last revised by the International Conference assembled for that purpose and published by the World Health Organization – *The Fatality Inquiries Act*, Section 1(d)).

Hanging – intentional self-harm by hanging.

Manner of Death:
("manner of death" means the mode or method of death whether natural, homicidal, suicidal, accidental, unclassifiable or undeterminable – *The Fatality Inquiries Act*, Section 1(h)).

Suicidal

Circumstances under which Death occurred:

A. Introduction

This Fatality Inquiry concerned the death of Mehari Wodaje (Wodaje). Wodaje was a Federal serving prisoner in transit at the Edmonton Institution, awaiting transfer to the Bowden Institution (Bowden). While waiting to be transferred to Bowden, Wodaje committed suicide by hanging.

B. Preliminary Matters

Ms. Jennifer Stengel represented the Solicitor General, and was counsel for the purpose of conducting this Public Fatality Inquiry.

Pursuant to section 49(2)(d) of the *Fatality Inquiries Act,* RSA 2000, c. F-9 ("*FIA*") Correctional Service Canada applied, and was granted Interested Person Status. Mr. Kerry Boyd followed by Ms. Debjani Poddar was counsel representing Correctional Service Canada.

Pursuant to section 49(2)(a) of the *FIA,* Wodaje's next-of-kin were notified and advised of their right to appear and participate in the Fatality Inquiry either personally or through counsel. The next-of-kin did not exercise their right to participate.

C. Procedural History

The Fatality Inquiry was heard on May 7 and 8, 2015. During these two days, the Court heard from ten witnesses, and four documents were entered as Exhibits. The Inquiry was then adjourned *sine die* awaiting preparation of an expert report. Two further documents were entered as Exhibits #5 and #6 on later dates.

Exhibit #1 was voluminous. Along with the Medical Examiner's Certificate of Death, and the medical, hospital and emergency personnel documents; the Exhibit #1 binder also contained numerous documents provided by Correctional Service Canada. Among these documents was a Board of Investigation Report (the Board) located at Tab 20. The Board conducted an investigation into Wodaje's death by reviewing files, emails, and documentation from Grierson Institution where Wodaje was an inmate, until two days prior to his suicide. The Board conducted interviews with staff at the Edmonton and the Grierson Institutions; reviewed videos from the day of the incident; and toured the Edmonton Institution. The investigation concluded with the Board making several findings, but no recommendations.

Exhibit #2 was a brief DVD clip of the post use of force interview conducted by Edmonton Institution staff. In compliance with policy, since Wodaje had seen a can of OC/pepper spray on his transit from the Grierson Institution to the Edmonton Institution, the post use of force assessment was necessary, regardless that the OC spray had not been used on Wodaje.

Exhibit #3 was the *Curriculum Vitae* of Sherry Antonucci, B.A., M.Ed., Ph.D., Provisionally Registered Psychologist who had been Wodaje's psychologist while he was an inmate at Grierson.

Exhibit #4 was a CD from Correctional Service Canada. Included on this CD are five separate items: 1) both the online and in-class course description for the Suicide and Self-injury Intervention Refresher Training course (SSIRT); 2) SSIRT participant handouts for both the mens' and womens' institutions; 3) the SSIRT facilitator manual; 4) facts sheets; and 5) Correctional Service Canada Prevention of Suicide and Self-Injury Initial Training Program. Despite there being a reference that the training package was the 'old' training package, I was informed that it is the one currently used. There is reference in the CD to a Train the Trainer Package – used to train the mental health workers who would then be responsible for training the front line workers.

At the conclusion of the inquiry on May 8, 2015, I requested that Inquiry Counsel seek out an expert who could provide a report in the area of suicide detection and prevention. After considerable efforts by Inquiry Counsel, Dr. James L. Knoll, IV, M.D. (Dr. James Knoll) from Upstate Medical University in the State of New York was identified as an expert in the this field, with particular focus on suicide risk assessment and prevention in institutions. Entered as Exhibit #5 is the *Curriculum Vitae* of Dr. James Knoll, IV, M.D.

At this point, the inquiry was adjourned *sine die* awaiting receipt of Dr. James Knoll's expert report.

On May 10, 2016 the Fatality Inquiry resumed. Both counsel agreed to enter Dr. James Knoll's report as Exhibit #6, without the necessity of calling Dr. James Knoll to testify.

I have read the expert report prepared by Dr. James L. Knoll, IV, M.D. Dr. James Knoll was asked to address five questions, with clear instructions that no opinion was to be expressed regarding legal responsibility. The questions Dr. James Knoll was asked to address were as follows:

1. What are the risk factors for suicide generally?
2. Are inmates at higher risk for suicide than non-inmates?
3. Are there special suicide risks in a prison setting that staff should be aware of, and if yes, what are they?
4. What training would you recommend for prison staff?
5. What measures should be taken in prisons to decrease suicide attempts?

D. Mehari Wodaje's Background

On February 18, 2002, Wodaje murdered his girlfriend by strangulation; he then attempted suicide. Wodaje was hospitalized for five days, prior to being released into police custody. Wodaje was cooperative with police, and admitted to killing the victim.

On November 5, 2007, Wodaje pled guilty, and was sentenced to an indeterminate life (10) year sentence for the offence of second-degree murder. Since Wodaje was subject to an indeterminate sentence, there was no expiry date, meaning after 10 years he would be eligible for parole, but the sentence would never expire. He would always be subject to some form of supervision.

At the time Wodaje was sentenced for the offence of second-degree murder, he had no prior criminal record. He had however, been charged with a number of violent offences against his ex-wife. The offence dates for these offences were between January 2000 and June 2001. In 2005, the Crown stayed these charges.

For anyone serving a life sentence, it is mandatory that a minimum of two years of the sentence be at a maximum security facility. Wodaje spent the maximum security portion of his sentence at Edmonton Institution, prior to his re-classification to medium security and subsequent transfer to the Bowden Institution in March 2010. In March 2011, Wodaje was re-classified from medium to minimum security, and on January 31, 2012 Wodaje was transferred to the Grierson Institution, a minimum security facility.

At Wodaje's request, he received psychological counselling while serving his sentence at Bowden Institution. Wodaje continued to attend counselling once he transferred to Grierson – he attended four counselling sessions with Sherry Antonucci, Provisionally Registered Psychologist, and an additional five sessions with Dr. Deveda Mah.

During Wodaje's time at the Grierson Institution, he had undertaken some escorted temporary absences and had applied for two unescorted temporary absences. A Correctional Plan dated August 16, 2012 and an Assessment for Decision completed on September 17, 2012, were in support of these unescorted temporary absences, with one of the conditions being that Wodaje was to report all intimate relationships with females. The Parole Board Committee was the body that would authorize such absences, and the hearing before this Board was set for November 2012.

Subsequent to the 'Correctional Plan' being prepared in August 2012, the Community Management Team (CMT) received new information in regards to Wodaje's relationship with a female community support worker. During a routine cell search on October 2, 2012, the staff at Grierson found a number of Wodaje's journal entries. These entries outlined some of Wodaje's interactions with the community support worker. The CMT was extremely concerned with the nature of these entries. The overture of the entries suggested that Wodaje and the community support worker were becoming romantically involved, a concern that the CMT had previously discussed with both Wodaje and the community support worker. Based on this new information, it was determined that both Wodaje and the community support worker had been lying to the CMT. As a result, on October 9, 2012 the CMT completed a new security re-classification scale for Wodaje. The resulting score was a 15.5, which falls within the minimum range, but the CMT supported an increase to medium security based on a change in ratings for both institutional adjustment and public safety – two categories that the CMT had discretion to alter.

The CMT brought Wodaje in for a meeting to advise him that the team was recommending Wodaje be re-classified to medium security. Since the Grierson Institution was a minimum security facility, they had no means to adequately house Wodaje, and as such he was temporarily transferred to the Edmonton Institution, a maximum security facility until his re-classification was approved by the Board and a determination was made as to what prison he would be transferred to.

When an inmate is subject to an emergency involuntarily re-classification, the inmate will be transferred out of the institution and the re-classification paperwork/report follows within 48 hours. Once the inmate receives the re-classification report, he/she has 48 hours to rebut their re-classification.

Wodaje was re-classified by the CMT at Grierson Centre on October 9, 2012, and immediately transferred to the Edmonton Institution on a temporary basis, with a recommendation that Wodaje be sent to Bowden Institution. On the morning of October 11, 2012 Mr. Jacknicke, a Parole Officer, attended the Edmonton Institution to serve Wodaje with the re-classification report, which would have started the 48 hour clock for Wodaje to rebut his re-classification. It was at this time that the staff at the Edmonton Institution found Wodaje in his cell, having committed suicide by hanging.

E. Circumstances Under Which the Death Occurred

On October 9, 2012, the CMT at the Grierson Institution involuntarily transferred Wodaje to the Edmonton Institution. At the time of Wodaje's transfer, there was a Memorandum of Understanding between Grierson Institution and Edmonton Institution facilitating these types of temporary transfers.

Upon arriving at the Edmonton Institution, a nurse met with Wodaje, after which, Wodaje was placed in administrative segregation, awaiting transfer to a medium-security prison.

Over the next few days, while Wodaje was in segregation, the staff at the Edmonton Institution had the opportunity to interact with Wodaje. None of the staff at Edmonton Institution noticed anything of concern regarding Wodaje's behaviour.

Correctional Officer, Steven Ross, first interacted with Wodaje on October 11, 2012 when he served Wodaje's breakfast around 7:00 a.m. He again spoke with Wodaje around 9:55 a.m., when Wodaje inquired whether he could get a new mattress.

Subsequent to this, Parole Officer Jacknicke attended Wodaje's cell around 10:20 a.m. to serve Wodaje with the re-classification report. After receiving no verbal response, and unable to gain a visual into Wodaje's cell, Mr. Jacknicke attended the sub-control post to inquire of Wodaje's whereabouts. Correctional Officer, Roy Croucher, attended with Mr. Jacknicke to establish contact with Wodaje. With the aid of a flash light, Mr. Croucher was able to see inside Wodaje's cell, and observed Wodaje hanging from a noose attached to the window. Mr. Coucher did not have a radio or personal alarm on him, and so returned to the sub-control post to acquire a 911 tool. Mr. Croucher returned to the cell, where Correctional Officer Steven Ross met him. The two entered Wodaje's cell, cut him loose and began to perform cardiopulmonary resuscitation (CPR). Nursing staff arrived minutes later, and took over CPR until Edmonton Emergency Medical Services arrived at 10:46 hours. Wodaje was pronounced dead at 11:44 hours at the Royal Alexandra Hospital.

F. Board of Investigation Findings

Upon concluding their investigation, the Board made several findings, but made no recommendations.

The Board of Investigators interviewed staff at the Edmonton Institution. Some of these staff also testified at the Fatality Inquiry. Pursuant to policy, upon an inmate arriving at the Edmonton Institution as well as upon an inmate being placed in segregation, the staff are required to interview the inmate, and complete a number of checklists. The Board found that some of these

interviews and checklists were not completed. While the Board did not identify any known pre-incident indicators to the incident, they did identify Wodaje's placement in segregation as one potential proximal precipitating event. Nonetheless, from the accounts of all that interacted with Wodaje, there was no evidence to suggest that Wodaje was suicidal or at risk of self-harm.

The Board found that the decision to remove Wodaje from Grierson Institution, and re-classify him to a medium security facility was appropriate.

Grierson staff believed there was a Memorandum of Understanding between the Grierson Institution and the Edmonton Institution that allowed for these temporary transfers. The Board of Investigation found that "while Commissioner's Directive 709, Administrative Segregation, paragraph 21, provided the authority to establish Memorandums of Understanding, it did not provide the authority to establish a Shared Services Agreement in relation to the use of segregation facilities. Therefore, Grierson Institution's Standing Order 709, Administrative Segregation, and the Shared Services Agreement were contrary to policy." (Exhibit #1, Tab 20, pages 00209-00210).

The Board noted two minor compliance issues in relation to the first Correctional Officer who attended Wodaje's cell with Parole Officer Jacknicke. The first was that the Correctional Officer did not possess either a portable radio or personal alarm; the second was that the Correctional Officer signaled for an additional officer to be present at Wodaje's cell rather than directing that the cell door be opened. Since Mr. Jacknicke was present with the Correctional Officer, pursuant to Commissioner's Directive 566-4, the two staff requirement prior to opening an inmate's door was satisfied. There was no need for another Correctional Officer to attend.

The Board identified one further compliance issue, relating to the four health care staff that responded to Wodaje's cell. None of the staff had his/her re-certification on the International Trauma Life Support and Cardio Pulmonary Resuscitation. There was no evidence however, that any of the actions taken by the staff at the Edmonton Institution were improper.

Evidence at the Fatality Inquiry indicated that the training provided in 2012, specific to suicide detection and prevention, involved an annual online thirty minute training session.

G. Steps Initiated Subsequent to this Event

a. *Training Initiatives*

In relation to the re-certification of staff in regards to trauma life support and cardio pulmonary resuscitation, the Institution subsequently developed an action plan and follow-up training was undertaken.

b. *Suicide Detection/Prevention Training*

In addition to an annual online one hour suicide detection and prevention training course, the Institution implemented a two hour in-class refresher course offered every two years.

c. *Structural Modifications*

The Edmonton Institution had the windows in the segregation cells retrofitted, with the window cranks moved from the top of the window, where they were in 2012, to the bottom of the window, in an effort to prevent a similar incident from occurring.

H. Recommendations for the Prevention of Similar Deaths:

a. *Scope*

It is useful to begin by recalling that the purpose of this Inquiry is to enable me to prepare a report for the Attorney General that addresses five factual matters: the identity of the deceased, the date, time and place of death, the circumstances under which the death occurred, the cause of death and the manner of death. In addition, I may make recommendations as to the prevention of similar deaths.

I have considered the evidence of the witnesses that testified at the Inquiry, and I have reviewed all the documentation and reports entered as Exhibits. Exhibit #6 was the expert report prepared by Dr. James L. Knoll, IV, M.D. Dr. James Knoll was asked to address the following five questions:

1. What are the risk factors for suicide generally?
2. Are inmates at higher risk for suicide than non-inmates?
3. Are there special suicide risks in a prison setting that staff should be aware of, and if yes, what are they?
4. What training would you recommend for prison staff?
5. What measures should be taken in prisons to decrease suicide attempts?

Given the complexity of some of his answers, and in an effort to share these resources with those who may benefit from Dr. James Knoll's expertise, I have included a copy of Dr. James Knoll's *Curriculum Vitae* (Attachment "**A**"), as well as a copy of his report (Attachment "**B**"). To avoid any uncertainty, Dr. James Knoll's report is *not* intended to provide any opinion regarding legal responsibility.

b. *Recommendations*

None of the staff from the Edmonton Institution that interacted with Mr. Wodaje noted anything of concern regarding Mr. Wodaje being a potential suicide risk; therefore, it is uncertain whether the implementation of any recommendations would have prevented Mr. Wodaje's suicide. Nor was there anything to suggest that the health care workers that responded to Wodaje's cell did anything improper. Nevertheless, there is always opportunity to learn from these unfortunate situations, and to implement change in an effort to reduce similar incidents in the future.

Given Dr. James Knoll's extensive education, training, experience and specialty in psychiatry with particular focus on suicide risk assessment and prevention (see Attachment "**A**" – Dr. James Knoll's *Curriculum Vitae*), I adopt the recommendations outlined at pages 28 through 30 of Dr. James Knoll's expert report in their entirety (see Attachment "**B**" – Expert Report prepared by Dr. James Knoll).

Attached to this Fatality Inquiry Report are the following two documents:

Attachment "**A**" – *Curriculum Vitae* of Dr. James L. Knoll, IV, M.D. – entered as Exhibit #5 at the Fatality Inquiry.

Attachment "**B**" – Expert Report of Dr. James L. Knoll, IV, M.D. – entered as Exhibit #6 at the Fatality Inquiry.

DATED May 16, 2016,

at Edmonton, Alberta.

Original signed by

D.M. Groves
A Judge of the Provincial Court of Alberta

State University of New York

Upstate Medical University

Exhibit Tag
Provincial Court

Case No.	
14056829611	
Case Name	
Fatality Inquiry	
Wadaje Mehari	
Marked Ident.	**Entered Exhibit No.**
	FI-5

Submitted By

☑ ~~Crown~~/Plaintiff ☐ Defence/Respondent

AUG 11 2015 — Date

BB — Clerk

CTS0501 (2008/10)

JAMES L. KNOLL, IV, M.D.

SUNY Upstate Medical University
Department of Psychiatry
Division of Forensic Psychiatry

knollj@upstate.edu

This is Attachment "**A**" referred to in the Public Fatality Inquiry Report of **Mehari Wodaje**

Licensure New York 241389

Board Certification
American Board of Psychiatry and Neurology,
Certificate number 46704

American Board of Psychiatry and Neurology,
Subspecialty Certification in Forensic Psychiatry,
Certificate number 1352

Current Positions
Professor of Psychiatry
Director of Forensic Psychiatry
Chief Officer of Quality Improvement
SUNY Upstate Medical University– Department of Psychiatry

Training Director– Forensic Psychiatry Fellowship Program
Central New York Psychiatric Center &
SUNY Upstate Medical University

Professional Experience

1994 – 1995	6-month Medical Internship, Parkland Memorial Hospital, Dallas, Texas
1995 – 1998	Psychiatric Residency, Parkland Memorial Hospital, Dallas, Texas Chief Resident, 1997 – 1998
1997 – 1998	Staff Psychiatrist, Parkland Memorial Hospital, Psychiatric Emergency Room, Dallas, Texas
	Staff Psychiatrist, V.A. Medical Center, Psychiatric Emergency Consultant Dallas, Texas
	Correctional Psychiatrist, Dallas County Jail, Dallas, Texas
1998 – 1999	Forensic Psychiatry Fellowship, Case Western Reserve University, Cleveland, Ohio
1999 – 2000	Attending Psychiatrist - Inpatient Forensic Unit Northcoast Behavioral Healthcare System Northfield Campus, Northfield, Ohio
	Violence Risk Assessment Team Northcoast Behavioral Healthcare System Northfield Campus, Northfield, Ohio
	Independent Court Appointed Forensic Evaluator, Court Psychiatric Clinic Cuyahoga County Court of Common Pleas Cleveland, Ohio
	Independent Court Appointed Forensic Evaluator, Court Psychiatric Clinic Cleveland Municipal Court Cleveland, Ohio

1999 – 2004	Consulting Forensic Examiner, U.S. Department of Justice Drug Enforcement Administration
2000 – 2001	Director, Division of Psychiatry & Law, Northwestern University Medical School Chicago, Illinois
2001 - 2006	Director of Forensic Psychiatry, Dartmouth Medical School
	Medical Director of Forensic Services, New Hampshire Department of Corrections Concord, New Hampshire
2006 – present	Director of Forensic Psychiatry, Director of the Forensic Psychiatry Fellowship, Associate Professor of Psychiatry, SUNY Upstate Medical University
2009 – present	Astronaut Suitability Evaluator for National Aeronautics and Space Administration (NASA); Behavioral Health & Performance Group; Johnson Space Center Houston, Texas
2013 – 2014	Independent Forensic Evaluator Onondaga County Justice Center Syracuse, NY
2015 – present	Quality Improvement Officer Department of Psychiatry SUNY Upstate Medical University

Education

1990	B.A. (with special honors), Psychology, University of Texas
1990 – 1994	M.D., University of Texas Southwestern Medical School, Dallas, Texas
1994 – 1998	Psychiatric Residency, University of Texas Southwestern Medical School

1998 – 1999	Forensic Psychiatry Fellowship, Case Western Reserve University
	Board Certified, American Board of Psychiatry and Neurology (Number 46704)
2001	Board Certified in Forensic Psychiatry (Number 1352)
2009	Board Re-Certified (Maintenance of Certification), American Board of Psychiatry and Neurology (Number 46704)
2011	Board Re-Certified (Maintenance of Certification), American Board of Psychiatry and Neurology Forensic Psychiatry (Number 1352)

Academic

1998	Assistant Instructor of Psychiatry, University of Texas Southwestern Medical Center
1999 – 2000	Supervising Instructor and Lecturer, Forensic Psychiatry Fellowship Case Western Reserve University Medical School
	Adjunct Professor of Mental Health Law, Akron University School of Law
	Assistant Clinical Professor of Psychiatry, Case Western Reserve University Medical School
2000 - 2001	Assistant Professor of Psychiatry, Northwestern University Medical School
2001 – 2006	Director, Forensic Psychiatry Fellowship, Dartmouth Medical School
	Assistant Professor of Psychiatry, Dartmouth Medical School
2003 – 2006	American Board of Psychiatry & Neurology Oral Board Examiner

2004 – present	Contributing Editor: *Correctional Mental Health Report*
2006 – 2013	Associate Professor of Psychiatry SUNY Upstate Medical University
2007 – 2010	Co-Editor: *Correctional Mental Health Report*
2008 – present	Regular contributor to *Psychiatric Times*; "Psychiatry and the Law" Column
2009	Peer Review Chair: Forensic Psychiatry Special Report *Psychiatric Times*
2009 – 2011	Adjunct Instructor, Syracuse University Course: *Basic Principles of Forensic Psychiatry* Forensic Science Program, Department of Chemistry
2010 – present	Regular contributor to the *Psychiatric Times* Blog At: http://www.psychiatrictimes.com/blog/couchincrisis
2010 – 2014	Editor-In-Chief *Psychiatric Times* At: http://www.psychiatrictimes.com
2011 – 2012	Program Chair – 43rd Annual Meeting American Academy of Psychiatry and the Law
2012 – 2015	Councilor American Academy of Psychiatry and the Law
2013	Professor of Psychiatry SUNY Upstate Medical University
2014 – present	Emeritus Editor-In-Chief Psychiatric Times
2014 – present	Teaching Faculty – Forensic Psychiatry Review Course American Academy of Psychiatry and the Law http://www.aapl.org/review.htm
2015	Vice President American Academy of Psychiatry and the Law

Committees

1999 – 2000	Ethics Committee North Coast Behavioral Healthcare System
2001	Ethics Committee Illinois Psychiatric Society
2001 – present	Criminal Behavior Committee American Academy of Psychiatry and the Law
2001 – 2005	Law Enforcement Liaison Committee American Academy of Psychiatry and the Law
2002 – 2004	New Hampshire Advisory Committee for Comprehensive Sex Offender Management Planning Grant
2003 – 2010	Group for the Advancement of Psychiatry (GAP) Committee on Psychiatry and the Law
2003 – 2006	Research & Planning Internal Review Board New Hampshire Department of Corrections
2003 – 2006	Governor's Commission on Domestic & Sexual Violence Substance Abuse & Mental Health Committee
2003 – 2006	State Forensic Planning Committee New Hampshire Division of Behavioral Health
2005	American Society for Industrial Security (ASIS) Workplace Violence Prevention & Response Guideline Committee
	New Hampshire State Suicide Prevention Committee
2006 – 2014	Medical Board President American Foundation for Suicide Prevention (AFSP), Central New York Chapter
2008 – present	Institutional Review Board: Forensic Review Committee Office of Mental Health, New York State
2010 – present	American Academy of Psychiatry and the Law Forensic Psychiatry Boards Maintenance of Certification Question Writing Committee & Task Force

2011	Program Committee American Academy of Psychiatry and the Law
2014 – present	Human Rights & National Security Committee American Academy of Psychiatry and the Law

Honors/Awards

Undergraduate:

1987	Outstanding College Students of America
1990	Phi Beta Kappa Honor Society
1990	Special Honors in Psychology
1990	Outstanding Academic Achievement Award

Medical/Postgraduate:

1993 – 1994	President of the Medical Student Psychiatry Organization U. T. Southwestern Medical School
1993 – 1994	Outstanding Medical Student in Psychiatry
1993 – 1994	Sandoz Award for Academic Achievement
1995 – 1996	Outstanding Resident Contribution to Medical Student Education
1996 – 1997	President of the Psychiatry Residency Organization U. T. Southwestern Medical School
1997 – 1998	Chief Resident of Psychiatry University of Texas Southwestern Medical School
1997 – 1998	Most Outstanding Psychiatry Resident Award
1998 – 1999	American Psychoanalytic Association Fellowship
2007	Best Teacher in a Forensic Psychiatry Fellowship Program Award American Academy of Psychiatry and the Law

2007	Excellence in Teaching Award (Given by SUNY Upstate Medical University Psychiatric Residents)
2009	Certificate of Appreciation Central New York Association of Chiefs of Police
2009	183 Best Doctors: Chosen By Their Peers Central New York Magazine, November/December, 2009
2010-2014	Best Doctors in America Best Doctors in America database & Central New York Magazine
2015	Bruce Dearing Writing Award Center for Bioethics & Humanities SUNY Upstate Medical University

Research Grants

2010	SUNY Upstate Technology Accelerator Fund (50K) Awarded for custodial suicide prevention device (patented)

Professional Organizations

1994 – present	American Psychiatric Association
1994 – present	American Academy of Psychiatry and the Law
2001 – 2008	Association of Threat Assessment Professionals
2002 – present	Association of Directors of Forensic Psychiatry Fellowships
2003 – 2010	Group for the Advancement of Psychiatry
2003 – 2006	National Association of State Mental Health Program Directors: Forensic Division Associate Member

Teaching Experience

1998 – 2000	Psychiatry Resident & Forensic Fellowship Instructor and Supervisor
1999 – 2000	Law student adjunct professor

2000 – present	Supervision and instruction of Psychiatry Residents, Medical Students, Psychology Graduate Students
2001 – present	Didactic teaching and supervision of Forensic Fellows
2001 – present	Forensic Seminar instruction to community mental health professionals
2001 – present	Mental Health Training for Correctional Officers and Staff
2003 – 2006	Supervision of sex offender therapists and community forensic mental health professionals
2007 – present	Guest lecturer, Syracuse College of Law
2008 – present	Guest lecturer, Syracuse University Project Advance
2009 – 2011	Adjunct Instructor, Syracuse University Forensic Science Program, Department of Chemistry Course: "Basic Principles of Forensic Psychiatry"

Forensic Experience

- Qualified as an expert witness in Psychiatry & Forensic Psychiatry in State & Federal Courts (OH, IL, NH, NY), as well as military court (NY)
- Consultant to U.S. District Attorney's Offices (NH, IL, IN, NY)
- Consultant to Capital Defender's Office in Death Penalty cases (IL)
- Consultant to ACLU – Pro Se Competence of immigrant detainees
- Consultant to National Aeronautics and Space Administration (NASA) – Astronaut Suitability Evaluator; Behavioral Health & Performance Group (Houston, TX)
- Invited expert to consult on FBI Violence in the Workplace Symposium, June 2002
- Invited expert to consult on American Society for Industrial Security (ASIS International) Workplace Violence Prevention and Response Guideline Committee
- Consultant to AMRIC Associates, Ltd. (professional investigative & security consulting firm: www.amric.com)
- Consultant to DEA – Fitness for Duty evaluations for agents
- Independent Court-appointed Forensic Examiner (OH)
- Independent Forensic Examiner of Competence to Stand Trial (NY)
- Legislative testimony on forensic mental health issues (NH)
- State forensic services planning and policy making (NH)
- Consultant to Police & Fireman's Disability & Pension Fund – Fitness for Duty evaluations, Disability evaluations
- Consultant to local law enforcement
- Consultant to private law firms and corporations
- Consultant to Onondaga County Medical Examiner Office for Psychological Autopsies (NY)
- Consultant to New York State Office of Mental Health, Division of Forensic Services – National Instant Criminal Background Check System (NICS) Relief from Firearm Disqualification evaluations

- Consultant in case of *Jose Antonio Franco-Gonzalez, et al., v. Eric Holder, Jr., Attorney General*. Helped develop the 1st detailed standard for "pro se competency" in the U.S. and for Immigration Judges
- Areas of expertise:

  Suicide, Psychological Autopsies, Stalking, Mentally Ill Offenders & Correctional Mental Health Issues, Insanity Defense, Competency, Detection of Malingered Mental Illness, Violence Risk & Threat Assessment, Analysis of Inappropriate Communications, Psychiatric Malpractice

National Presentations

1989	*Testosterone Effects on Motor Behavior and Dopamine Binding in Rana Pipiens*. Nineteenth Annual Conference of the Society for Neuroscience; Phoenix, Arizona
October 25, 1998	*Testamentary Capacity*. American Academy of Psychiatry and the Law, Annual Meeting; New Orleans, Louisiana
October 16, 1999	*Filicide and Murder Suicide*. American Academy of Psychiatry and the Law, Annual Meeting; Baltimore, Maryland
April 15, 2000	*Serial Murder*. American Academy of Psychiatry and the Law, Midwest Chapter Meeting; Cleveland, Ohio
April 7, 2001	*Psychiatric Evaluations in Death Penalty Cases* – Discussion Panel. American Academy of Psychiatry and the Law, Midwest Chapter Meeting; Chicago, Illinois.
May 8, 2001	*Dangerous Offenders* (Scientific and Clinical Report Chairperson). American Psychiatric Association, Annual Meeting; New Orleans, Louisiana
October 21, 2004	*Correctional Suicide Risk Assessment*. American Academy of Psychiatry and the Law, Annual Meeting; Scottsdale, Arizona
October 22, 2004	*Domestic Violence Risk Assessment and the Forensic Expert.* American Academy of Psychiatry and the Law, Annual Meeting; Scottsdale, Arizona

October 26, 2006	*Real World Challenges in Correctional Psychiatry.* American Academy of Psychiatry and the Law, Annual Meeting; Chicago, Illinois
May 31, 2007	*The Murder-Suicide Phenomenon* LTC (Ret) Kenneth L. Artiss Memorial Symposium, Walter Reed Army Medical Center, Department of Psychiatry; Washington, D.C.
October 18, 2007	*Stalking: From Risk Assessment to Prosecution* American Academy of Psychiatry and the Law, Annual Meeting; Miami, Florida
October 20, 2007	*Mass Murder & Mind Control: Understanding the Jonestown Tragedy.* American Academy of Psychiatry and the Law, Annual Meeting; Miami, Florida
October 23, 2008	*Becoming the Victim: Beyond Sadism in Serial Sexual Murder.* American Academy of Psychiatry and the Law, Annual Meeting; Seattle, Washington (Co-presented with Roy Hazelwood – FBI, ret.)
October 23, 2008	*Effects of Work Environment on the Attitudes of Correctional Psychiatrists.* American Academy of Psychiatry and the Law, Annual Meeting; Seattle, Washington
October 29, 2009	*Survey of Judges – Competence to Represent Oneself* (Research In Progress presentation). American Academy of Psychiatry and the Law, Annual Meeting; Baltimore, Maryland
October 30, 2009	*Stalking Risk Assessment and Prevention: Theory to Practice* American Academy of Psychiatry and the Law, Annual Meeting; Baltimore, Maryland
October 31, 2009	*Forensic Psychiatric Analysis of Dictators: Historical Lessons* American Academy of Psychiatry and the Law, Annual Meeting; Baltimore, Maryland
May 24, 2010	*Supermax Units & Death Row.* American Psychiatric Association, 163rd Annual Meeting; New Orleans, Louisiana (Session title: "Advances in Correctional Psychiatry: From Provision of Care to Malpractice Prevention")

October 21, 2010 — *High Risk Suicidal Patients*
American Academy of Psychiatry and the Law, 41st Annual Meeting; Tucson, Arizona

October 22, 2010 — *Punitive Segregation & SMI: Human Rights, Litigation & New York's Solution*
American Academy of Psychiatry and the Law, 41st Annual Meeting; Tucson, Arizona

March 11, 2011 — *The Pseudocommando Mass Murderer*
Grand Rounds; Case Western Reserve Department of Psychiatry Cleveland, Ohio

June 3, 2011 — *Stalkers: Analysis of Communications*
Annual Forensic In-Service Training; University of Massachusetts Medical School & Commonwealth of Massachusetts Department of Mental Health; Westborough, MA

October 27, 2011 — *A Chilling Trifecta: Child Murder, Serial Murder, Serial Arson in One Woman* (Scientific Poster Presentation)
American Academy of Psychiatry and the Law, 42nd Annual Meeting; Boston, MA

October 28, 2011 — *A Preservative of Insanity: Embalming Fluid* (Scientific Poster Presentation) American Academy of Psychiatry and the Law, 42nd Annual Meeting; Boston, MA

October 28, 2011 — *Pro Se Competence: Toward An Evidenced-Based Standard*
American Academy of Psychiatry and the Law, 42nd Annual Meeting; Boston, MA

March 8, 2012 — *Prevention of Psychiatric Malpractice*
American Physician Institute for Advanced Professional Studies Ft. Lauderdale, FL

April 4, 2012 — *Suicide Risk Assessment*
14th Annual Forensic Visiting Scholars Program
University of California at Davis & Napa State Hospital
Napa Valley Opera House, Napa CA

April 4, 2012 — *Antisocial Personality Spectrum*
14th Annual Forensic Visiting Scholars Program
University of California at Davis & Napa State Hospital
Napa Valley Opera House, Napa CA

October 25, 2012 — *The Legal & Ethical Considerations for Cancer Chemotherapy & Psychotropics Over Objection* (scientific poster presentation)
American Academy of Psychiatry and the Law,
43rd Annual Meeting; Montreal, Canada

October 27, 2012 — *Revisiting the Lessons of Osheroff v. Chestnut Lodge*
American Academy of Psychiatry and the Law,
43rd Annual Meeting; Montreal, Canada

February 15, 2013 — *Antisocial Personality Disorder*
Georgia Psychiatric Physicians Association
Atlanta, Georgia

October 24, 2013 — *Mass Murder & Mental Illness* (Debate)
American Academy of Psychiatry and the Law,
44th Annual Meeting; San Diego, CA

The Sadistic Symbiosis of Sadist & Spouse
(scientific poster presentation)

October 25, 2013 — *Breivik – Extreme Ideologist or Mentally Deranged?*
American Academy of Psychiatry and the Law,
44th Annual Meeting; San Diego, CA

Breivik: All-Consuming Hatred Approaching Psychosis?
Co-presented with Terje Torrissen, M.D.,
(Breivik forensic evaluator from Norway)

October 26, 2013 — *Forensic Psychiatric Consulting for Crisis Negotiation*
(scientific poster presentation)
American Academy of Psychiatry and the Law,
44th Annual Meeting; San Diego, CA

October 27, 2013 — *Not Guilty By Reason of Medication: Your Drugs Made Me Do It*
American Academy of Psychiatry and the Law,
44th Annual Meeting; San Diego, CA

October 21, 2014 — *Sexual Harassment*
AAPL Forensic Psychiatry Review Course
Chicago, IL

October 21, 2014 — *Fitness For Duty*
AAPL Forensic Psychiatry Review Course
Chicago, IL

October 21, 2014 — *The Ethics of Pro-Se Competency in Immigration Hearings*
American Academy of Psychiatry and the Law,
45th Annual Meeting; Chicago, IL

October 22, 2014 — *Death Penalty Testimony: Slippery Slopes*
American Academy of Psychiatry and the Law,
45th Annual Meeting; Chicago, IL

October 21, 2014 — *NY's SAFE Act: Are Patients Aware? Will it Scare them Off?*
(scientific poster presentation)
American Academy of Psychiatry and the Law,
45th Annual Meeting; Chicago, IL

May 18, 2015 — *Mass Distractions & Socio-Cultural Factors in Mass Shootings*
American Psychiatric Association, 168th Annual Meeting;
Toronto, Canada

State/Local Presentations

April 1, 1999 — *Dyadic Deaths and Double Danger: The Homicide – Suicide Phenomenon.* Psychiatric Court Clinic Conference;
Cleveland, Ohio

June 17, 1999 — *Risk Assessment for Violence.* Department of Family Medicine,
Case Western Reserve University; Cleveland, Ohio

August 19, 1999 — *Malingering and Sociopathy.* Northcoast Behavioral Healthcare System – Statewide video broadcast lecture; Northfield, Ohio

January 19, 2000 — *The Right to Refuse Treatment.* Northcoast Behavioral Healthcare System – Statewide Video Broadcast lecture;
Northfield, Ohio

December 13, 2000 — *Psychiatric Malpractice.* Grand Rounds. Northwestern University Medical School, Department of Psychiatry;
Chicago, Illinois

September 20, 2001 — *Stalkers.* Association of Threat Assessment Professionals,
Chicago Branch; Chicago, Illinois

December 18, 2001 — *Antisocial Personality Spectrum.* Grand Rounds. Dartmouth Medical School, Department of Psychiatry;
Lebanon, New Hampshire

January 15, 2002	Testimony on ***House Bill 1189***. *Guilty But Mentally Ill.* Legislative Office Building, New Hampshire
April 22, 2002	*Psychiatric Aspects of Stalking*. Forensic Grand Rounds. New Hampshire Hospital; Concord, New Hampshire
May 20, 2002	*Correctional Mental Health.* Interbranch Criminal & Juvenile Justice Council. Legislative Office Building; Concord, New Hampshire
August 26, 2002	*Federal Insanity*. Forensic Grand Rounds. New Hampshire Hospital; Concord, New Hampshire
November 12, 2002	*Stalkers.* Grand Rounds. Dartmouth Medical School, Department of Psychiatry. Video Broadcast lecture; Maine & New Hampshire
December 17, 2002	*Competence & the Capitol Shooter*. Grand Rounds. Dartmouth Medical School, Department of Psychiatry. Video Broadcast Lecture; Maine & New Hampshire
April 28, 2003	*Confidentiality & Privilege*. Forensic Grand Rounds. Video Broadcast lecture; New Hampshire Hospital & Augusta Mental Health Institute
August 25, 2003	*Treating the Morally Objectionable*. Forensic Grand Rounds. Video Broadcast lecture; New Hampshire Hospital & Augusta Mental Health Institute
November 11, 2003	*Forensic & Correctional Mental Health.* National Alliance For The Mentally Ill – Nashua Chapter; Nashua, NH
January 5, 2004	*Domestic Violence Risk Assessment.* Forensic Grand Rounds. Video Broadcast lecture; New Hampshire Hospital & Augusta Mental Health Institute
January 15, 2004	*The Insanity Defense*. New Hampshire Hospital Grand Rounds. Video Broadcast lecture; New Hampshire Hospital & Augusta Mental Health Institute
May 7, 2004	*Stalking Risk Management*. New Hampshire Association for Treatment of Sexual Abusers Conference; Laconia, NH
September 10, 2004	*Mental Illness & Suicide*. New Hampshire Public Defenders Training Seminar; Concord, NH

December 6, 2004	*Paternal Filicide.* Forensic Grand Rounds. New Hampshire Hospital
January 11, 2005	Testimony on House Bill 112 *Psychiatric evaluations in competency hearings.* Legislative Office Building; Concord, New Hampshire
May 12, 2005	*Post-mortem Suicide Risk Assessment* Youth Suicide Prevention Association; Concord, NH
June 10, 2005	*Threat Assessment & Profiling of the Unknown Stalker.* 11th Statewide Conference on Domestic & Sexual Violence; Bedford, NH
November 4, 2005	*The Psychiatric Autopsy.* 2nd Annual Youth Suicide Prevention Association Conference; Waterville Valley, NH
November 30, 2005	*Correctional Health Care.* NH Medical Society; Concord, NH
April 6, 2006	*Understanding Homicide-Suicides.* New Hampshire Hospital Grand Rounds; Concord, NH
April 18, 2006	*Recognition & Effective Representation of Clients With Mental Illness.* Vermont Law School, VT
June 8, 2006	*The Assessment of Communicated Threats.* 12th Statewide Conference on Domestic and Sexual Violence and Stalking; Waterville Valley, NH (Co-presented with Gene Rugala - FBI Supervisory Special Agent, ret.)
June 9, 2006	*Did She Kill Herself? Using the Psychiatric Autopsy in Criminal Cases.* 12th Statewide Conference on Domestic and Sexual Violence and Stalking; Waterville Valley, NH (Co-presented with Gene Rugala - FBI)
February 11, 2008	*Psychiatry Residency for Lawyers* Professor Sanjay Chhablani's Criminal Law Class, Syracuse College of Law, Syracuse, NY.
April 9, 2008	*Mass Murderers & School Shootings.* Syracuse University Project Advance. The Lubin House; New York City.

April 17, 2008	*Educator Sexual Misconduct.* 7th Annual Current Diagnostic And Treatment Challenges In Child And Adolescent Psychiatry Conference. Oncenter Complex. Syracuse, NY
April 24 – 25, 2009	*Keynote Speaker.* Forensic Science Workshop; Syracuse University Project Advance; Minnowbrook Conference Center; Blue Mountain Lake, NY
June 9, 2009	*Psychology of the Stalker: Using Written Communications to Determine Stalker Type, Risk and Intervention.* Central NY Association of Chiefs of Police – 2009 Law Enforcement Executive Symposium; Minnowbrook Conference Center; Blue Mountain Lake, NY
July 28, 2009	*Correctional Suicide: Research, Assessment, Prevention* Central New York Suicide Prevention Coalition Hutchings Psychiatric Center; Syracuse, NY
August 6, 2009	*The "Pseudocommando" Mass Murderer & the Language of Revenge.* 1st Annual Forensic Psychiatry Conference SUNY Upstate Medical University; Syracuse, NY
August 5, 2010	*Correctional Suicide: Assessment & Prevention.* 2nd Annual Forensic Psychiatry Conference SUNY Upstate Medical University; Syracuse, NY
September 18, 2010	*The Psychological Autopsy: Methods & Uses* Fall Conference: New York State Association of County Coroners and Medical Examiners (NYSACCME) Genesee Grand Hotel; Syracuse, NY
March 18, 2011	*Understanding Homicide-Suicides* Spring Conference: New York State Association of County Coroners and Medical Examiners (NYSACCME) Watkins Glen Harbor Hotel; Watkins Glen, NY
April 1, 2011	*Special Issues with High Conflict Families: Paternal Filicide-Suicide.* Association of Family and Conciliation Courts (AFCC) – NY Chapter; 2011 Upstate Conference. Genesee Grand Hotel; Syracuse, NY
June 9, 2011	*Anatomy of the Insanity Defense* American Psychiatric Association Central NY District Branch Meeting; Syracuse, NY

June 15, 2011	*Clinical Violence Risk Assessment* Emergency Medicine Grand Rounds Department of Emergency Medicine Upstate Medical University; Syracuse, NY
July 20, 2011	*Approaches for the Assessment & Management of Malingering* Statewide Video Broadcast Grand Rounds NY State Office of Mental Health; Albany, NY
August 11, 2011	*Stalking: Risk, Prevention & Victim Services.* 3rd Annual Forensic Psychiatry Conference SUNY Upstate Medical University; Syracuse, NY
August 25, 2011	*The Concept of Free Will in Psychiatry & Law* Grand Rounds – Department of Psychiatry SUNY Upstate Medical University; Syracuse, NY
March 29, 2012	*Psychiatric Malpractice: Lessons from the Battlefield* Grand Rounds – Department of Psychiatry SUNY Upstate Medical University; Syracuse, NY
May 31, 2012	*The Duty to Protect in New York State* Grand Rounds – Department of Psychiatry SUNY Upstate Medical University; Syracuse, NY
July 27, 2012	*Child Murder by Parents* Summit for Professionals Responsible for Children & Families at Risk for Abuse, Neglect & Maltreatment Syracuse University Department of Child & Family Studies Syracuse University; Syracuse, NY
August 2, 2012	*Clinical Risk Management* 4th Annual Forensic Psychiatry Conference SUNY Upstate Medical University; Syracuse, NY
October 4, 2012	*Zen & the Art of Documentation* Statewide Medical Staff Organization Conference Central New York Psychiatric Center; Marcy, NY
January 15, 2013	*Psychiatry for Law Enforcement* Hostage Negotiation Course – Syracuse Police Department Destiny USA; Syracuse, NY
February 11, 2013	*The Psychology of School Violence: Beyond Newtown* Syracuse University; Syracuse, NY

February 19, 2013	*Guns & America: Joining the Conversation* Syracuse University; Syracuse, NY
August 1, 2013	*NYSAFE Act: Key Points for Mental Health Professionals* Grand Rounds – Department of Psychiatry SUNY Upstate Medical University; Syracuse, NY
August 9, 2013	*NYSAFE Act: Why It Won't Prevent School Shootings* 5th Annual Forensic Psychiatry Conference SUNY Upstate Medical University; Syracuse, NY
October 10, 2013	*What is Forensic Psychiatry?* National Alliance on Mental Illness (NAMI) Educational Conference; Syracuse, NY
January 9, 2014	*The Antisocial Personality Spectrum* Grand Rounds – Department of Psychiatry SUNY Upstate Medical University; Syracuse, NY
May 30, 2014	*Tragedy & Tragic Reasoning* The Naomi Chernoff Creativity Conference SUNY Upstate Medical University; Syracuse, NY
August 8, 2014	*Suicide Prohibition: Shame, Blame or Social Aim?* Thomas Szasz: A Celebration of His Life & Work Everson Museum of Art SUNY Upstate Medical University; Syracuse, NY
April 29, 2015	*Involuntary Commitment – Panel Discussant* Recovering in the Hospital: Creating a Healing Experience 2nd Annual Recovery Conference; Hutchings Psychiatric Center Syracuse, NY

Publications

Peer Reviewed

1. Meloy J, Mohandie K, **Knoll J**, Hoffman J: *The Concept of Identification in Threat Assessment*. Beh Sci Law, 2015

2. **Knoll J**: *The Psychiatrist's Duty to Protect*. CNS Spectrums, 2015; 1-8.

3. Neuman Y, Assaf D, Cohen, Y, **Knoll J**: *Profiling School Shooters: Automatic Text-Based Analysis.* Frontiers in Psychiatry, 2015; 6, 86.

4. **Knoll J**: *Open Access Publishing in the Forensic Sciences.* Journal of the American Academy of Psychiatry and the Law, 2014; 42:315–21.

5. **Knoll J,** Meloy R: *Mass Murder & the Violent Paranoid Spectrum.* Psychiatric Annals, 2014; 44(5): 236-243.

6. **Knoll J,** Hatters-Friedman S: *The Homicide – Suicide Phenomenon: Findings of Psychological Autopsies.* J Forensic Science, in press.

7. Leonard C, Annas D, **Knoll J,** Terje Tørrissen T: *The Case of Anders Behring Breivik–Language of a Lone Terrorist.* Behavioral sciences & the law, 2014

8. **Knoll J:** *Malingering & Dissimulation.* In: AAPL Guidelines for the Forensic Psychiatric Evaluation. Journal of the American Academy of Psychiatry and the Law In press.

9. Way B, Kaufman A, **Knoll J,** Chlebowski S: *Suicidal Ideation among Inmate-Patients in State Prison: Prevalence, Reluctance to Report, and Treatment Preferences.* Behavioral Sciences & the Law, 2013

10. **Knoll J**: *Mass Murder: Causes, Classification, and Prevention.* Psychiatric Clinics of North America, 2012: 757–780.

11. Kaufman A, **Knoll J**, et al.: *Survey of Forensic Mental Health Experts on Pro Se Competence after Indiana v. Edwards.* Journal of the American Academy of Psychiatry and the Law, 2011; 39(4): 565-70.

12. **Knoll J,** et al.: *Pilot Study of Judges Opinions on Pro Se Competence after Indiana v. Edwards.* Journal of the American Academy of Psychiatry and the Law, 2010; 38(4): 536-539.

13. **Knoll J**: *Correctional Suicide: Assessment, Prevention, & Professional Liability.* Journal of Correctional Healthcare, 2010; 16(3): 1-17.

14. **Knoll J:** *The Pseudocommando Mass Murder: Part II, The Language of Revenge.* Journal of the American Academy of Psychiatry and the Law, 2010; 38(2): 263-72.

15. **Knoll J:** *The Pseudocommando Mass Murder: Part I, The Psychology of Revenge & Obliteration.* Journal of the American Academy of Psychiatry and the Law, 2010; 38(1): 87-94.

16. **Knoll J**: *Teacher Sexual Misconduct: Grooming Patterns & Female Offenders.* Journal of Child Sexual Abuse, 2010; 19:371–386

17. **Knoll J**, Hazelwood R: *Becoming the Victim: Beyond Sadism in Serial Sexual Murder.* Aggression and Violent Behavior, 2009; 14: 106-114.

18. **Knoll J**: *The Psychological Autopsy Part II: Towards a Standardized Protocol.* Journal of Psychiatric Practice, 2009; 15(1): 52-59.

19. **Knoll J**: *The Psychological Autopsy, Part I: Applications & Methods.* Journal of Psychiatric Practice, 2008; 14 (6): 393-397.

20. **Knoll J,** Resnick P: *Insanity Defense Evaluations: Toward a Model for Evidenced-Based Practice.* Brief Treatment and Crisis Intervention, 2008; 8(1):92-110

21. **Knoll J:** *The Recurrence of an Illusion: The Concept of "Evil" in Forensic Psychiatry.* Journal of the American Academy of Psychiatry and the Law, 2008; 36(1): 105-116.

22. **Knoll J,** Resnick P: *Deposition Do's and Don'ts.* Current Psychiatry 7(3): 25-40, 2008.

23. **Knoll J**, Resnick P: *Stalking Intervention.* Current Psychiatry 6(5): 31-38, 2007.

24. **Knoll J**, Resnick P: *The Detection of Malingered PTSD.* Psychiatric Clinics of North America (2006). Sep;29(3):629- 647.

25. **Knoll J:** *A Tale of Two Crises: Mental Health Treatment in Corrections.* The Journal of Dual Diagnosis (2006). 3(1): 7-21.

26. **Knoll J**, Gerbasi J: *Psychiatric Malpractice Case Analysis: Striving for Objectivity.* Journal of the American Academy of Psychiatry and the Law, 2006. 34:215-223.

27. Resnick PJ, **Knoll J**: *Detecting Malingered Psychosis.* Current Psychiatry (2006). 4(11): 13-25.

28. Noffsinger SG, and **Knoll JL**: *Assessing the Risk of Suicide and Attempted Suicide.* Drug Benefit Trends (2003). 15 (6): 25-31.

29. Buckley PF, Noffsinger SG, Smith DA, Hrouda DR, **Knoll JL**: *Treatment of the psychotic patient who is violent.* Psychiatric Clinics of North America (2003). 26: 231-272.

30. **Knoll JL**: *Legal Digest.* The Journal of the American Academy of Psychiatry and the Law (2000). 28 (4): 483-488.

31. **Knoll JL**, Resnick PJ: *U.S. v. Greer*: *Longer Sentences for Malingerers.* The Journal of the American Academy of Psychiatry and the Law (1999). 27 (4): 621-625.

32. **Knoll JL**, et al.: *Clinical Experience Using Gabapentin Adjunctively in Patients with a History of Mania or Hypomania.* Journal of Affective Disorders (1998). 49 (3): 229-233.

33. **Knoll JL**, et al.: *Heterogeneity of the Psychoses: Is There a Neurodegenerative Psychosis?* Schizophrenia Bulletin (1998). 24 (3): 365 – 379.

34. Lee AM, **Knoll JL**, Suppes T: *The Atypical Antipsychotic Sertindole: A Case Series.* Journal of Clinical Psychiatry (1997). 58: 410-416.

35. **Knoll JL**: *Clozapine-related Speech Disturbance.* Journal of Clinical Psychiatry (1997). 58: 219.

<u>*Regular articles*</u>

36. Hatters-Friedman S, Hall R, Kenedi C, **Knoll J**: *Your Drugs Made Me Do It.* American Academy of Psychiatry and the Law Newsletter, 2014; 39(3): 24-25.

37. Resnick P, **Knoll J:** *Being an Effective Psychiatric Expert Witness.* Psychiatric Times (2007) 24(13): 9-12.

38. **Knoll J:** *Current Issues in Psychopathy.* American Academy of Psychiatry and the Law Newsletter (2007), 32(3): 11-13.

39. **Knoll J:** *Editorial.* The Journal of Dual Diagnosis (2006). 3(1): 3-5.

40. **Knoll J:** *Review of: Double Jeopardy: A Counselor's Guide to Treating Juvenile Male Sex Offenders/Substance Abusers.* The Journal of Dual Diagnosis (2006). 3(1): 113-117.

41. **Knoll J:** *Serial Murder: A Forensic Psychiatric Perspective.* Psychiatric Times. March (2006), 24 (3): 64, 67-68.

42. **Knoll J** and Noffsinger S: *Recognizing Suicide Risk in the Emergency Department.* Psychiatric Issues in Emergency Care Settings. (2004), 3(3): 17-19.

43. Noffsinger G and **Knoll J**: *Suicide Risk: Assessment and Emergency Management.* Psychiatric Issues in Emergency Care Settings. (2004), 3(3): 8-13.

44. **Knoll J**: *The D.C. Snipers and the Perils of Profiling.* Ohio Psychiatric Association Newsletter (2003). 27 (4): 12.
At:http://www.ohiopsych.org/winter03/winter03_sniper.htm

45. Resnick PJ, **Knoll JL**: *The Psychiatric Expert Witness.* The Israeli Journal of Psychiatry (2000). 37 (2): 145-153.

Book Chapters

46. **Knoll J:** *Individual Psychotherapy in Corrections.* In: The Oxford Textbook of Correctional Psychiatry. New York, NY: Oxford University Press, 2015; Chapter 41.

47. **Knoll J:** *Evaluation of Malingering in Corrections.* In: The Oxford Textbook of Correctional Psychiatry. New York, NY: Oxford University Press, 2015; Chapter 23.

48. **Knoll J**, Annas D: *Mass Murder and Mental Illness.* In: Gun Violence and Mental Illness. American Psychiatric Publishing, in press.

49. **Knoll J:** *Clinical Framework for the Treatment Relationship.* In: Practical Guide to Correctional Mental Health and the Law (F. Cohen, Ed.). Civic Research Institute: Kingston, NJ, 2011; Chapter 8

50. **Knoll J:** *Ethics in Forensic Psychiatry.* In: Textbook of Forensic Psychiatry, 2nd Editions (R. Simon and L. Gold, Eds.). Washington, DC: American Psychiatric Publishing, Inc., 2010; Chapter 5

51. **Knoll J**, Bevens G: *Supermax Units & Death Row.* In: Handbook of Correctional Mental Health – 2nd Edition (C. Scott, Ed.). Washington, DC: American Psychiatric Publishing, Inc., 2010; Chapter 16; pp. 435 – 475.

52. **Knoll J:** *Treating the Morally Objectionable.* In: Handbook of Violence Risk Assessment and Treatment: New Approaches for Mental Health Professionals (J. Andrade, Ed.). New York: Springer Publishing Company, 2009; Chapter 10, pp. 311-345.

53. **Knoll J:** *Educator Sexual Misconduct: Grooming Patterns and Female Offenders. In: Practical Aspects of Rape Investigation: A Multidisciplinary Approach, Fourth Edition* (R. Hazelwood, A. Burgess, Eds.). Boca Raton, FL: CRC Press, 2009; Chapter 28, pp. 517-527.

54. Resnick P, **Knoll J**: *Malingered Psychosis.* In: Clinical Assessment of Malingering and Deception – 3rd Edition (R. Rogers, Ed.). New York: The Guilford Press, 2008; Chapter 4, pp. 51-68.

55. **Knoll J,** Ressler R, Hazelwood R, Burgess A: *Serial Homicide.* In: Wiley Encyclopedia of Forensic Science, (A. Jamieson, A, Moenssens, eds.) Chichester, UK: John Wiley & Sons, Ltd., 2009; pp. 2311-2324.

56. **Knoll J,** Hazelwood R: *Psychological Autopsy.* In: Wiley Encyclopedia of Forensic Science, (A. Jamieson, A, Moenssens, eds.) Chichester, UK: John Wiley & Sons, Ltd., 2009; pp. 2161-2173.

57. **Knoll J**: *Violence Risk Assessment for Mental Health Professionals.* In: Wiley Encyclopedia of Forensic Science, (A. Jamieson, A, Moenssens, eds.) Chichester, UK: John Wiley & Sons, Ltd., 2009; pp. 2597-2602.

58. **Knoll J,** Resnick P: *Evil: Illusion of.* In: Wiley Encyclopedia of Forensic Science, (A. Jamieson, A, Moenssens, eds.) Chichester, UK: John Wiley & Sons, Ltd., 2009; pp. 977-985.

59. **Knoll J,** Baden M: *Autoerotic Deaths.* In: Wiley Encyclopedia of Forensic Science, (A. Jamieson, A, Moenssens, eds.) Chichester, UK: John Wiley & Sons, Ltd., 2009; pp. 243-248.

60. **Knoll J**: *Risk Management of Stalking*. Chapter 3. In: GAP Report on Psychiatric Aspects of Stalking (D. Pinals, Ed.) Oxford University Press, Inc.: New York, 2007

61. **Knoll J:** *The Impact of the Structure & Function of Corrections on Inmates' Mental Health.* Chapter 2. In: Correctional Psychiatry: Practice Guidelines and Strategies (O. Thienhaus, M. Piasecki, Eds.) Civic Research Institute: Kingston, NJ, 2007

<u>*Correctional Mental Health Report*</u>

62. **Knoll J**: *The Psychiatrist's Obligation: Same As It Ever Was.* Correctional Mental Health Report. (2014), 15(5): 69-70.

63. **Knoll J:** *Drugging Aggression Behind Bars.* Correctional Mental Health Report. (2013), 15(2): 17, 29-31.

64. **Knoll J:** *Szasz In Memoriam & Personal Reflections.* Correctional Mental Health Report. (2012), 14(4): 53-55.

65. Hatters Friedman S, **Knoll J:** *Neonaticide.* Correctional Mental Health Report. (2012), 13(6): 85-86, 95-96.

66. **Knoll J:** *The Correctional Psychiatrist: Healer – Teacher – Leader.* Correctional Mental Health Report. (2011), 13(3): 35, 47-48.

67. **Knoll J:** *"Fine-Tuned Mental Capacity Decisions": Trial Court Judges' Opinions on Pro Se Competence after* ***Indiana v. Edwards.*** Correctional Mental Health Report. (2010), 12(2): 29, 32.

68. **Knoll J:** *A Bit About Benzos.* Correctional Mental Health Report. (2010), 12(2): 19-20, 26, 32.

69. Cerny C, Hatters-Freidman S, **Knoll J:** *Stockholm Syndrome.* Correctional Mental Health Report. (2010), 12(2): 17-18, 25-28.

70. **Knoll J:** *Severe Sexual Sadism.* Correctional Mental Health Report. (2010), 11(6): 81-82, 86, 89-92.

71. **Knoll J:** *Keeping Up With the Suicide Literature.* Correctional Mental Health Report. (2010), 11(6): 85-86.

72. **Knoll J:** *PsychoPharm Briefs.* Correctional Mental Health Report. (2010), 11(69): 90.

73. **Knoll J:** *New York SHU Legislation Update.* Correctional Mental Health Report. (2010), 11(5): 65, 68.

74. **Knoll J:** *The Political Diagnosis: Psychiatry in the Service of the Law.* Correctional Mental Health Report. (2010), 11(5): 67-68.

75. **Knoll J:** *A Closer Delineation of Suicidal Behavior.* Correctional Mental Health Report. (2010), 11(5): 77

76. **Knoll J:** *Between Resilience & Reality.* Correctional Mental Health Report. (2009), 11(4): 53-54, 64.

77. **Knoll J:** *Mass Murderers & the Psychology of Revenge.* Correctional Mental Health Report. (2009), 11(4): 49, 55, 58-63.

78. **Knoll J:** *Focus on Mental Illness & the Justice System: Research Review.* Correctional Mental Health Report. (2009), 11(3): 41 – 42.

79. Leonard C, **Knoll J:** *Evaluating Competence to Stand Trial in Non-Traditional Locations.* Correctional Mental Health Report. (2009), 11(3): 35 – 36.

80. **Knoll J:** *Malingering – Are You Really, Really Sure?* Correctional Mental Health Report. (2009), 11(2): 1, 22, 30.

81. **Knoll J:** *Manic Patient's Treatment Refusal Absolves Psychiatrist From Duty to Treat.* Correctional Mental Health Report. (2009), 11(2): 29.

82. **Knoll J:** *Literature Update.* Correctional Mental Health Report. (2009), 11(2): 21, 31, 32.

83. **Knoll J:** *Moral Judgments & Emotional Pain.* Correctional Mental Health Report. (2009), 11(1): 5-6, 16.

84. **Knoll J:** *Female Teacher Sexual Misconduct: A Different Type of Sex Offender?* Correctional Mental Health Report. (2009), 11(1):1-2, 12-15.

85. **Knoll J:** *Treatment on Death Row: Ethical Dilemmas.* Correctional Mental Health Report. (2009), 10(6): 81, 92, 94-96.

86. **Knoll J:** *No Remorse.* Correctional Mental Health Report. (2009), 10(6): 85-86, 90, 93.

87. **Knoll J:** *Correctional Suicide Risk Assessment & Prevention.* Correctional Mental Health Report. (2009), 10(5): 65-66, 68-72, 74-79.

88. **Knoll J:** *Dignity in the Gray Zone.* Correctional Mental Health Report. (2008), 10(4): 51-52, 62-63.

89. **Knoll J:** *Junk Science and the Flight of the Junco.* Correctional Mental Health Report. (2008), 10(3): 35-36.

90. **Knoll J:** *As Far As the Eye Can See.* Correctional Mental Health Report. (2008), 10(3): 37-39, 41.

91. **Knoll J:** *Schizophrenia and Glutamate.* Correctional Mental Health Report. (2008), 10(2): 19-20.

92. **Knoll J:** *Empatheia et Inspiratio.* Correctional Mental Health Report. (2008), 10(2): 25, 31-32.

93. **Knoll J:** *Fearful Synergy: Society & Psychiatry Perpetuating the Criminalization of the Mentally Ill.* Correctional Mental Health Report. (2008), 10(1): 3-4, 12-16.

94. **Knoll J:** *Psychopharm News.* Correctional Mental Health Report. (2008), 10(1): 5-6.

95. **Knoll J:** *Psychopathy & Controversy.* Correctional Mental Health Report. (2008), 9(6): 83-86.

96. **Knoll J:** *Empatheia et Inspiratio.* Correctional Mental Health Report (2008) 9(6): 87-88.

97. **Knoll J:** *Punishment for Symptoms: Disciplinary Hearings for Mentally Ill Inmates.* Correctional Mental Health Report (2008) 9(5): 65-66, 70-71.

98. Aslam S, **Knoll J:** *Borderline Personality Disorder in Corrections.* Correctional Mental Health Report (2008) 9(5): 67-69.

99. **Knoll J:** *Beware: Something Evil This Way Comes.* Correctional Mental Health Report (2008) 9(5): 72-73.

100. **Knoll J:** *Empatheia et Inspiratio: Empathy & Inspiration for Correctional Mental Health Professionals.* Correctional Mental Health Report (2008) 9(5): 74-75.

101. **Knoll J:** *Research Review & Commentary. Is Reentry Deadly?* Correctional Mental Health Report. (2007), 9(4): 59.

102. **Knoll J:** *Research Review & Commentary. Suicide in Solitary.* Correctional Mental Health Report. (2007), 9(2): 21, 32.

103. **Knoll J:** *Discussing the Meaning of Life with a Lifer.* Correctional Mental Health Report (2006), 8(4): 51-52, 59-60.

104. **Knoll J:** *Research Review & Commentary. Results from STAR*D: Something to be Modest About.* Correctional Mental Health Report. (2006), 8(5): 74-75.

105. **Knoll J:** *Commentary: My Brother's Keeper.* Correctional Mental Health Report (2006), 8(1): 7, 15.

106. **Knoll J:** *Splitting the Wrongfulness Hair: Texas v. Yates.* Correctional Mental Health Report (2005), 7(2): 22,26.

107. **Knoll J:** *Correctional Suicide.* Correctional Mental Health Report (2005), 7(1): 1, 13-15.

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Workplace Violence Prevention and Response. American Society for Industrial Security (ASIS). 2005.
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Misc. Activities

March 13, 2013	Sandy Hook Promise Presentation – Violence, Loss & Emotional Healing; Newtown, CT
2013 – present	Co-Facilitator for Trauma & Healing Seminars Karma Triyana Dharmachakra Buddhist monastery Woodstock, NY

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UPSTATE
MEDICAL UNIVERSITY

James L. Knoll, IV, MD
Professor, Department of Psychiatry
Director, Division of Forensic Psychiatry
Forensic Psychiatry Fellowship Program

2/16/16

Jennifer Stengel
Barrister and Solicitor
Legal Services Division – Civil Litigation
9th Floor Peace Hills Trust Tower
10011 – 109 Street
Edmonton, Alberta T5J 3S8
Canada

Re: Public Fatality Inquiry into the death of Mehari Wodaje

Dear Barrister Stengel,

At your request, I reviewed the records and materials you sent for the purpose of answering questions about correctional suicide risk assessment and prevention. In particular, you asked that I address the following questions:

1. *What are the risk factors for suicide generally?*
2. *Are inmates at higher risk for suicide than non-inmates?*
3. *Are there special suicide risks in a prison setting that staff should be aware of, and if yes, what are they?*
4. *What training would you recommend for prison staff?*
5. *What measures should be taken in prisons to decrease suicide attempts?*

The above questions are presented in the context a Public Fatality Inquiry into the death by suicide of Mr. Mehari Wodaje. Mr. Wodaje was a 46 year old Ethiopian Canadian man who was serving an indeterminate life sentence for second degree murder. In early October 2012, as a result of security concerns, his security level was reclassified from minimum to moderate. While in administrative segregation at the Edmonton Institution (maximum security) awaiting transfer to the Bowden Institution (medium security) he was found to have died by suicide on 10/11/12.

750 East Adams Street | Syracuse, NY 13210 | Ph: 315 464 3104 | Fax: 315 464 7188 | www.upstate.edu | State University of New York | Email: knollj@upstate.edu

It is my understanding that the purposes of the Inquiry, as well as the opinions expressed in this report, are solely to provide recommendations on correctional suicide prevention. Nothing in this report is intended to set forth opinions on legal responsibility.

SOURCES OF INFORMATION:

In preparation of this report, I reviewed the following sources of information pertaining to Mr. Wodaje. The sources listed below are of a type reasonably relied upon by experts in the field in forming opinions.

1. Correctional Service Canada (CSC) records pertaining to Mr. Wodaje
2. Court transcript of proceedings In the Matter of the Death of Mehari Wodaje, Provincial Court of Alberta, dated 5/7/15 to 5/8/15 (pgs. 1 – 171)
3. Document titled Sharing of Information Fifth Working Day Review, dated 10/11/12
4. Document titled Review of Offenders Segregated Status Fifth Working Day Review, dated 10/12/12
5. Mr. Wodaje's personal journal (spiral bound date planner), pages dated 6/24/12 to 9/27/12
6. Psychological/Psychiatric Assessment Report prepared by Dr. Chant, dated 5/30/12, and signed by Mr. Wodaje on 9/5/12
7. Psychological services clinical progress notes, dated 3/26/12 to 7/12/12
8. Psychological/Psychiatric Assessment Report prepared by Dr. Mah, dated 10/15/12
9. Health Services Transfer Summary for Mr. Wodaje, dated 10/9/12
10. Intake Health Status Assessment dated, 10/9/12
11. Doctor's orders and progress notes, dated 9/10/12 to 11/10/12
12. Document titled Assessment for Decision, dated 10/9/12
13. Officer's Statement/Observation Report, dated 10/11/12
14. Document titled Health Services Transfer Summary
15. Sample form titled Immediate Needs Checklist Suicide Risk
16. Sample form titled Immediate Needs Checklist Suicide Risk (Institutional Version)
17. Instruction Sheet for completing the Immediate Needs Checklist – Suicide Risk
18. Sample form titled Intake Health Status Assessment Section I
19. Sample form titled Intake Health Status Assessment Section II
20. CSC Suicide Prevention Training Materials
21. CSC Suicide and Self-Injury Intervention Refresher Training (SSIRT)
22. Letter From the Honourable Donna M. Groves (Provincial Court Judge) to Jennifer Stengel, dated 8/31/15

QUALIFICATIONS:

I am a licensed medical doctor in New York, who is board certified in both psychiatry and forensic psychiatry. I devote more than 75% of my time to active clinical practice and teaching in my specialty at the State University of New York (SUNY) Upstate Medical University in Syracuse, NY, and the Central NY Psychiatric Center in Marcy, NY. I have been qualified as an expert in psychiatry in both state and federal courts. I am currently a Professor of Psychiatry, and Director of Forensic Psychiatry, at SUNY Upstate Medical University. In my role as an expert in psychiatry, I have been retained by both the plaintiff and defense.

Over the course of my career, I have served on two State Suicide Prevention Committees. I served as the medical board president for the American Foundation for Suicide Prevention, Central New York Chapter. In these roles, among other things, I give expert advice on suicide risk assessment and prevention. I have given lectures at the state and national level on the subjects of clinical suicide risk assessment and prevention. I have also published multiple articles on these subjects.

Beginning in 1997, I served as a correctional psychiatrist for the Dallas County Jail in Dallas, Texas. From approximately 2001 to 2006, I was the director of psychiatric services for the New Hampshire State Prison System. Some my duties included being an inpatient psychiatrist in the prison's Secure Psychiatric Unit in Concord, NH. This unit housed and treated both state prison inmates, as well as local jail inmates. My duties frequently involved the assessment and management of suicidal inmates. In addition, I was responsible for creating mental health and suicide prevention policy and procedure for the entire NH State Prison System.

In my capacity as a clinical and forensic psychiatrist, I now regularly provide consultation and treatment recommendations for the Central New York Psychiatric Center, which is a 200 bed psychiatric inpatient hospital for forensic and correctional patients. My consultation and treatment recommendations frequently involve suicide risk assessment and prevention efforts. By virtue of my medical education, graduate and post-graduate training, clinical practice, teaching, knowledge, and experience, I am competent to testify as an expert on the subject of the standard of care for assessing and treating suicidal patients. I am familiar with the accepted standards of care for the assessment and treatment of suicidal patients in correctional facilities.

Please refer to my attached curriculum vitae for additional information on my background and qualifications to render expert opinions in this matter, which I incorporate herein by reference as though fully set forth.

BRIEF SYNOPSIS OF MR. WODAJE'S CASE:

Mr. Wodaje was a 46 year old Ethiopian Canadian man serving an indeterminate life sentence for second degree murder. His offense occurred on 2/18/02 when he strangled an ex-intimate spouse to death, and then attempted suicide by drinking bleach and cutting his wrists. His only other known criminal history involved a stay of proceedings for allegedly attempting to choke his ex-wife. With the exception of his suicide attempt following his index offense, he had no known psychiatric history. After his conviction, Mr. Wodaje spent five years in the Provincial system awaiting sentencing and was transferred to the Federal system in 2007. He was eligible for Day Parole on 2/18/09 and for Full Parole on 2/18/12. He arrived at the Grierson Institution (minimum security) from the Bowden Institution (medium security) on 2/3/12.

During a routine search of Mr. Wodaje's room on 10/2/12, Grierson staff discovered a personal journal which suggested that Mr. Wodaje and [redacted] (community support person) had been in the early stages of developing an intimate relationship. Mr. Wodaje's Case Management Team (CMT) had previously addressed concerns with Mr. Wodaje about the nature of his relationship with [redacted] Mr. Wodaje had assured them that the relationship was merely

professional. After finding his journal entries, the CMT concluded that Mr. Wodaje had violated his conditions at Grierson, and his security classification was reassessed back to moderate. Prior to the journal entries being discovered, Mr. Wodaje had demonstrated very good compliance with his correctional plan and had not received any institutional charges at Grierson.

Mr. Wodaje was then involuntarily admitted to administrative segregation at the Edmonton Institution (maximum security) on 10/9/12 while awaiting final transfer to the Bowden Institution (medium security). From 10/9/12 to 10/10/12, receiving staff at the Edmonton Institution described Mr. Wodaje as cooperative and "positive." Health Services forms indicate he gave responses of "no" to questions about suicidal and self-injurious thinking. On 10/11/12, Mr. Wodaje was found to have died by suicidal asphyxiation in his cell. The mechanism of his death involved bedding wrapped around his neck and secured to a fixture that opened a window in his cell.

SUMMARY OF CSC RECORDS:

The Psychological/Psychiatric Assessment Report prepared by Dr. Chant, dated 5/30/12, was also signed by Mr. Wodaje on 9/5/12. Mr. Wodaje had been referred to Dr. Chant for "an updated Risk Assessment" that would be considered in the context of his future conditional release. Dr. Chant noted that Mr. Wodaje's medical and substance use history were unremarkable. Mr. Wodaje reported having a good education in Ethiopia, obtaining a Bachelor of Arts Degree in political science and international affairs. After coming to Canada, he had been working towards a nursing degree at a community college at the time of his index offense. Dr. Chant's report states:

> [Mr. Wodaje] is currently serving an indeterminate sentence (life/10) for second degree murder.... Mr. Wodaje and the victim were in an off and on relationship for about one and half years leading up to the index offense. On 12/25/01, the victim returned to her home country of Ethiopia where she married her old boyfriend.... Mr. Wodaje subsequently learned of her marriage. Mr. Wodaje attended the victim's residence on the afternoon of 2/17/02. Mr. Wodaje forced the victim to come with him.... He drove the victim to his residence.... attempted to physically remove the victim from his car but she fought him off. He left the victim in the vehicle, went to his apartment and returned a short time later presenting the victim with various gifts. He drove the victim back to her residence.... engaged in conversation with her, acting in a threatening manner and yelling... expressing anger at her recent marriage. He eventually left, and the victim called a friend to come and stay with her as she was afraid of him.
>
> Mr. Wodaje left a suicide note at his residence and returned to the victim's residence on 2/18/02 in the morning. The victim authorized Mr. Wodaje to enter her residence, as he was acting in a calm manner, and the victim's friend was present. The victim's friend later left the residence, leaving Mr. Wodaje alone with the victim. While alone with the victim, Mr. Wodaje wrapped a telephone cord around her neck and strangled her. He then cut his wrist and drank bleach. Next, he attended to a neighboring residence and requested an ambulance...
>
> ***
>
> Offender's version: .... He said that her reason for marrying her old boyfriend was that she did not believe that he was really going to marry her. He said he felt destroyed.... decided to commit suicide because he said he believed that hell was a better fate for him than what he felt like at that time.... he

said that they had consensual sexual intercourse. He claimed that he started drinking the bleach shortly afterward. The victim tried to stop him.... They struggled while he kept on drinking the bleach. The victim screamed, "Kill me first" which is a cultural idiom not to be taken literally, he admitted. However, at that moment he strangled her to death. He then continued to drink bleach and he said he was surprised he did not die. He stated that he tried hanging himself but the phone cord broke and he fell on the floor. He said that he tried to slash his wrists. Finally, the excruciating pain of drinking the bleach caused him to go to the neighbors to phone the police.

Dr. Chant's report indicates that Mr. Wodaje's past criminal history included a "stay of proceedings... for assault with a weapon, uttering threats (3), overcome resistance by attempting to choke, suffocate or strangle another person." However, Mr. Wodaje said that his ex-wife had filed these charges because he had cancelled their wedding plans. Mr. Wodaje said that he had grown up in Ethiopia on the "eve of change," as the country was being transformed into a "Marxist society." His father had been a Democrat and was "murdered" by the Marxist Government. His mother became a single parent who worked to support her children. Mr. Wodaje was married in Ethiopia in 1990. He told Dr. Chant that his wife wanted to divorce him when she discovered he had a low sperm count. They eventually divorced in 2001; however, his ex-wife told him she had become pregnant with his child and they both agreed to remarry. Mr. Wodaje said he called off the marriage when he found out she had become pregnant with another man's child. He asserted that it was shortly after he called off the marriage that she charged him with assault, but the charges were later stayed.

Dr. Chant's report states:

Mr. Wodaje has one charge that was withdrawn on file for refusing to lockup in 2010.... In 2008, Mr. Wodaje spent a total of 31 days in involuntary segregation for personal safety reasons. His urinalysis tests have returned negative.

... Clinical interview: ....He appears to have exhibited some characteristic of narcissistic personality disorder, such as a sense of entitlement and feelings of rage and homicidal aggression when rejected by intimate partners.... He stated he is not suicidal.... Mr. Wodaje scored within the low risk/needs range (on the Level of Service Inventory – Revised).... [He] appears to be presently in the low to moderate range [for violence per the HCR-20].... Overall Mr. Wodaje's risk to reoffend violently appears to be presently in the lower to moderate range, and he appears to be at low risk to reoffend generally. His risk to reoffend may increase sharply if he experiences rejection or jealousy in intimate relationships with women.

***

Mr. Wodaje, in summary, seems to have a pattern with his last two intimate partners; that is, when his ex-wife wanted a divorce or his girlfriend told him she married someone else, he strangled them – resulting in the assault of his ex-wife and the death of his girlfriend. His narcissistic injury suffered in intimate relationships causes him to feel hollow, degraded and empty. It seems that he reacted with defiance and rage in both instances of his perceived rejection by his partners.

The document titled Assessment for Decision[1] is dated 10/9/12, and was completed by Parole Office Breeness and supervised by Director Otto. The document indicates that Mr. Wodaje's final recommendations included involuntary transfer to the Bowden Institution under medium security. His family contact, community peer mentoring, and community service at the Mustard Seed were all canceled. The document states:

> The two primary risk factors identified in this case are personal/emotional orientation and marital/family.... Despite positive program reports Wodaje has been lying to the CMT for several months about the nature of his relationship with a community support worker, [redacted] Wodaje was spoken to several times over the past few months about the nature of his relationship as the CMT were concerned that it may develop into something more than that of community support. One note of concern... was in relation to Wodaje making an unauthorized phone call while he was on an ETA. After this incident was brought forth the CMT had several conversations with Wodaje about always being completely open and honest with his CMT and Wodaje agreed that he would be honest about any relationship and about his actions.... In previous conversations with Wodaje we have discussed the physical contact he has had with [redacted] and Wodaje has denied that anything inappropriate has occurred. The journal entries that were discovered.... outline a very different physical relationship than what Wodaje talked about...
>
> Wodaje is aware that although no specific special conditions were imposed on any temporary absence out of Grierson (all ETAs), reporting relationships with females was recommended as a condition... and would likely be recommended for a potential day parole as well.... Prior to these journal entries being discovered Wodaje had demonstrated a high level of engagement in following his correctional plan...

The Health Services Transfer Summary for Mr. Wodaje[2], dated 10/9/12, indicates a checkbox response of "no" to the following two questions: "offender has history of being suicidal" and "offender is currently suicidal." The Intake Health Status Assessment[3], dated 10/9/12, indicates a checkbox response of "yes" under the section for "history of suicide attempts." This section states, "Eleven years ago, does not consider part of history." This form also indicates check box responses of "no" to the questions of: "current suicidal ideation or plan" and "current threats of self-injurious behavior." A Progress Note, dated 10/9/12, states, "History of suicide attempt eleven years ago. Inmate feels this is not part of his history."

The document titled Sharing of Information Fifth Working Day Review[4], dated 10/11/12, states:

> This is Mehari Wodaje's Fifth Day Institutional Review of his placement into segregation.... On 10/2/12 during a routine cell search, several journal entries were discovered in Wodaje's cell. These entries outlined some of Wodaje's interactions with [redacted] (a community support person) over the past several months. There are numerous entries that discuss Wodaje and [redacted] interactions at church, during visits at Grierson and at the HIV Edmonton Office where Wodaje attends Lifeline meetings. The Case Management Team are extremely concerned with the nature of these entries as intimate relationships with women are Wodaje's primary risk factors.... Prior to the

[1] Bates Stamp 00078
[2] Bates Stamp 00043
[3] Bates Stamp 00046
[4] Bates Stamp 00138

discovery of these journal entries the CMT had numerous conversations with Wodaje about the need for him to be completely open and honest about all relationships with women. It is apparent that Wodaje has been lying to the CMT for several months.

The Officer's Statement/Observation Report[5], dated 10/11/12, states:

Wodaje arrived at the Edmonton Institution at approximately 14:10 hours. He was processed in A & D and moved into segregation at approximately 15:20. At 16:30, I visited inmate Wodaje at his cell door and asked him how he was doing both physically and mentally. I asked him if he understood why he was moved here and if he had any concerns at this time. Wodaje was very cooperative and stated that he was doing okay and understood that he wouldn't be here very long. He asked if he could have a phone call and I informed him that as a new admittance he was entitled to a call. I instructed him to give the unit Officer a request form with the number he would like to call. He agreed to talk to the next Officer during his range walk. I again asked him if he was going be okay and informed him that he could ask for me if he needed anything. I also informed him that I would be moving him to another range very soon and we would talk more then. Wodaje appeared to be content with this conversation and said thank you. This ended our conversation.

During my initial conversation with him he appeared to be positive and gave me the impression that he was looking forward to moving to another cell. I did not see any signs of physical or mental health issues with him at this time. The following day I had him moved to cell 227 on Upper 3 Range. Wodaje appeared to be happy with this move.... No physical or mental health issues were identified at that time.

The Psychological/Psychiatric Assessment Report prepared by Dr. Mah, dated 10/15/12, states:

[Mr. Wodaje] had been receiving counseling services while incarcerated at Bowden Institution and had informed his Parole Officer Kerri Breeness that he wanted to continue receiving counseling once he was transferred to Grierson Institution. He subsequently attended four counseling sessions.... He expressed desire to continue so his file was subsequently transferred....

***

Mehari attended a total of five sessions with the writer.... He articulated a willingness and motivation toward behaving differently as well as making changes in his life. He states that he was a Christian and motivated to bettering his life through Christ. This writer, however, was of the view that though he appeared to display behavior that suggested that he articulated well she hoped he was going to be able to walk the talk.... He denied experiencing any depression or anxiety during this session as well as throughout all of the remaining sessions that he attended. He also denied having any thoughts of self-harm or suicide.

***

He said that he was upset that Dr. Chant had reported that he was narcissistic, i.e. that he had killed his girlfriend in a jealous rage. He reiterated his perspective, that she had uttered the words "kill me now," so he did as she requested. Said he assumed that she was in pain and wanted to die like he did so he did what he did.... Said he wanted to commit suicide and thought she wanted to end it all too.

[5] Bates Stamp 00153

.... [His parole officer] asked him whether he was involved in an intimate relationship with [redacted]. He said he told her no, that she was just a community support person for him. He said he advised her he was willing to terminate his relationship with this community support person if keeping this relationship would jeopardize his chance at obtaining parole. He said his P.O. informed him that that was unnecessary.

....He said he was doing well otherwise and not experiencing any feels of depression or anxiety. Also denied having any thoughts of self-harm or suicide.... Throughout his session, as well as other sessions, he spoke about his excitement about moving forward in life. He also stated he was happy to be able to contribute to society and specifically to help others, stating that he enjoyed working at the food bank at the Mustard Seed Church. He spoke about his future plans, i.e. to obtain either actual employment at the Mustard Seed Church or to obtain training at a machinery type trade.

.... Sessions were spent helping him explore ways he could manage his transition to the community more effectively, as well as how he could manage stress more effectively. Even when he described challenging situations that he had to endure, he consistently informed the writer that what he was experiencing was manageable, denying any feelings of depression or anxiety. He also denied having any thoughts of self-harm or suicide.

SUMMARY OF MR. WODAJE'S PERSONAL JOURNAL:

Mr. Wodaje's personal journal appears to be a spiral bound date planner. The materials sent for review were pages dated 6/24/12 to 9/27/12. The entry for 6/24/12 states: "I met [redacted] at Central Baptist. We had a moment of blessing together. We worshiped him... our hands intertwined, our heads bowed, our hearts humble. At 1:15 we had to separate. She kissed me for the first time on my lips. I wanted more than a touch though. We argued for the first time over the phone."

The entry for 6/25/12 states: "She told me she decided to let me know about her boyfriend or other relationship. We met at Lifeline and she told me that she doesn't have a boyfriend – one reason she was pretending as if she has a boyfriend was to keep people away from making advances. I was immeasurably happy to hear that. It makes the playing field level."

The entry for 7/3/12 states: [redacted] came to visit me. For the first time, me and her, sitting alone in my environment for uninterrupted three hours.... We discussed about what the boundaries of our relationship at this time should be. We expressed the feelings we have to each other but we admitted that we are not at a place and time to act upon it. We are just close friends now. I accompanied her to her car and before she got in I gave her a hug and she buried her face in my neck with her exposed cleavage. I wish that moment lasted forever." An entry on 7/8/12 indicates that [redacted] shared with Mr. Wodaje about her past relationship with her ex-boyfriend.

The entry for 7/9/12 indicates that Mr. Wodaje was at a Lifeline meeting when [redacted] asked to see him. They met alone in a staff meeting room. The entry states: [redacted] was standing there. I ran to her and she ran to me. We embraced each other as if we had never seen each other for ages. To my absolute surprise she came straight to my lips with an open mouth kiss. Oh my lord, I had to make a choice on that split second. I avoided her! It feels like I lost the whole world!

And yet, I got the world back, for if I kissed her, she would have blamed me for moving too fast.... She still tried, talking about 'we don't need this tension' – sexual tension."

SUMMARY OF COURT PROCEEDINGS:

A transcript of the Provincial Court of Alberta proceedings In the Matter of the Death of Mehari Wodaje was provided for review. The testimony of Sherry Antonucci, B.A., M.Ed., Ph.D. (Provisionally Registered Psychologist) indicates that Dr. Antonucci was working part-time performing counseling services at the Edmonton Parole Office, and she provided psychological services to Mr. Wodaje. They had a total of four counseling sessions together.

Regarding Mr. Wodaje's psychological health during their counseling periods Dr. Antonucci stated, "He presented as quite stable emotionally, quite regulated, motivated to be in the counseling process and work on that." She did not have any concerns that he might have a particular diagnosis or significant mental health condition. She did not conclude that he was ever suicidal during their work together.

Dr. Antonucci said that when she had to go on maternity leave, Dr. Mah took over counseling with Mr. Wodaje. Dr. Antonucci described Mr. Wodaje as a well-educated person who had good status within his culture. In her opinion, Mr. Wodaje's reassignment back to medium security was quite a step back for him in terms of the trajectory of what he wanted for his life. She stated, "He was hoping to go to school and hoping to... become a bit more of a present member in his own community. So I would suspect that having a change like that would have been quite the external stressor for him."

Dr. Antonucci explained that there are clinical factors and nuances that would not necessarily be picked up by checkboxes on suicide screening forms, and that these factors would have to be skillfully elicited during a clinical evaluation. It was her understanding that Suicide Prevention Training for the Edmonton Institution occurred once every two years (which consisted of a two hour class course), which alternated with an annual 30 minute online refresher course.

Regarding the Suicide Prevention Training Dr. Antonucci states, "It's much more of a skeletal kind of training, but not necessarily always the right questions or always enough questions. And I think sometimes there's a bit of a taboo even to ask those questions [about suicide] .... I get that there would be some training... I'm not sure that that would necessarily be enough."

SUMMARY OF CSC SUICIDE PREVENTION TRAINING MATERIALS:

The Suicide and Self-Injury Intervention Refresher Training, dated April 2014, was reviewed. In addition, a series of Power Point slides titled Suicide and Self-Injury Refresher Training for Institutions, dated January 2014, was reviewed. Slide number three of the refresher training course indicates that the total duration of the training is two hours.

A course brochure titled Suicide and Self-Injury Intervention Refresher Training (SSIRT) lists the following courses and durations: "Online – Suicide and Self-Injury Intervention Refresher

Training: one hour to be completed yearly at site," and "In class Suicide and Self-Injury Intervention Refresher Training: two hours to be completed every two years at site."

SUMMARY OF CSC FORMS & CHECKLISTS:

The Immediate Needs Checklist Suicide Risk[6] is a three page document. Under the Instructions Section, the document indicates that it is a "screening tool for the evaluation of risk for suicide in institutions." The document states:

> The indicators below will help you make a judgment about whether an inmate maybe at risk to attempt suicide.... Use these indicators to estimate the level of suicide risk, which will guide the action you take to manage the risk. However, regardless of the pattern of the indicators shown below, if you have a reason to believe that the inmate is at imminent risk for suicide, you must make an immediate referral (by telephone or in person) to a healthcare professional (e.g. a psychologist or a nurse), if onsite, and inform the Duty Correctional Manager.... The inmate should not be left unsupervised until he/she has been seen by a healthcare professional.

Under the Key Questions Section, the document indicates that an immediate referral should be made if there is a "yes" response to any of the following questions:

- Have you been feeling hopeless – thinking that your life is not worth living?
- Have you been thinking within the last week about hurting yourself?
- Have you been thinking within the last week about killing yourself?

The Key Information/Observations Section instructs to make an immediate referral (by telephone or in person) to a healthcare professional, if onsite, and inform the Duty Correctional Manager if there is a "yes" response to any of the following:

- You have received reports that the inmate has threatened to attempt suicide
- You are very concerned that the inmate is not safe (i.e. that he/she may attempt suicide)
- You are aware that the inmate has a history of suicide attempts and is currently emotionally distressed

The Background Questions/Supplementary Questions Section states that a non-urgent referral to a healthcare professional should be offered if any of the following questions elicit a "yes" response:

- Have you been feeling sad or worried?
- Have you ever tried to kill yourself?
- Have you received any bad news recently?
- Have you ever been treated for emotional or mental health problems?

[6] Tab 24A

The Observations Section indicates that a non-urgent referral to a healthcare professional should be made if the inmate is observed exhibiting "one or two" of the following behaviors. It is also specified that an immediate referral should be made if the inmate is observed to exhibit "three or more" of the following behaviors:

- Inmate is crying/tearful
- Inmate reports inability to sleep or poor appetite
- Inmate is withdrawn or uncommunicative
- Inmate has been giving away possessions
- Inmate shows signs of recent injury (e.g. cuts, burn marks, bruises)
- Inmate shows bizarre behavior, suggesting serious mental disorder

The Immediate Needs Checklist Suicide Risk (Institutional Version)[7] gives the following instructions: "The questions below, along with observations of the offender's behavior, will help you make a decision about whether an offender may be at risk to commit suicide. Observe the offender's behavior, and engage the offender in conversation, beginning with the background questions as a warm up."

The Background Questions Section lists the following questions:

- Have you been feeling sad?
- Have you been feeling worried?
- Have you received any bad news recently?
- Have you ever been treated for emotional or mental health problems?

The Required Action Section instructions indicate that if an offender answers "yes" to any of the above questions, or does not respond, and is not exhibiting either of the behavioral signs described in the Behavioral Observation Section a referral is not necessary.

The Key Questions Section lists the following four questions:

- Within the last three months have you done anything or prepared to do anything with the intent to die? Examples: taking pills, cut yourself with goal to end life, try to hang yourself, collected pills, created a noose/ligature, wrote a suicide note, gave away needed possessions, etc.
- Are you thinking about killing yourself now?
- Do you have a plan to kill yourself?
- Do you wish you were dead?

The Required Action Section instructions indicate that if an offender answers "yes" to any of the above questions, displays either of the behavior signs, or does not respond and displays either of the behavioral signs an immediate referral to a mental health professional should be made.

The Behavioral Observations Section states, "Shows signs of significant agitation (extremely stirred up, excited, or extremely tense), or significant emotional distress, to the point that you

[7] Tab 24D

have serious concerns about the offender's safety." The required actions for this section are the same as for the Key Questions Section.

The Instruction Sheet for the Immediate Needs Checklist – Suicide Risk[8] states that the Immediate Needs Checklist Suicide Risk "is a screening tool designed to help non-clinical CSC staff identify offenders who may be at risk for suicide and who therefore require immediate referral to a mental health professional for assessment." The Instruction Sheet further indicates that the Checklist can be used by staff anytime there is a concern about an offender's risk of suicide. The Instruction Sheet explicitly states that "if the offender responds yes to any of the Background Questions but there are no other indications of distress (based on responses to Key Questions or Behavioral Observations), referral to a mental health professional is not necessary."

The Intake Health Status Assessment Section I contains a Section titled Current Mental Health on the second page.[9] The document indicates that it utilizes the Columbia Suicide Severity Rating Scale "screen version with triage points adapted." This section lists actions required as follows:

1. Make an urgent referral if the offender answers yes to questions numbered 3, 4, 5 or 6 (if what he or she did to end or prepare to end life was within the past three months).

2. Make a non-urgent referral if the offender answers yes to question 6 (if what he or she did to end or prepare to end life was between three months and a year ago) and an urgent referral is not required.

3. Consider making a non-urgent referral if the offender answers yes to question 1 (about wishing to be dead) or 2 (general thoughts of killing one's self), or question 6 (if what he or she did to end or prepare to end their life was over a year ago), and in your clinical judgment, you believe a mental health assessment is needed.

The form lists the following 6 questions to ask:

1. Wish to be dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wakeup. Have you wished you were dead or wished you could go to sleep and not wakeup?

2. Suicidal thoughts: General nonspecific thoughts of wanting to end one's life/commit suicide, "I've thought about killing myself" without general thoughts of ways to kill oneself/associated methods, intent, or plan. Have you actually had any thoughts of killing yourself?

3. Suicidal thoughts with method (without explicit plan or intent to act): Person endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different that a specific plan with time, place or method details worked out. "I thought about taking an overdose but I never made a specific plan as to when, where or how I would actually do it... and I would never go through with it." Have you been thinking about how you might kill yourself?

[8] Tab 24E
[9] Tab 25A

4. Suicidal intent (without specific plan): Active suicidal thoughts killing oneself and patient reports having some intent to act on such thoughts, as opposed to "I have the thoughts but I will definitely not do anything about them." Have you had these thoughts and had some intention of acting on them?

5. Suicide intent with specific plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. Have you started to work out or work out the details of how to kill yourself? Do you intend to carry out this plan?

6. Suicide behavior question: "Have you ever done anything, started to do anything, or prepared to do anything to end your life?" .... If yes, ask: How long ago did you do any of these? Action – If over 1 year ago consider making a non-urgent referral. If between 3 months and 1 year ago, make a non-urgent referral. Within the last 3 months, make an urgent referral.

The Intake Health Status Assessment Section I continues with:

> Suicide Behavior Question: "Have you ever done anything, started to do anything, or prepared to do anything to end your life? Examples: collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump, or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. If yes, as: how long ago did you do any of these?
>
> ***
>
> Action: If over one year ago consider making an non-urgent referral... if between three months and one year ago make a non-urgent referral... within the last three months make an urgent referral."

The Intake Health Status Assessment Section II contains a Mental Health Admission Assessment on page four. This Section also contains a Brief Psychiatric Rating Scale. The Health Services Transfer Summary[10] contains a question under subsection B which states, "Offender has history of being suicidal." There is also a space for recording when the last attempt was and the "nature of attempt."

OPINIONS:

All opinions below, expressed in the form of answers to questions, are given to a reasonable degree of medical certainty.

Question 1: What are the risk factors for suicide generally?

Suicide risk factors are research and empirically derived elements that are associated with an increased (risk enhancing) or decreased (risk reducing, protective) risk of suicide. While risk factors are characteristics associated with suicide, they might not be direct causes. It is possible

[10] Tab 26A

to conceptualize risk enhancing factors as falling into two broad categories – dynamic or static.[11] *Dynamic risk factors* are fluid and potentially modifiable. The clinical importance of dynamic risk factors lies in the clinician's potential ability to target them with interventions. *Static risk factors* do not change (e.g., past suicide attempts, age) and have shown a statistical relationship with violence risk. Risk factors may also be acute or chronic in nature, and originate from biological, psychological or social circumstances.

Protective factors are those that buffer individuals from suicidal thoughts and behavior. Protective factors have not been studied as extensively or rigorously as risk enhancing factors; however, they are equally as important in terms of suicide prevention.[12] The evidence-based research on suicide risk factors is constantly evolving, and it is necessary to stay abreast of new and reliable research.

In a mental health evaluative context, suicide risk factors are used as a part of a structured clinical suicide risk assessment. The process uses the evidence-based research on known risk factors, in combination with a thorough clinical evaluation to determine important clinical nuances that would not be detected by "scoring" risk factors in isolation. An adequate structured clinical suicide risk assessment is required to uncover individual-specific risk factors and to determine how much weight should be given to any individual risk factor for a specific person.

The structured clinical suicide risk assessment is a process encompassing identification, analysis and synthesis of risk and protective factors that inform treatment and safety management. The procedure is endorsed and generally accepted by overwhelming clinical consensus.[13, 14, 15] The overall assessment of risk is a product of clinical judgment structured by evidence-based risk factors, thorough clinical evaluation and review of relevant collateral sources (e.g., psychiatric records, interviews of important social contacts, etc.). The waxing and waning nature of suicidality requires that assessments be repeated over time as necessary, according to an individual's clinical status. By way of analogy, the suicide risk assessment is similar to checking a patient's temperature when clinically indicated to see if she has a fever.

The standard of practice in mental health does not require the clinician to "predict" suicide. The standard of practice in the field is to perform an adequate *assessment* of risk when clinically indicated. Both law and psychiatry recognize the "inability to predict behaviors with low base rates" such as suicide, and the variable or "fluid nature of suicide risk."[16] Therefore, the

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[11] Mills J, Kroner D, Morgan R: Clinician's Guide to Violence Risk Assessment. New York, NY: The Guilford Press, 2011.

[12] http://www.cdc.gov/violenceprevention/suicide/riskprotectivefactors.html

[13] American Psychiatric Association (APA). Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors. Am J Psychiatry, 2003.

[14] Logan J, Hall J, Karch D: Suicide Categories by Patterns of Known Risk Factors. Arch Gen Psych, 2011; 68(9): 935-941.

[15] Simon R: Suicide. In: The American Psychiatric Publishing Textbook of Psychiatry, 5th Edition, 2008; Ch. 43.; Simon RI: Assessing and Managing Suicide Risk: Guidelines for Clinically Based Risk Management. Arlington, VA, American Psychiatric Publishing, 2004

[16] Rudd, M: Fluid vulnerability theory: A cognitive approach to understanding the process of acute and chronic suicide risk. In T. E. Ellis (Ed.), Cognition and Suicide (1st ed., pp. 14). Washington DC: American Psychological Association, 2006.

clinician has an obligation to perform a basic suicide risk assessment at the clinically appropriate times.

It is best to perform a comprehensive suicide risk assessment as soon as the patient's clinical status permits, and soon after relevant clinical events or changes.[17, 18] Relevant clinical events include: significant changes in a patient's mood, behavior and relevant circumstances. A comprehensive suicide risk assessment is a procedure that includes the following elements:

1. General clinical evaluation (mental status exam, differential diagnosis, etc.)
2. Review of relevant records
3. Gathering necessary collateral information
4. Careful exploration of suicidal ideation, behavior, planning, desire and intent
5. Identifying risk enhancing factors (acute, chronic, dynamic & static)
6. Identifying protective factors
7. Synthesizing all of the above
8. Employing clinical judgment to assess overall risk level
9. Crafting a risk reduction plan targeting modifiable factors

Risk assessment should include some form of analysis of risk factors, and a general estimate of overall risk level (low, moderate, or high). The risk level should be followed by a treatment plan (suicide risk management plan) that directly addresses each relevant dynamic risk factor. Unfortunately, at the present time, there is no single, reliable "litmus test" for suicide risk. Most authorities believe that checklists and screening devices are helpful when used to "structure" clinical judgment, insofar as they remind the clinician to inquire about certain risk factors. Yet it is still incumbent upon the clinician to explore a relevant risk factor and how it impacts a particular patient.

The following table contains a list of suicide risk factors derived from evidence-based research, and should not be considered exhaustive.[19, 20, 21, 22, 23, 24]

Historical Risk Enhancing Factors
▪ Past attempts

[17] Simon R: Suicide risk assessment: what is the standard of care? J Am Acad Psychiatry Law, 2002; 30(3), 340-344.

[18] Roberts, A., Monferrari, I., Yeager, K: Avoiding malpractice lawsuits by following risk assessment and sucide prevention guidelines. Brief Treatment and Crisis Intervention, 2008; 8, 5-14.

[19] American Psychiatric Association (APA). Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors. Am J Psychiatry, 2003.

[20] Logan J, Hall J, Karch D: Suicide Categories by Patterns of Known Risk Factors. Arch Gen Psych, 2011; 68(9): 935-941.

[21] Simon R: Suicide. In: The American Psychiatric Publishing Textbook of Psychiatry, 5th Edition, 2008; Ch. 43.; Simon RI: Assessing and Managing Suicide Risk: Guidelines for Clinically Based Risk Management. Arlington, VA, American Psychiatric Publishing, 2004

[22] Linehan M: Linehan Risk Assessment and Management Protocol (LRAMP), 2014

[23] Giner L, et al.: Violent and Serious Suicide Attempters: One Step Closer to Suicide? J Clin Psych, 2014; 75(3): e191-e197.

[24] http://www.cdc.gov/violenceprevention/suicide/riskprotectivefactors.html

▪ Violent or serious past attempts
▪ Age: teens, elderly
▪ Male gender
▪ Past inpatient psychiatric treatment (esp. < 3 to 6 months after discharge)
▪ Unemployed
▪ Single, widowed, divorced
▪ Living alone
▪ Family history of suicide
▪ Childhood physical or sexual abuse
Clinical Risk Enhancing Factors
▪ Suicidal ideas (consider syntonic vs. dystonic)
▪ Depression
▪ Impaired concentration, difficulty making decisions
▪ Substance abuse
▪ Pervasive hopelessness, pessimism
▪ Constricted thinking (black and white, tunnel vision, catastrophizing)
▪ Irritation, agitation
▪ Impulsivity
▪ Psychosis
▪ Chronic physical illness
▪ Panic attacks, significant anxiety
▪ Proximal life crisis or situational factors
▪ Unwilling to accept help or treatment
▪ Access to lethal means (guns, pills)
Acute Risk Enhancing Factors
▪ Severe anxiety & rumination
▪ Acts of anticipation (tying up loose ends, wills)
▪ Global insomnia
▪ Suicidal plan
▪ Suicidal intent
▪ Access to suicidal means
▪ Psychosis with delusions of poverty or doom
▪ Recent alcohol use
Risk Enhancing Factors (associated with Emergency Room visits)[25]
▪ Current alcohol misuse
▪ Suicidal intent or plan
▪ Prior non-suicidal self-injury
▪ High school education or less
▪ ER visit in last 6 months

[25] Arias S, et al.: Factors Associated With Suicide Outcomes 12 Months After Screening Positive for Suicide Risk in the Emergency Department. Psychiatric Services, 2015

Protective Factors
▪ Good social, family or community support
▪ Stable, supportive marriage
▪ Responsibility for a child under 18
▪ Willingness to accept help and/or treatment
▪ Good therapeutic alliance with clinician
▪ Future-oriented thinking, hopefulness for future
▪ Religious, spiritual or cultural beliefs discouraging suicide
▪ Low symptom severity
▪ Female gender
▪ Employed
▪ Absence of suicidal ideas or intent
▪ Demonstrated resilience and effective coping under stress

Question 2: Are inmates at higher risk for suicide than non-inmates?

The answer to this question depends upon the correctional setting of the inmate. A consistent finding in the research is that jail suicide rates significantly exceed both prison and general community rates. Suicide has been the leading cause of death in jails every year since 2000. The suicide rate for U.S. jail inmates was 46 per 100,000 inmates in 2013.[26] In contrast, the suicide rate in U.S. state prisons was 15 per 100, 000 inmates in 2013. Finally, the suicide rate in the U.S. general population for approximately same time period was 13 per 100, 000 individuals (the global suicide rate is approximately 16 per 100, 000 individuals).

Thus, the rate of suicide for jail inmates is about 3.5 times that of the general population, whereas the rate for prison inmates is approximately the same or only slightly higher than the general population. While suicide and suicide prevention remain prominent concerns in U.S. prisons, illness-related deaths (e.g., liver disease, heart disease cancer) accounted for 89% of all deaths in prison in 2013.

As a matter of historical interest, correctional suicide prevention efforts have resulted in substantial improvements over the past three decades. Prior to the 1980s, correctional suicide prevention efforts across the U.S. were relatively underdeveloped and of inconsistent quality. Legal action and research resulted in more effective suicide prevention policy and procedure, leading to significant reductions in correctional suicide – particularly jail suicides. Whereas suicide among jail inmates in 1983 occurred at a rate of 129 per 100,000 inmates, by 1993 the rate had been reduced by more than half (54 per 100,000 inmates).[27] In 2002, the jail suicide rate had fallen to a third of 1983 rate (47 per 100,000).

[26] Noonan M, Rohloff H, Ginder S: Mortality in Local Jails and State Prisons, 2000–2013. U.S. Department of Justice, Bureau of Justice Statistics, August 2015

[27] Mumola C: Suicide and Homicide in State Prisons and Local Jails. Bureau of Justice Statistics Special Report, 2005.

Although not as pronounced, a similar trend was observed in state prisons during the same time period. While suicide rates in state prisons have always been lower than rates in jails, the rate of state prison suicide dropped from 34 per 100,000 in 1980 to 14 per 100,000 inmates in 2002. Authorities have observed that these reduced rates were a product of better screening during the initial booking process, enhanced suicide prevention training and increased staff awareness.[28]

In sum, the suicide rate in prison inmates is approximately the same, or only slightly higher than non-inmates. However, the suicide rate in jail inmates is currently about 3.5 times higher than non-inmates.

Question 3: Are there special suicide risks in a prison setting that staff should be aware of, and if yes, what are they?

Yes, there are suicide risk factors that are specific to correctional settings. Examples are given in the table below which are derived from the research literature. Correctional suicide prevention training efforts must stay current with evolving research.

Many of the standard suicide risk factors seen in the community (discussed above in the answer to Question 1) still apply to a correctional setting; however, there are also important risk factors that are unique to corrections. For example, in a review of 154 completed suicides in the California Department of Corrections and Rehabilitation, suicides were associated with: having a history of psychiatric treatment (73%); being single-celled (73%); and recent punitive sanctions (e.g., new charges, receiving an unexpected sentence).[29]

It has long been observed that inmate suicides occur in close proximity to a court hearing or disciplinary sanctions. Disciplinary sanctions often result in the inmate being sentenced to some form of punitive isolation. This represents another corrections specific risk factor – placement in disciplinary or administrative segregation.[30] Thus, mental health screenings and/or evaluations for inmates on the mental health case load or those who have a prior history of suicidal behavior are recommended around these periods of risk.

The subject of disciplinary hearings (intra-facility hearings to determine the consequences of disciplinary infractions by inmates) has been gaining increasing legal attention. Disciplinary hearings have very serious consequences for mentally ill offenders who are more likely to be charged with rule violations than inmates without mental illness.[31] The mentally ill inmate charged with a disciplinary infraction may or may not be entitled to mental health consultation or expert testimony, owing to the fact that there is considerable variability in how hearings are

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[28] Hayes L: Suicide Prevention in Correctional Facilities: Reflections and Next Steps. Int J Law Psychiatry, 2013; 36: 188–194.

[29] Patterson R, Hughes K: Review of completed suicides in the California Department of Corrections and Rehabilitation, 1999 to 2004. Psychiatr Serv, 208; 59: 676-682.

[30] Patterson & Hughes, 2008; Way et al, 2007

[31] James D., Glaze L.: Mental Health Problems of Prison and Jail Inmates. Bureau of Justice Statistics Special Report September, 2006, pps. 1-12; Lovell, D., Cloyes K., Allen, D., and Rhodes, L: Who Lives in Super Maximum Custody? A Washington State Study. Federal Probation, 2000; 64: 33-43.

conducted, as well as the criteria and procedure for placing inmates in administrative segregation.

In a nationwide U.S. survey, considerable diversity among states was found regarding the role of mental health staff in disciplinary hearings.[32] Most states had policies on the issue, but there was no clear consensus on whether mental health staff should offer "ultimate opinions" regarding competency or sanity in the disciplinary process. In addition, the role of the clinician in these hearings may raise concerns about the dual agency dilemma.[33] According to NCCHC recommendations, the services of outside providers or someone on the institutions staff who is not involved in a therapeutic relationship with the inmate should be obtained for such proceedings. This is analogous to the ethical bind in which the psychiatrist acts as both treating physician *and* forensic evaluator, and is generally to be avoided.[34] Testimony by an uninvolved clinician may be critical, as the severely mentally ill patient is not likely to be able to effectively advocate for himself or explain his mental state at the time of the offense with the same impact as a trained clinician.

For example, in *Anderson v. Coughlin*, inmates in several NY Department of Corrections' Secure Housing Units (SHU) alleged, inter alia, that their due process rights had been violated by the way that disciplinary hearings were conducted.[35] In 2002, a private settlement agreement regarding the disciplinary due process issue was reached, resulting in amendments to the NY Dept. of Corrections' SHU regulations. The agreement required specific criteria be used by hearings officers in determining when an inmate's mental state or intellectual capacity is at issue during a hearing. Further, testimony is required by correctional mental health staff to address: 1) the extent to which the inmate's current mental health status affects his fitness to proceed with the hearing, 2) the extent to which the inmate's mental status at the time of the incident did or did not affect his responsibility for the offense, and 3) the extent to which the inmate's current mental health status or clinical history make him suitable or unsuitable for SHU placement.

A second example comes from the California Department of Corrections and Rehabilitation (CDCR) in the case of *Coleman v. Brown*.[36] In Brown, it was found that mentally ill inmates who acted out were treated with punitive measures without regard for their mental status, or whether the conduct was the result of mental illness. As a result, the CDCR agreed to implement policies and procedures concerning mental health input into the inmate disciplinary process. In both *Anderson* and *Coleman*, mental health staff who testify at inmate disciplinary hearings must be trained to do so, and their testimony is subject to review and quality assessment by senior mental health administrators.

While intake screening remains an essential front-end prevention tool, equally as important is the determination of suicide risk by observations of current behavior displayed by an inmate

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[32] Krelstein, M: The Role of Mental Health in the Inmate Disciplinary Process: A National Survey. The Journal of the American Academy of Psychiatry and the Law, 2002; 30(4): 488-496.
[33] Metzner J: The Role of Mental Health in the Inmate Disciplinary Process. The Journal of the American Academy of Psychiatry and the Law, 2002; 30(4): 497-499.
[34] American Academy of Psychiatry and the Law. 2005. Ethics Guidelines for the Practice of Forensic Psychiatry. At: http://www.aapl.org/ethics/htm.
[35] Anderson v. Coughlin, (N.D. N.Y.) 1987.
[36] Coleman v. Brown, 938 F. Supp.2d 955, 974, n.35 (E.D.Cal.), 2013.

throughout his incarceration. Finally, in addition to the importance of identifying risk factors, clinical experience suggests that it is equally important to consider individual-specific vulnerabilities and their interplay with the correctional environment.[37] This involves considering how a particular inmate's vulnerabilities are likely to interact with correctional environment demands, such as negative life events or noxious conditions. This type of assessment of an individual inmate's unique vulnerabilities and coping methods is best carried out by qualified mental health professionals.

The following consists of a list of suicide risk factors derived from evidence-based research that are specific to corrections. The list should not be considered exhaustive, and should be utilized alongside the above risk factors listed in Question 1 for individuals in the community.

Historical Factors
▪ Past suicide attempts[38]
▪ History of psychiatric treatment and/or mental illness[39]
▪ History of substance abuse[40]
▪ History of traumatic life events: childhood physical or sexual abuse, abandonment[41]
▪ Conviction for a Violent Crime against a person (esp. homicide, rape, child molesting)[42]
▪ First incarceration[43]
▪ Long prison sentence[44]
Clinical Factors
▪ Mood disorder[45]
▪ Hopelessness[46]
▪ Psychotic disorder[47]

[37] Ivanoff A., Hayes L: Preventing, Managing, and Treating Suicidal Actions in High-Risk Offenders. Jail Suicide/Mental Health Update, 2002; Summer 11: 1-11.

[38] Fruehwald, S., Matschnig, T., Koenig, F., Bauer, P., Frottier, P: Suicide in custody: case-control study. Br J Psych, 2004; 185: 494-498; Hayes L: National Study of Jail Suicide 20 Years Later. J Corr Health Care, 2010; 18: 233-245.

[39] Daniel, A., Fleming, J: Suicides in a State Correctional System, 1992-2002: A Review. J Corr Health Care, 2006; 12: 24-35; Way, B, Miraglia, R., Sawyer, D, Beer, R., Eddy, J: Factors related to suicide in New York state prisons. Int J Law Psych, 2005; 28: 207-221; Patterson & Hughes, 2008.

[40] Shaw, J., Baker, D., Hunt, I. M., Moloney, A., Appleby, L: Suicide by prisoners. National clinical survey. Br J Psych, 2004; 184: 263-267; Green, C., Kendall, K., Andre, G., Looman, T., Polvi, N: A study of 133 suicides among Canadian federal prisoners. Med Sci Law, 1993; 33: 121-127; Way et al. 2005

[41] Blaauw, E., Arensman, E., Kraaij, V., Winkel, F. W., Bout, R: Traumatic life events and suicide risk among jail inmates: the influence of types of events, time period and significant others. J Trauma Stress, 2002; 15: 9-16.

[42] Guthe G, Hazard A, Kensey A, Pan Ke Shon J: Suicide among male prisoners in France: A prospective population-based study. For Sci Int, 2013; 233: 273-277; Mumola, 2005.

[43] Daniel & Fleming, 2006

[44] Frottier P, Fruehwald S, Ritter K, Eher R, Schwaerzler J, & Bauer P: Jailhouse blues revisited. Social Psychiatry and Psychiatric Epidemiology, 2002; 37(2), 68-73.

[45] He, X, Felthous, A, Holzer, C, Nathan, P., Veasey, S: Factors in prison suicide: one year study in Texas. J For Sci, 2001; 46: 896-901.

[46] Ivanoff, A., Jang, S: The role of hopelessness and social desirability in predicting suicidal behavior: a study of prison inmates. J Consult Clin Psych, 1991; 59: 394-399.

▪ Impulsive, aggressive traits[48]
▪ Severe personality disorder[49]
Social Factors
▪ Recent harassment: bullying, humiliation, sexual assault, peer conflict[50]
▪ Victim of sexual or physical violence (without also perpetrating it) in last 12 months[51]
▪ Recent life crisis (e.g., loss, recent bad news, recent punitive sanctions)[52]
Environmental Factors
▪ Overcrowded conditions[53]
▪ Secure Housing Unit/Isolation/Single Celled[54]
▪ First 2 months of punitive isolation placement[55]
▪ Ligature points accessible
Acute Items
▪ Anxiety, agitation[56]
▪ Recent substance use or intoxication[57]
Risk Reducing Factors
▪ Receiving visits from family members[58]
▪ Purposeful activity[59]

[47] He et al., 2001

[48] Dumais A, et al.: Risk factors for suicide completion in major depression: a case-control study of impulsive and aggressive behaviors in men. American Journal of Psychiatry, 2005; 162(11), 2116-2124.

[49] He et al., 2001

[50] Blaauw, E., Winkel, F., Kerkhof, A: Bullying and Suicidal Behavior in Jails. Crim Jus Beh, 2001; 28: 279-299; Way et al., 2005

[51] Encrenaz G, Miras A, Contrand B, Galera C, Pujos S, Michel G, Lagarde E: Inmate-to-inmate violence as a marker of suicide attempt risk during imprisonment. J For Leg Medicine, 2014; 22: 20-25.

[52] Kovasznay, B., Miraglia, R., Beer, R., Way, B: Reducing suicides in New York State correctional facilities. Psychiatr Q, 2004; 75: 61-70;

[53] Opitz-Welke A, Bennefeld-Kersten K, Konrad N, Welke J: Prison suicides in Germany from 2000 to 2011. Int J Law Psych, 2013; 36: 386-9; Kovasznay et al., 2004

[54] Reeves R, Tamburello A: Single cells, segregated housing, and suicide in the New Jersey Department of Corrections. J Am Acad Psych Law, 2014; 42: 484-8; Daniel & Fleming, 2006; Fruehwald et al., 2004; Guthe et al., 2013

[55] Way, B, Sawyer, D, Barboza, S., Nash, R: Inmate suicide and time spent in special disciplinary housing in New York State prison. Psych Serv, 2007; 58: 558-560.

[56] Kovasznay et al., 2004

[57] Hayes, 2010

[58] Guthe et al., 2014

[59] Leese, M., Thomas, S., Snow, L: An ecological study of factors associated with rates of self-inflicted death in prisons in England and Wales. Int J Law Psych, 2006; 29: 355-360

Question 4: What training would you recommend for prison staff?

Suicide prevention training for prison staff should be accompanied by a separate training on basic mental health concepts. Basic mental health training is important because it provides context and important knowledge that augments and improves the quality of the suicide prevention training and the suicide prevention goals of the facility.

Training on suicide prevention should be meaningful and substantive. The training is best provided in a live, class room type setting. Because the topic of suicide prevention is complex and the skills perishable, it should be done in a live, interactive environment to include correctional, mental health and medical staff.[60] This reinforces the necessary reality of collaboration between the disciplines needed for suicide prevention.

Suicide prevention training that is reduced to solitary staff members passively watching instructional videos or on-line webinars are likely to be of questionable value. Correctional institutions are turning towards on-line instructionals for mandated trainings such as sexual harassment or record keeping. However, suicide prevention is a day to day, vital skill for front line correctional staff. Thus, training must inculcate long-lasting, dynamic skills. On-line suicide prevention trainings may risk promoting a tone of quick compliance at best, and a tone of complacent disregard at worst.

Suicide prevention training should be provided both initially and annually to all staff. The initial training for beginning staff should be approximately four hours, and the annual training should be approximately two hours. Both trainings should be live and on-site, or otherwise at the facility's education and training center. Training should include lessons on how to recognize verbal and behavioral cues suggesting suicide risk, mental health concerns and how to respond appropriately.

The initial and annual trainings should constructively address the problem of negative attitudes sometimes seen in correctional staff. Negative attitudes impede meaningful suicide prevention efforts by suggesting a passive acceptance of some suicides, or notions such as: "If someone really wants to kill themselves there's generally nothing you can do about it." This places the facility at a disadvantage insofar as they are beginning with a defeatist attitude.

Training should also cover how to properly use and understand the required screening forms used by the correctional facility. Correctional staff should learn that the assessment of suicide risk does not consist of a single opportunity at intake; rather, it is an on-going process. Since the inmate may become suicidal at any point while incarcerated, suicide prevention must continue until the inmate is released. Suicide prevention training is considered one part of a comprehensive suicide prevention program, as described below. Other areas that should be considered in suicide prevention training include methods and procedures for follow-up monitoring of suicidal inmates, personal observation of inmates on suicide watch and CPR policy and practices.

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[60] Hayes L: Suicide Prevention in Correctional Facilities: Reflections and Next Steps. Int J Law Psychiatry, 2013; 36: 188-194.

Question 5: What measures should be taken in prisons to decrease suicide attempts?

Prisons seeking to decrease suicide attempts and deaths by suicide should develop and maintain a robust and high quality suicide prevention program. Suicide prevention in correctional settings requires a well-coordinated effort by mental health staff, corrections officers and correctional administrators. Comprehensive suicide prevention programs consist of key components designed to address the special challenges of corrections. Suicide prevention programs must be prioritized and vigorously supported by administrative and system-wide efforts.

The essential components of a reasonable suicide prevention program include training of all correctional, medical, and mental health staff on both an initial and annual basis; intake and on-going screening/assessment for suicide risk; procedures that encourage communication between outside entities and correctional facilities, as well as internally between and among facility staff and the suicidal inmate; suicide-resistant housing and precautionary measures commensurate with risk level; procedures for emergency response to a suicide attempt; reporting and notification of a suicide to the facility's chain of command and family of suicide victim; and multidisciplinary examination of the inmate suicide through a mortality review.[61]

Both the research literature and authoritative organizations such as the National Commission on Correctional Healthcare (NCCHC) have strongly recommended correctional facilities adopt comprehensive Suicide Prevention Programs (SPP) as a primary measure for preventing deaths by suicide.[62] The NCCHC has recommended key components of a SPP which are listed in the table below.

Suicide Prevention Program – Key Components	
Training	Meaningful, substantive training to recognize verbal and behavioral cues and respond appropriately. Initial and annual on-site, live training
Identification	Effective screening and appropriate response
Referral	Timely evaluations by qualified mental health professionals
Evaluation	Comprehensive mental health evaluation and suicide risk assessment by a qualified mental health professional
Treatment	Services and suicide risk management plan addressing modifiable risk factors
Housing & Monitoring	Safe and effective precautions, observation and monitoring according to the level of risk determined by ongoing evaluations
Communication	Reliable procedures for communicating risk between shifts, correctional staff and transferring facilities

[61] Knoll J, Kaufman A: Correctional Suicide: Risk & Prevention. In: Principles & Practice of Forensic Psychiatry 3rd Edition. (R. Rosner & C. Scott, eds.) In press.

[62] National Commission on Correctional Healthcare (NCCHC): Standards for Mental Health Services in Correctional Facilities. NCCHC, 2015.

Intervention	Procedures to address suicide attempts, as well as first-aid measures, CPR
Notification & Reporting	Procedures for notifying administrators, relevant staff and family members of deaths by suicide, as well as tracking attempted suicides
Review	Procedures for psychiatric and administrative review of suicides or serious suicide attempts (psychological autopsies)
Debriefing	Timely, thoughtful, empathic debriefing of affected staff

The following discussion is a distillation of the leading U.S. standards for comprehensive suicide prevention programs. *Screening* is the principle way to identify inmates with a potentially elevated suicide risk. Receiving mental health screening is done immediately on admission through brief observation, structured interview and relevant communications from the sending facility. At this point in the process, the screening necessarily casts a wide net. Any suicide ideation or history of hospitalization typically leads to further assessment. Next, intake screening is performed by trained staff who make further inquiry into relevant risk factors, usually as part of the obligatory comprehensive medical/health evaluation. This screening is more extensive than the receiving stage, but does not approximate the intensity and professionalism required in the formal structured clinical suicide risk assessment procedure described below, and in more detail in the answer to Question 1.

Another critical period for screening is upon an inmate's return from court, disciplinary hearing or after receiving bad news. Inmates in punitive segregation and isolation are also at an elevated risk and should be screened more frequently and observed at least daily for warning signs.[63] Punitive isolation consisting of single-cell status has been associated with a particularly high risk for suicide.[64] Familiarity with the evolving research on correctional suicide is a must for proper screening, risk assessment and formulating correctional suicide prevention policy and procedure.

Screening should be performed by trained staff. Checklists or validated questionnaires should be utilized to ensure consistent and thorough procedure to identify at risk individuals. Upon completion of the screening process, there should be clear guidelines as to when and how an individual will be referred for further assessment, and whether they should be placed on suicide precautions in the interim. It is important that screening instructions for correctional officers not be so inflexible that single key risk factors do not result in an urgent referral or suicide precautions merely because they do not exceed some pre-determined "score." No suicide screening tool is able to produce a score that reliably determines when immediate action should or should not be taken. Flexibility and judgment on the part of well-trained correctional officers must be allowed in cases where a low screening score contains key risk factors suggestive of actual high risk.

[63] Way, et al., 2007.
[64] Reeves & Tamburello, 2014

A comprehensive mental health evaluation by a qualified mental health professional, incorporating the clinical suicide risk assessment procedure discussed in the answer to Question 1, is conducted when screenings and/or observations raise concern. In such cases, an urgent referral is made while the inmate remains on suicide precautions. When an urgent referral is not needed, correctional institution policy typically requires that such evaluations be conducted within a specific time frame – usually within a two week period.

A comprehensive psychiatric evaluation is the essential, core element of the suicide assessment process.[65] A thorough evaluation enables the clinician to: 1) identify risk factors, 2) assess the overall degree of suicidality, and 3) implement precautions and treatment interventions designed to reduce a specific inmate's suicide risk. The value of identifying risk factors goes beyond assessment of risk, in that it allows the clinician to target potentially *modifiable* risk factors with appropriate treatment interventions. It is important that the evaluation of the inmate be performed in a safe and confidential setting. The clinician should not allow convenience or other factors to result in a "cell side" evaluation, or similar setting that would reduce an inmate's willingness to speak about sensitive issues.

It is critical to note that simply asking the inmate about suicidal ideation does not ensure that accurate or complete information will be received. Suicides may occur impulsively, so that a present state denial of suicidal ideas does not eliminate risk for suicide. Further, individuals seriously contemplating suicide may not report their thoughts.[66] A study of prison inmates found that a third or more of inmates would not report suicidal thoughts to mental health staff for various reasons, including aversion to being placed in an observation cell.[67] Thus, the denial of suicidal ideas by an inmate whose overall suicide risk is elevated must be considered in the totality of his clinical circumstances. While inquiring about suicidal ideas is an important part of an adequate risk assessment, it is only one piece of the overall suicide risk assessment process.

The immediate response to an inmate's suicidal cognitions or behavior should involve crisis intervention.[68] Crisis intervention consists of the following procedures carried out by trained correctional mental health staff: 1) establishing psychological contact with the inmate, 2) defining the precipitating problem, 3) encouraging exploration of the inmate patient's emotional conflict, 4) exploring and assessing past attempts to cope, 5) generating and examining alternative solutions, 6) taking action to restore cognitive and emotional functioning, and 7) dynamic reassessment of suicide risk over time.

In terms of psychotherapeutic approaches, dialectical behavior therapy (DBT) has demonstrated effectiveness in reducing suicidal behavior in randomized clinical trials. DBT is a program comprised of weekly group skills training and individual psychotherapy. Skills training targets include: life threatening behaviors, treatment interfering behaviors, and quality of life behavior. Other skills commonly addressed include: distress tolerance, emotion regulation, and interpersonal effectiveness. When compared to treatment as usual, DBT has shown significant

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[65] APA, 2003

[66] Resnick, P: Recognizing that the suicidal patient views you as an "Adversary". Curr Psych, 2002; 1(8).

[67] Way B, Kaufman A, Knoll J, Chlebowski S: Suicidal Ideation among Inmate-Patients in State Prison: Prevalence, Reluctance to Report, and Treatment Preferences. Beh Sci Law, 2013; 31: 230-238.

[68] Ivanoff & Hayes, 2002

decreases in suicidal behavior and self-mutilation. DBT has been modified for a correctional setting (DBT-Corrections Modified), and used to help inmate patients reduce impulsive-aggressive behaviors.[69]

The management of an inmate's suicide risk typically involves three main approaches: 1) monitoring/safety, 2) ongoing risk assessment, and 3) interventions to reduce risk. Inmates who are at high or unknown risk are observed carefully in a safe environment until their risk diminishes. Simultaneously, a treatment and risk management plan should be crafted that addresses each modifiable suicide risk factor.

There are a variety of *housing & monitoring* procedures for inmates at risk of suicide, and they can be conceptualized as on a spectrum according to level of risk. Inmates at highest risk are placed in a suicide observation cell which contains tamper-proof light fixtures, smoke detectors, sprinkler heads, and ceiling/wall air vents that are protrusion-free. Fiberglass-molded bunks in these cells have rounded edges and no tie-off points.[70] These cells are constructed to be devoid of any ligature points. The inmate's clothing is usually removed and replaced with a smock made of material that cannot be easily torn or otherwise used to form a ligature. Bedding material is also replaced with a mattress, pillow and blanket made of similar "strong cloth" material. Potentially dangerous items, such as razors or plastic bags, are removed from the inmate's possession.

Beyond these measures, the presence of less dangerous items, such as reading materials, personal hygiene items (e.g. toothbrush), and writing instruments may vary according to facility practice and the inmate's clinical condition. Some of these procedures may increase safety, but with a potential loss of therapeutic intervention. Further, experience suggests that inmates may simply begin denying suicidal thinking in order to leave the often harsh conditions of observation cells. More therapeutic use of suicide observation conditions should be an active area of future research.

Interval observation by correctional or medical staff is a commonly used monitoring procedure. Interval times vary according to facility policy, but generally include visual observation every 15, 30 or 60 minutes. Fifteen minutes checks are often used for inmate patients who are either high or moderate risk. Fifteen minute checks became a standard interval, not as a result of scientific evidence, but out of convenience and tradition. One staff member can briefly observe a large number of individuals in a very short time while walking down tier hallways.

One potential problem with 15 minute checks is that they still leave enough unmonitored time for an inmate to die by suicide. Hanging/strangulation is by far the most common method of suicide in corrections. Permanent brain damage can occur within 4-5 minutes, and death may occur in 5-6 minutes.[71] Thus, for some inmates at risk of suicide, the 15 minute interval is too long to prevent serious morbidity or mortality. More than one fifth of jail suicide victims were

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[69] Shelton, D., Sampl, S., Kesten, KL., Zhang, W., Trestman, R: Treatment of impulsive aggression in correctional settings. Beh Sci Law, 2009; 27: 787-800.

[70] Hayes, 2013

[71] American Heart Association, Emergency Cardiac Care Committee and Subcommittees: Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiac Care. J Am Med Assoc, 1992; 268:2172–83.

found less than 15 minutes after last being observed and over 6% of all jail suicides from 2005 to 2006 occurred while being observed every 15 minutes or more frequently.[72] To prevent deaths by suicide in inmates on 15 minute checks, it has been recommended that checks be conducted at irregular and/or staggered intervals.[73]

Continuous observation, or 1 to 1 monitoring, is reserved for inmates who represent an acute or high risk of suicide. Inmates on 1 to 1 in correctional facilities are almost always isolated in special cells, where a staff member can sit in front of their cell to provide constant supervision. The use of video surveillance may not be reliable, and in the case of an inmate with high or unknown risk, this method should not be reflexively accepted as a primary method of observation. Another strategy involves altering architectural structure so that a greater number of cells are in the line of sight of a staff member. Unfortunately, even with continuous monitoring, suicides still occur due to lapses of attention.

Other suicide prevention efforts involve creating more interaction between inmates and correctional, medical and mental health personnel. Such efforts may include: 1) requiring regular follow-up of all inmates released from suicide precautions, 2) increasing rounds of correctional staff, and 3) providing additional mental health screening to inmates admitted to disciplinary/administrative segregation.[74]

In addition to the NCCHC recommendations for suicide prevention, researchers have recommended the following prevention considerations[75]:

- Increased clinical monitoring of inmates in high-security units
- Group therapy for inmates in segregation who are on the mental health caseload
- Improved CPR policy and practices
- Adequate confidential interviewing space
- Careful review of prior documentation by clinicians
- Effective communication between shifts and disciplines regarding an inmate's suicide risk
- Timely completion of all documentation of the suicide assessment and management process

The NCCHC has recommended performing a comprehensive review of all suicides to include a "root cause analysis" and psychological autopsy. Forward thinking institutions may wish to form "suicide prevention improvement teams" consisting of representative staff from mental health, security, medical, administration and quality improvement. The team meets on a regular basis to focus on identifying opportunities for change and improvement.

CONSIDERATIONS REGARDING THE WODAJE CASE:

Upon consideration of the materials reviewed with regard to the Wodaje case, it is clear that CSC has implemented an impressive correctional mental health system and suicide prevention program. For example, CSC's use and adaptation of the Columbia–Suicide Severity Rating

[72] Hayes L: National Study of Jail Suicide 20 Years Later. J Corr Health Care, 2010; 18: 233-245.
[73] World Health Organization: Preventing Suicide in Jails and Prisons, 2007.
[74] Hayes, 2013
[75] Patterson & Hughes, 2008; Knoll & Kaufman, in press

Scale and its inclusion of the Brief Psychiatric Rating Scale in its mental health screening and assessment procedures is to be commended. Use of these tools suggests an informed approach that considers the evolving research.[76]

The following recommendations are offered for the purpose of providing considerations for enhancing suicide prevention efforts. They are based solely on my review of the materials provided and as such, may be limited in terms of my lack of familiarity with the correctional institutions involved and the constraints of the records provided. I have not personally visited the relevant correctional institutions, nor have I conducted a live review of the suicide prevention training at these sites. As noted previously, nothing in this report is intended to set forth opinions on legal responsibility.

Suicide Prevention Considerations:

1. *Suicide prevention training* – the documents reviewed suggest that much of the suicide prevention training is done via on-line courses. As noted above in the answer to Question 4, training should be meaningful and substantive. It is recommended that training be carried out in a live, class room type setting that encourages interaction and question asking. On-line training may risk promoting a tone of passive compliance as opposed to the development of vital, dynamic skills.

   Suicide prevention training should be provided both initially and annually to all staff. The best setting for training would involve multiple disciplines (i.e., correctional officers, medical staff, and mental health staff) in class together to promote collaboration. The initial training for beginning staff should be approximately four hours, and the annual training should be approximately two hours. Both trainings are best done live and on-site, or otherwise at the facility's education and training center.

2. *Professional boundary training* for all staff – the documents reviewed suggest that Mr. Wodaje's death by suicide occurred two days after a reclassification and move to administrative segregation. The cause of his set back was his alleged relationship with a "community support" person. Here, I assume that [redacted] had some affiliation with CSC, or otherwise had to be vetted in some manner in order to serve the correctional institution in this role.

   Typically, all correctional staff receive initial training on the importance of maintaining proper and professional boundaries with inmates. This is particularly important for some inmates who have histories of interpersonal and relationship difficulties. A concern in this instance would be that an inmate with a history of tumultuous intimate relationships is

[76] Posner K, et al.: The Columbia–Suicide Severity Rating Scale: Initial Validity and Internal Consistency Findings From three Multisite Studies with Adolescents and Adults. Am J Psychiatry, 2011; 168:1266–1277

nearing "re-entry" to the community. The re-entry period has been found to be a very mentally and physically stressful time for inmates.[77]

Although the alleged relationship appears to have been mutually consenting, in the correctional setting this can never be the case due to professional boundaries and the inherent power imbalance between inmates and correctional staff. The correctional staff, or staff acting under the auspices of a correctional institution, bears the burden of maintaining appropriate professional boundaries.

The nature of [redacted] job and affiliation with CSC was not clear to me from the documents reviewed. However, she appeared to be in some type of supportive and perhaps mentoring role to Mr. Wodaje. If the allegations are true that she embarked on an intimate or otherwise professionally inappropriate relationship with Mr. Wodaje, this may represent an opportunity for improvement in terms of assuring all staff are appropriately screened and trained on the importance of maintaining professional boundaries with inmates.

3. *Communication of past suicide attempts* – past suicide attempts have been clearly shown to increase the risk of future death by suicide.[78] Past suicide attempts are static risk factors which do not change, and will always serve as risk enhancing factors. Thus, it is critical that past attempts be reliably and clearly communicated to relevant correctional staff.

   Although Mr. Wodaje's health records do indicate a past suicide attempt, they also state: "Eleven years ago, does not consider part of history," and "Inmate feels this is not part of his history." In addition, his Health Services Transfer Summary, dated 10/9/12, incorrectly indicates he had "no" history of being suicidal.[79]

   Such documentation could risk confusion among correctional staff who may conclude that this important risk factor can be discounted. This seems particularly the case when considered alongside the form "Intake Health Status Assessment Section I" which instructs staff to make a non-urgent referral if the suicide attempt was "over one year ago." The form also instructs staff: "if [the suicide attempt was] between three months and one year ago make a non-urgent referral… within the last three months make an urgent referral."

   There is no evidence-based research to support the notion that the mere passage of time after a suicide attempt reduces future risk or urgency. A concern would be that staff might take these instructions too literally. When communicating past suicide attempts to other relevant correctional and/or mental health staff, it is much more helpful to characterize the nature of the past suicide attempt, as opposed to merely stating that the inmate had a past attempt.

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[77] Western B, Braga A, Davis J, Sirois C: Stress and Hardship after Prison. AJS, 2015; 120(5):1512-47; Binswanger I, Blatchford P, Mueller S, Stern M: Mortality after prison release: Opioid overdose and other causes of death, risk factors, and time trends from 1999 to 2009. Annals of internal medicine, 2013; 159(9), 592-600.

[78] Suominen, K., Isometsa, E., Suokas, J., Haukka, J., Achte, K., & Lonnqvist, J: Completed suicide after a suicide attempt: a 37-year follow-up study. Am J Psychiatry, 2004; 161(3), 562-563.

[79] Health Services Transfer Summary, dated 10/9/12, which indicates a checkbox response of "no" to the question: "offender has history of being suicidal" (Bates Stamp 00043)

For example, it would be important to know that Mr. Wodaje's suicide attempt allegedly involved some lethality, and consisted of him trying three different methods in succession (drinking bleach, cutting his wrists, attempted hanging). It would also be important for relevant staff to know that the suicide attempt was in the context of the loss of a relationship and murder of his ex-intimate spouse. These important details provide more data points for assessing suicide risk than the mere presence or absence of a past attempt.

In sum, it is critical that past suicide attempts be considered permanent, static risk factors and their nature and context understood. Moreover, this information should be reliably communicated between relevant correctional staff, particularly those involved in risk-associated events such as disciplinary sanctions.

4. *Suicide proof architecture* – asphyxiation by ligature strangulation is the mechanism of death in the vast majority correctional suicides. The documents reviewed suggest that the type of cell Mr. Wodaje was found in had an accessible ligature point, but that this issue had been resolved after his death. Thus, I would simply recommend that all such segregation/isolation cells be similarly fixed so as to eliminate ligature points.

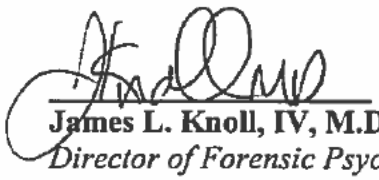
5. *Assessing suicide risk after reclassification or disciplinary hearings* – as noted in the answer to Question 3, recent disciplinary sanctions and bad news are events that have been associated with increased suicide risk in correctional settings. One consideration would be for mental health staff to be involved in terms of evaluation and review within 24 hours of placement in segregation of inmates with past suicide attempts or those on the mental health case load. Per the hearing transcripts, the issue of placing the inmate in a maximum security facility, as a temporary hold while en route to a medium security facility, has been recognized as problematic and changed.

In summary, I have discussed the evidenced-based suicide risk factors observed in the community and in correctional settings. I have addressed how suicide risk factors are used in the context of screening and in clinical suicide risk assessment procedures. It is my opinion that suicide prevention training for prison staff should be accompanied by a separate training on basic mental health concepts, and that the training is best provided in a live setting.

It is also my opinion that prisons should develop and maintain a robust, high quality suicide prevention program. I have discussed the key components of a comprehensive suicide prevention program. Finally, I have suggested some suicide prevention considerations in light of the death of Mr. Wodaje. I have not made any findings regarding causation or legal responsibility.

Please do not hesitate to contact me with any questions, or if I can be of further assistance in this matter.

Respectfully submitted,



James L. Knoll, IV, M.D.
Director of Forensic Psychiatry
Professor of Psychiatry
SUNY Upstate Medical University

Exhibit Tag
Provincial Court

Case No.
140569096II
Case Name
R vs Wodaje, Mehari J.

Marked Ident.	Entered Exhibit No.
	F-6

Submitted By

☑ Crown/Plaintiff ☐ Defence/Respondent

May 10/16 — Date

SD — Clerk

CTS0501 (2008/10)