

A Performance Audit of
Utah Department of
Corrections Security
Operations for
Behavioral Healthcare
in State Prisons

A Review of Safety and Facilitation of Care

Office of the Legislative
Auditor General

Report to the UTAH LEGISLATURE



LEGISLATIVE AUDITOR GENERAL



1975 - 2025



THE MISSION OF THE LEGISLATIVE AUDITOR GENERAL IS TO

AUDIT · LEAD · ACHIEVE

WE HELP ORGANIZATIONS IMPROVE.

Audit Subcommittee

President J. Stuart Adams, Co-Chair
President of the Senate

Senator Kirk Cullimore
Senate Majority Leader

Senator Luz Escamilla
Senate Minority Leader

Speaker Mike Schultz, Co-Chair
Speaker of the House

Representative Casey Snider
House Majority Leader

Representative Angela Romero
House Minority Leader

Audit Staff

Kade R. Minchey, Auditor General, CIA,
CFE

Brian Dean, Manager, CIA, CFE

Nicole Luscher, Audit Supervisor

Brendon Ressler, Lead Auditor

Tanner Taguchi, Audit Staff

Office of the Legislative Auditor General

olag.utah.gov





Office of the Legislative Auditor General

Kade R. Minchey, Legislative Auditor General

W315 House Building State Capitol Complex | Salt Lake City, UT 84114 | Phone: 801.538.1033

Audit Subcommittee of the Legislative Management Committee
President J. Stuart Adams, Co-Chair | Speaker Mike Schultz, Co-Chair
Senator Kirk Cullimore | Representative Casey Snider
Senator Luz Escamilla | Representative Angela Romero

November 18, 2025

TO: THE UTAH STATE LEGISLATURE

Transmitted herewith is our report:

“A Performance Audit of Utah Department of Corrections Security Operations for Behavioral Healthcare in State Prisons: A Review of Safety and Facilitation of Care” [Report #2025-24].

An audit summary is found at the front of the report. The scope and objectives of the audit are included in the audit summary. In addition, each chapter has a corresponding chapter summary found at its beginning.

Utah Code 36-12-15.3(2) requires the Office of the Legislative Auditor General to designate an audited entity’s chief officer. Therefore, the designated chief officer for the Utah Department of Corrections is Jared Garcia. Jared Garcia has been notified that they must comply with the audit response and reporting requirements as outlined in this section of *Utah Code*.

We will be happy to meet with appropriate legislative committees, individual legislators, and other state officials to discuss any item contained in the report in order to facilitate the implementation of the recommendations.

Sincerely,

Kade R. Minchey, CIA, CFE

Auditor General

kminchey@le.utah.gov





PERFORMANCE AUDIT

AUDIT REQUEST

The Legislative Audit Subcommittee requested an audit of Utah’s behavioral health system. Our office conducted an initial risk assessment and identified potential concerns in the behavioral health services offered in Utah state prisons. Based on our findings, we chose to provide two separate reports – one directed to the Division of Correctional Health Services (CHS) within the Department of Health and Human Services (DHHS) and one directed to the Utah Department of Corrections (UDC).

BACKGROUND

While CHS oversees the mental health treatment of inmates within the Utah State Correctional Facility (USCF or Salt Lake City prison site) and the Central Utah Correctional Facility (CUCF or Gunnison prison site), UDC plays a crucial role in providing security and facilitating treatment for state inmates. The efforts of both entities are vital to providing quality care for inmates who suffer from severe mental illness.

A PERFORMANCE AUDIT OF UTAH DEPARTMENT OF CORRECTIONS SECURITY OPERATIONS FOR BEHAVIORAL HEALTHCARE IN STATE PRISONS



KEY FINDINGS

- ✓ **1.1** Inmate Suicide Watch Can Be More Effective and Consistent
- ✓ **1.2** Improved Coordination Can Help Return Inmates From Isolation in the Psychiatric Infirmery Sooner
- ✓ **2.1** UDC Should Review and Formalize Custody Practices for Working with Suicidal Inmates



RECOMMENDATIONS

- ✓ **1.1** The Department of Corrections and the Division of Correctional Health Services should collaborate and revise their policies and procedures to include the same definitions of *frequent and close* observation for suicidal inmates.
- ✓ **1.2** Department of Corrections leadership should ensure custody staff are adequately supervising suicidal inmates.
- ✓ **1.3** The Department of Corrections should improve coordination on transfers from the Utah State Correctional Facility psychiatric infirmery to ensure inmates are discharged when appropriate in a timely manner.
- ✓ **2.1** The Department of Corrections should conduct a review of current custody processes, including all issues identified in this report, and incorporate best practices for suicidal inmates into policy.

REPORT SUMMARY

UDC Can Improve Safety of Inmates Through Increased Oversight and Accountability

UDC plays a crucial role in facilitating treatment for state inmates with severe behavioral health concerns. A fundamental example of this is in the USCF psychiatric infirmary, which temporarily houses inmates who are acutely suicidal or homicidal or experiencing psychosis.

UDC should address multiple deficiencies to ensure the safety of inmates housed in the USCF psychiatric infirmary. These include performing insufficiently thorough or infrequent checks of inmates on suicide watch and a lack of coordination when transferring inmates out of the psychiatric infirmary.

UDC Should Make Additional Improvements to Increase Safety for Suicidal Inmates

UDC has made efforts to ensure the safety of suicidal inmates in the Utah State Correctional Facility (USCF) psychiatric infirmary and mental health housing unit; however, it should make additional improvements to increase the safety of inmates housed in these sections. These could include frequent reviews of the USCF psychiatric infirmary and mental health unit, standardization of search best practices for suicidal inmates, and improved management of UDC-issued items.

UDC should conduct a review of current custody processes and formalize best practices for suicidal inmates in policy. This will help ensure the safety of suicidal inmates housed in these areas.

Inmate Cells in the USCF Mental Health Housing Unit Do Not Appear Sufficiently Ligature Resistant

Inmate cells in the USCF mental health housing unit have multiple protrusions which inmates could use to attempt suicide by hanging. The opinions of our psychiatric consultant and CHS mental health staff support this conclusion. UDC should conduct a review of custody processes related to this issue along with other concerns identified in this report to enhance the safety of suicidal inmates.



Source: Photo taken from auditor observations of the USCF mental health housing unit.

Table of Contents

Introduction	1
Chapter 1 UDC Can Improve Safety of Inmates Through Increased Oversight and Accountability	5
1.1 Inmate Suicide Watch Can Be More Effective and Consistent	5
1.2 Improved Coordination Can Help Return Inmates From Isolation in the Psychiatric Infirmery Sooner	9
Chapter 2 UDC Should Make Additional Improvements to Increase Safety for Suicidal Inmates.....	15
2.1 UDC Should Review and Formalize Custody Practices for Working with Suicidal Inmates.....	15
Complete List of Audit Recommendations	25
Appendix	29
A. Example of Safety Checklist for Environmental Suicide Risks	31
Agency Response Plan	37





Introduction

This is the second of two audit reports on behavioral health care in Utah state prisons. In July 2023, oversight of prison healthcare services transitioned from the Utah Department of Corrections (UDC) to the division of Correctional Health Services (CHS or division) within the Utah Department of Health and Human Services (DHHS). While CHS oversees the behavioral health treatment of inmates within Utah state prisons, UDC plays a crucial role in providing security and facilitating care. The efforts of both entities are vital to providing quality care for inmates who suffer from severe mental illness.



This audit focuses on the role of UDC and its efforts to provide security, monitoring, and housing for inmates with severe mental illnesses.



The Division of Correctional Services (CHS or division) within the Utah Department of Health and Human Services (DHHS) oversees behavioral health treatment of inmates within Utah state prisons.



The Utah Department of Corrections (UDC) provides security for inmates receiving behavioral health treatment and facilitates care with Utah state prisons.

Source: Auditor generated based on CHS training materials and discussion with UDC's CHS liaison.

Our review of CHS found systemic deficiencies that negatively impact mental health patient outcomes. These are discussed in *“A Performance Audit of Correctional Health Services Behavioral Healthcare in State Prisons: A Review of Oversight and Adequacy of Care (2025-23).”* In addition to these findings, we also identified opportunities for UDC to improve in its efforts to provide security, monitoring, and housing for inmates with severe mental illnesses. These include improving 15-minute checks on inmates placed on suicide watch in the Utah



Addressing the concerns in both the DHHS and UDC audits will help ensure the safety of inmates with severe mental health issues as they are receiving care.

State Correctional Facility (USCF) psychiatric infirmary and providing additional suicide prevention measures.

Given the nature of our findings and the distinct roles now held by DHHS and UDC, we decided to release two separate audit reports, one directed to DHHS and the other to UDC. Addressing the concerns in both audits will help ensure the safety of inmates with severe mental health issues as they are receiving care.



BACKGROUND

UDC plays a crucial role in facilitating treatment for state inmates with severe behavioral health concerns. In the USCF psychiatric infirmary, medical staff from the Division of Correctional Health Services (CHS) within the Department of Health and Human Services (DHHS) oversee medical treatment but rely heavily on correctional staff to coordinate housing and maintain the safety of inmates during their stay.

FINDING 1.1 Inmate Suicide Watch Can Be More Effective and Consistent

RECOMMENDATION 1.1

The Department of Corrections and the Division of Correctional Health Services should collaborate and revise their policies and procedures to include the same definitions of *frequent and close observation* for suicidal inmates and monitor their implementation. This change should improve outcomes of 15-minute checks and ultimately the outcomes of inmates on behavioral health treatment.

RECOMMENDATION 1.2

Department of Corrections leadership should ensure custody staff are adequately supervising suicidal inmates. Adequate supervision should help ensure inmates under suicide watch are not engaging in self-harming behavior.

FINDING 1.2 Improved Coordination Can Help Return Inmates From Isolation in the Psychiatric Infirmary Sooner

RECOMMENDATION 1.3

The Department of Corrections should improve coordination on transfers from the Utah State Correctional Facility psychiatric infirmary to ensure inmates are discharged when appropriate in a timely manner.



CONCLUSION

The Utah Department of Corrections (UDC) should address multiple deficiencies to ensure the safety of inmates housed in the Utah State Correctional Facility (USCF) psychiatric infirmary. These include performing insufficiently thorough or infrequent checks of inmates on suicide watch and a lack of coordination when transferring inmates out of the psychiatric infirmary.





Chapter 1

UDC Can Improve Safety of Inmates Through Increased Oversight and Accountability

The Utah Department of Corrections (UDC) should address multiple deficiencies to ensure the safety of inmates housed in the Utah State Correctional Facility (USCF) psychiatric infirmary. Staff checks on severely mentally ill inmates are inconsistent, which increases the risk of inmates engaging in self-harming behavior. Additionally, lapses in communication have resulted in some patients staying in the psychiatric infirmary longer than provider orders, which is counterproductive to treatment. These deficiencies are the result of a lack of accountability, a lack of oversight, and unclear expectations from management.



UDC staff need to address multiple deficiencies to ensure the safety of inmates housed in the USCF psychiatric infirmary.

UDC plays a crucial role in facilitating treatment for state inmates with severe behavioral health concerns. A fundamental example of this is in the USCF psychiatric infirmary, which temporarily houses inmates who are acutely suicidal or homicidal or experiencing psychosis. In the psychiatric infirmary, medical staff from the Division of Correctional Health Services (CHS) within the Utah Department of Health and Human Services (DHHS) oversee medical treatment but rely heavily on correctional staff to coordinate housing and maintain the safety of inmates during their stay.

1.1 Inmate Suicide Watch Can Be More Effective and Consistent

We identified deficiencies in custody staff's efforts to perform unpredictable 15-minute (Q15) checks in the USCF psychiatric infirmary. These checks are required in UDC's internal policy and medical provider orders. They act as an important safety measure for suicidal inmates. We found instances where checks were not performed in a timely manner or when staff did not adequately observe the condition of the inmate. To address these deficiencies, UDC leadership should address staff noncompliance, improve oversight, and set clear expectations.

UDC correctional officers are instrumental in providing ongoing monitoring of inmates admitted to the psychiatric infirmary. These inmates require frequent and unpredictable monitoring to prevent them from harming themselves. This



monitoring occurs through Q15 checks, which are ordered by a medical provider.¹ UDC policy requires officer compliance with Q15 checks.

UDC Q15 Policy

“An officer shall complete visual checks on each inmate at least every 15 minutes and document these checks.”

These checks act as a necessary security measure for inmates who pose a serious risk to themselves. However, correctional officers are not always conducting



Some officers filled out Q15 logs without looking in the inmate’s cell or after merely glancing at the inmate without verifying their safety.

quality checks. During our observations of Q15 checks, we noted that some officers were filling out the Q15 logs without looking in the inmate’s cell or after merely glancing at the inmate without verifying their safety. Inconsistent Q15 checks increase the risk of inmates engaging in self-harm behaviors without the knowledge of custody staff. The negative impact of insufficiently thorough Q15 checks is demonstrated by the following examples:

Q15 Hanging Example

An inmate was admitted to the psychiatric infirmary after admitting suicidal ideation. This inmate used shreds of fabric that they tore from their clothing to fashion a noose which they used to hang themselves from their sink. From the time the inmate affixed the noose to the sink, UDC conducted seven Q15 checks on this inmate. The officer did not notice the deceased inmate for over an hour before initiating emergency procedures.

Q15 Razor Blade Example

An inmate with a history of suicide attempts was admitted to the psychiatric infirmary used a hidden razor blade to engage in self-harm. According to UDC records, an officer performed a Q15 check after the incident occurred and failed to verify the inmate’s safety. By the time an officer noted the attempt during the next Q15 check, the inmate had lost a significant amount of blood.

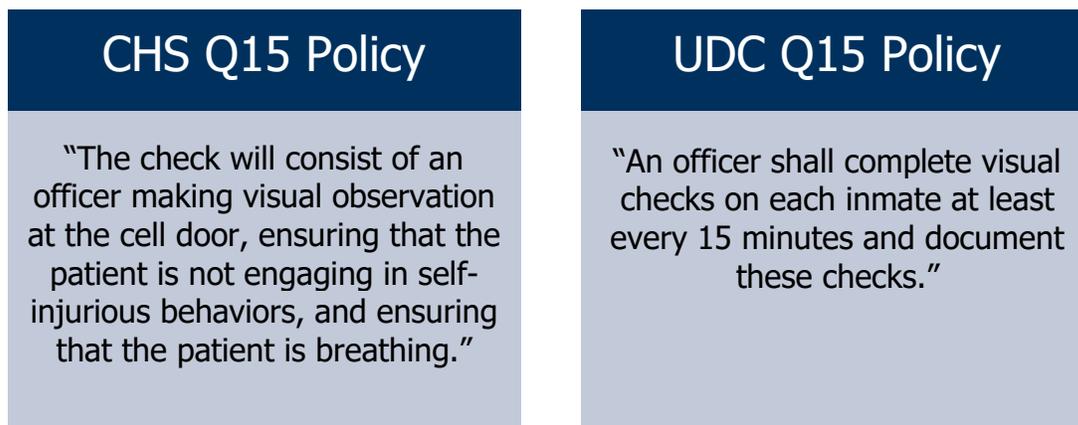
These examples demonstrate the importance of performing quality Q15 checks on inmates admitted to the psychiatric infirmary. The ultimate objective of Q15 checks is to ensure the safety of severely mentally ill inmates. Insufficiently

¹ CHS deficiencies related to Q15 checks are discussed in Chapter 1 of *A Performance Audit of Correctional Health Services Behavioral Healthcare in State Prisons: A Review of Oversight and Adequacy of Care* (Report 2025-23).



thorough checks reduce custody staff's ability to respond to an attempted suicide.

We also note CHS and UDC policies have different Q15 expectations, with CHS having more specific requirements. The following infographic illustrates these differences:



Source: Auditor generated based on CHS and UDC policy.

According to CHS, a Q15 check should consist of a visual observation of the inmate, which includes making sure they are not self-harming and are breathing. However, these requirements are not specified in UDC policy. While CHS staff oversee the medical and behavioral health treatment in the psychiatric infirmary, they rely on UDC staff to administer Q15 checks to ensure the safety of the inmates. Better defining expectations in UDC policy and monitoring checks after the policy revision could reduce the risk associated with inadequate Q15 checks. We therefore recommend that UDC and CHS collaborate and revise their policies and procedures to include the same definitions of *frequent and close observations*. They should also monitor the implementation of policy changes on Q15 checks following the revision. These changes can help improve expectations on the quality of Q15 checks and reduce the risk of suicide.

RECOMMENDATION 1.1

The Department of Corrections and the Division of Correctional Health Services should collaborate and revise their policies and procedures to include the same definitions of *frequent and close observation* for suicidal inmates. They should also monitor implementation following the revision. This change should improve outcomes of 15-minute checks and ultimately the outcomes of inmates in behavioral health treatment.



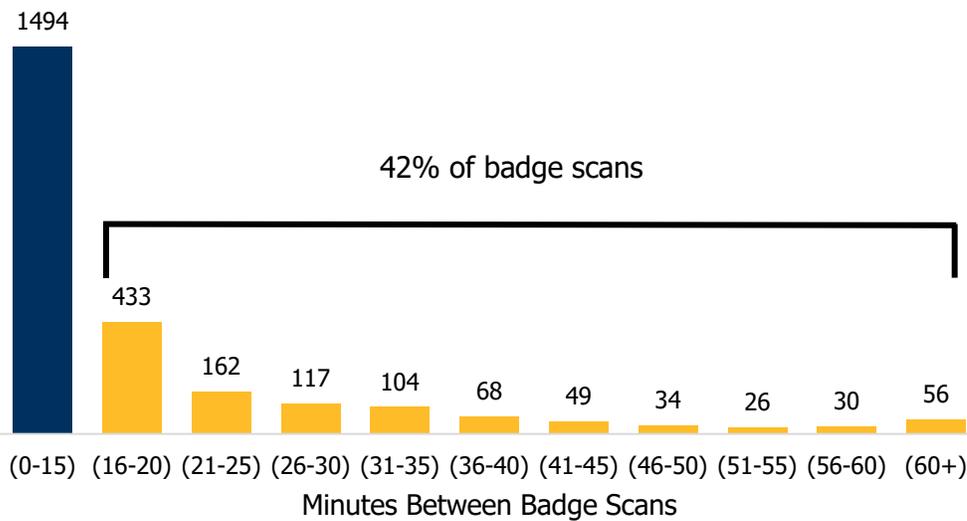
Correctional Officers Are Not Always Performing Q15 Checks Within the 15-Minute Standard

In addition to not performing quality checks, UDC officers are not always performing checks within the 15-minute standard. UDC officers conducting Q15 checks are required to scan their access badge at the start and end of their rounds and log those times in the unit officer log. In theory, this practice holds officers accountable for completing checks. We analyzed one month (over 2,500 scans) of badge-scanner data and found that custody staff did not conduct a check within the 15-minute standard 42% of the time. Additionally, in 56 instances, no Q15 check occurred for over an hour. The following figure shows the distribution of the data:



Custody staff did not conduct a check within the 15-minute standard 42% of the time.

Figure 1.1 Correctional Officer Checks Are Not Always in Compliance with the 15-Minute Standard. We analyzed one month of badge-scanner data and found that a Q15 check did not occur within the 15-minute standard 42% of the time. In 56 noted instances, at least 60 minutes elapsed between checks.



Source: Auditor generated using UDC badge-scanner data.

In July 2025, UDC updated its practices by including a log sheet next to each cell door for staff to record each time a check was performed. However, we continued to find instances of noncompliance after this new procedure was implemented. CHS staff also noted deficiencies after conducting a recent study of Q15 logs over 39 days. In their review, they found that only 5% of the patient logs were in full compliance with the 15-minute standard. Additionally, they noted that multiple inmate logs were missing and that some checks were done at predictable intervals, decreasing the effectiveness of the checks.



While the responsibility falls on individual correctional officers to perform these checks, management should provide greater accountability and oversight. Officers are individually accountable for performing these checks, but management is responsible for addressing culture.

Implementing processes such as frequent audits or reviews of Q15 checks should help improve accountability and oversight in this area.

Even short delays in Q15 checks have the potential to limit custody staff's ability to respond to a suicide attempt. This risk increases the importance of frequent and unpredictable checks. UDC should therefore ensure custody staff are adequately supervising suicidal inmates.



CHS staff conducted a review of Q15 logs and found that multiple logs were missing and that some checks were done at predictable intervals, decreasing their effectiveness.

RECOMMENDATION 1.2

Department of Corrections leadership should ensure custody staff are adequately supervising suicidal inmates. Adequate supervision should help ensure inmates under suicide watch are not engaging in self-harming behavior.

1.2 Improved Coordination Can Help Return Inmates From Isolation in the Psychiatric Infirmery Sooner

Inmates are sometimes kept in the psychiatric infirmary after medical providers issue an order to discharge them. This occurred in nearly one-third of a sample of 65 recent discharges that we reviewed.² These delays are partially due to a lack of coordination among correctional staff to coordinate their move. The primary purpose of the psychiatric infirmary is to maintain the safety of inmates who are a danger to themselves or others. UDC policy dictates that after a suicidal inmate has been stabilized, they should be promptly moved from the psychiatric infirmary to a less restrictive environment. Prompt transfers are important to the recovery of inmates as those housed in the psychiatric infirmary do not receive treatment until they return to the housing sections.

² Cases reviewed in our study were previously identified by CHS staff as having potentially experienced a delay.



The focus of the psychiatric infirmary is on safety and stabilization. Admission



Admission into the psychiatric infirmary can be a necessary protection for the acutely mentally ill; however, its use becomes counterproductive if prolonged without a good reason.

into the psychiatric infirmary can be a necessary protection for the acutely mentally ill; however, its use becomes counterproductive if prolonged without a good reason. Inmates who are admitted to the psychiatric infirmary have limited privileges to control for potential opportunities to harm themselves or others. Mental health providers briefly visit inmates daily and assess if they have stabilized sufficiently to increase their privileges; however, inmates in the psychiatric infirmary are kept in isolation for the duration of their stay.

The amount of time before inmates return to regular housing after a provider approves their transfer varies. We conducted a review of 65 discharges and found that nearly one-third experienced a delay ranging from 1 to 10 days. Four of these individuals were delayed a week or more. We show the distribution of these delays in the following table:

Figure 1.2 Some Inmates Are Experiencing Delays Leaving the Psychiatric Infirmary. We reviewed 65 discharges and found that nearly one-third experienced a delay. Four of these were delayed a week or more.

Days Delayed	Count	Percentage
0	44	68%
1	11	17%
2	0	0%
3	2	3%
4	2	3%
5	1	2%
6	1	2%
7	1	2%
8	2	3%
9	0	0%
10	1	2%

Source: Auditor generated using CHS discharge data and patient records.

To understand the reasons behind these delays, we worked with UDC and CHS management to review a sample of 10 cases. They reported that the primary reason behind the delays in these cases was UDC staff’s failure to reserve beds in regular housing units.



Requests to transfer inmates are primarily coordinated through a central office and are communicated through a shared spreadsheet. The central office can take steps to transfer inmates to an open bed, but the officer must request to place the bed on hold to reserve it. If this does not occur, leadership in the regular housing units may assign the bed to another individual. Additionally, some inmates require additional treatment in regular mental health housing or may have specific security requirements. These can complicate their release, increasing the importance of staff coordination.



In a sample reviewed by UDC and CHS management, the primary reason behind the delays in the transfer from the psychiatric infirmary was UDC staff's failure to reserve beds in the regular housing units.

Delayed release from the psychiatric infirmary unnecessarily prolongs the isolation of inmates with severe mental health needs. Moving inmates to less restrictive housing when appropriate will help ensure that the discharge of these individuals occurs in a manner that is appropriate with the level of care required.

RECOMMENDATION 1.3

The Department of Corrections should improve coordination on transfers from the Utah State Correctional Facility psychiatric infirmary to ensure inmates are discharged when appropriate in a timely manner.





BACKGROUND

The Utah Department of Corrections (UDC) has made efforts to ensure the safety of suicidal inmates in the Utah State Correctional Facility (USCF) psychiatric infirmary and mental health housing unit; however, it should make additional improvements to increase the safety of inmates housed in these sections. These could include frequent reviews of the USCF psychiatric infirmary and mental health unit, standardization of search best practices for suicidal inmates, and improved management of UDC-issued items.

FINDING 2.1 **UDC Should Review and** **Formalize Custody Practices** **for Working with Suicidal** **Inmates**

RECOMMENDATION 2.1

The Department of Corrections should conduct a review of current custody processes, including all issues identified in this report, and incorporate best practices for suicidal inmates into policy. The department should then monitor implementation and evaluate its effectiveness. These measures will help enhance the safety of suicidal inmates.



CONCLUSION

Many of the steps UDC has taken are encouraging; however, it should make additional improvements to increase the safety of inmates housed in these sections. To accomplish this, UDC should conduct a review of current custody processes and formalize best practices for suicidal inmates in policy. This will help ensure the safety of suicidal inmates housed in these areas.





Chapter 2

UDC Should Make Additional Improvements to Increase Safety for Suicidal Inmates

The Utah Department of Corrections (UDC) has made efforts to ensure the safety of suicidal inmates in the Utah State Correctional Facility (USCF) psychiatric infirmary and mental health housing unit. Many of these steps are encouraging; however, UDC should make additional improvements to increase the safety of inmates housed in these sections. For example, UDC should conduct a review of current custody processes and formalize best practices for suicidal inmates in policy. These improvements will help ensure the safety of suicidal inmates housed in these areas.



UDC has made efforts to ensure the safety of suicidal inmates, but additional improvements can be made.

2.1 UDC Should Review and Formalize Custody Practices for Working with Suicidal Inmates

UDC should review and formalize current custody practices to improve the safety of suicidal inmates housed in the USCF psychiatric infirmary and mental health housing unit. During our audit, we identified potential opportunities for improvement in UDC processes. For example, UDC could benefit from conducting frequent reviews of the layout of these areas to identify opportunities for preventing inmate suicides. UDC could also take additional steps to improve its prevention of contraband and monitoring of potentially harmful items within the psychiatric infirmary. These measures would help increase the security of the facility and improve UDC's efforts to prevent inmates from engaging in self-harming behaviors.

UDC Could Benefit from Conducting Frequent Reviews of The USCF Psychiatric Infirmary and Mental Health Unit for Safety

Multiple aspects of USCF's housing design pose a potential risk for suicidal inmates in the mental health housing unit and psychiatric infirmary. The layout of USCF is an important element in maintaining a secure environment for



suicidal inmates. According to the National Commission on Correctional Healthcare (NCCHC):³

NCCHC Essential Standard P-B-05

“All cells or rooms housing suicidal inmates [should be] as suicide-resistant as possible (e.g., without protrusions that would enable hanging).”

We noted multiple opportunities for improvement in USCF’s layout and processes that could help reduce the risk of suicide. UDC should consider modifying cells in the USCF mental health housing unit that which sometimes acts as a “step-down” unit for suicidal inmates. UDC could also benefit from continually reviewing areas that house suicidal inmates to identify potential hazards. Taking these additional measures could help reduce the ability of inmates in these areas to self-harm.

We identified ways for UDC to reduce the risk of suicide in the USCF mental health housing unit. UDC and CHS often send inmates who are released from the psychiatric infirmary to USCF’s mental health housing unit for observation and treatment. Many of the individuals in the mental health housing unit are at a high risk of suicide, increasing the need for ligature resistance.⁴ However, cells within this unit do not have ligature-resistant fixtures. We documented an example of one of these cells and noted fixtures that appear insufficiently ligature resistant.



Cells within the mental health housing unit lack ligature-resistant fixtures.

³ According to *Utah Code* 64-13-39, state correctional facilities are required to maintain NCCHC accreditation.

⁴ *Ligature resistant* is defined as without points where a cord, rope, bedsheet, or other fabric/material can be looped or tied to create sustainable point of attachment that may result in self-harm or loss of life.

Figure 2.1 Inmate Cells in the USCF Mental Health Housing Unit Do Not Appear Sufficiently Ligature Resistant. Inmate cells in the USCF mental health housing unit have multiple protrusions that inmates could use to attempt suicide by hanging.



Source: Photo taken from auditor observations of USCF mental health housing.

These fixtures are particularly concerning, considering our team documented that an inmate attempted to hang themselves from a bedpost similar to the one in Figure 2.1.

We note that UDC made special considerations for the psychiatric infirmary and mental health housing unit during USCF's construction process. For example, in the psychiatric infirmary, subsets of cells were built with the intention of



Considering that USCF fixtures have been used to self-harm, additional work is needed.

reducing the risk of inmates using various methods to self-harm. UDC also conducted an interdisciplinary review prior to opening which included prison medical and correctional staff. However, considering that USCF fixtures have been used to self-harm, additional improvements are needed.

The opinions of multiple mental health professionals support this conclusion. In addition to our review, our office, the Utah Office of the Legislative Auditor General (OLAG), hired a board-certified psychiatrist with specialized expertise in correctional and forensic mental health care. He noted his concerns regarding USCF cells housing suicidal inmates:

OLAG Psychiatric Consultant on Cells Housing Suicidal Inmates

"Cells housing suicidal inmates are not maximally suicide-resistant. They contain known protrusions that enable hanging."



CHS mental health professionals noted concerns with the lack of anti-ligature fixtures in the mental health housing unit after conducting a review of multiple sections with members of UDC management.

CHS mental health professionals noted the same concerns after conducting a review of multiple sections with members of UDC management. As a result, CHS made recommendations to modify the design. UDC should consider these recommendations and modify layouts to include cell features that help prevent suicide, such as anti-ligature fixtures. If UDC is unable to immediately make these modifications, management should take precautions to protect the inmates housed in these cells. UDC could accomplish this through additional monitoring and supervision.

Since USCF opened in July 2022, UDC has not conducted a general review of ligature resistance of the psychiatric infirmary. However, multiple instances of self-harm in this area using UDC-installed fixtures have occurred. The following examples are of a suicide and an attempted suicide that occurred in the psychiatric infirmary:

Sink Suicide Example

An inmate used a sink faucet in the psychiatric infirmary to commit suicide by hanging.

Shower Grate Suicide Attempt Example

A suicidal inmate tied a towel to a shower grate in the psychiatric infirmary in attempt to commit suicide.

Following the suicide in the first example, UDC modified the sinks in the psychiatric infirmary to prevent future suicide attempts. UDC and CHS also conducted an analysis of isolated incidents such as suicides, but a frequent and proactive review of the psychiatric infirmary and mental health housing unit could help prevent future events.



UDC should take a more proactive approach to suicide prevention.



Conducting frequent risk assessments to identify environmental hazards is a best practice in the medical community.

In the medical community, conducting frequent risk assessments to identify environmental hazards is a best practice. In Appendix A, we include an example of a periodic checklist that UDC could adapt to create an assessment for its psychiatric infirmary and mental health housing unit. Doing so could help provide oversight and mitigate future suicide risks.

Standardizing Best Practices for Conducting Inmate Searches Prior To Entering the USCF Psychiatric Infirmary Could Improve Safety

UDC could benefit from standardizing best practices for inmate searches, such as body scans prior to entering the USCF psychiatric infirmary, in policy. We found that custody staff use varying levels of thoroughness when searching inmates who are entering the psychiatric infirmary. These searches are important measures for preventing suicides. Inmates admitted to the psychiatric infirmary are commonly suicidal and, in some cases, have engaged in or plan to engage in self-harming behavior.⁵ As a result, all inmates admitted to the psychiatric infirmary must undergo a strip search prior to admission. This requirement is specified in UDC policy, which states:

UDC Psychiatric Infirmary Strip-Search Policy

"An inmate who is admitted to the [psychiatric infirmary] for suicide concerns, danger to self, or who poses a high-security risk shall always be strip-searched for contraband prior to being admitted."

Additionally, while not in policy, UDC management has posted the following instructions, requiring staff to conduct a body scan of inmates coming into the psychiatric infirmary:

UDC Psychiatric Infirmary Admission Instructions

"The following must happen for an inmate to be placed in the [psychiatric infirmary]...the inmate must be scanned by [the unit's] Core Staff. After being scanned, the inmate is to be escorted into the [psychiatric infirmary]. [The unit's] Core Staff will let you in the [psychiatric infirmary]."

⁵ Inmates may be admitted to the USCF psychiatric infirmary for suicidal or homicidal intent. They may also be admitted for acutely psychotic behavior.



The following infographic outlines the differences between the two searches.

 <p>A strip search requires a person to remove all their clothing and expose all parts of their body to visual search.</p>	 <p>A body scan is a scan with a machine that uses X-rays to create an image of a person's body to detect concealed objects such as weapons or other contraband.</p>
--	---

Source: Auditor generated based on UDC internal policy and institutional manual.

 **We found that contraband items were used in 4 of the 25 major instances of self-harm that took place in the psychiatric infirmary since USCF opened.**

Despite these measures, we found that contraband items were used in 4 of the 25 major instances of self-harm in our limited review that took place in the psychiatric infirmary since USCF opened. These items included razor blades, a piece of metal, and a shard of glass. In most cases, we were unable to determine how these items were brought into the psychiatric infirmary. However, we found that in one instance, the inmate hid a razor blade under their fingernail. This item could have potentially been

discovered using a body scanner. In each of these instances, UDC staff performed a strip search; however, it appears a body scan was only conducted in one of the four admissions. Furthermore, in the instance where a body scan was performed, it occurred an hour after the individual was placed in a cell in the psychiatric infirmary, presumably giving the inmate sufficient time to hide the contraband item. We also performed a limited review of other admissions and found additional instances where body scans did not occur.

Conducting body scans prior to admission to the psychiatric infirmary is not required in internal policy, but its use can act as an additional safeguard for custody. UDC should consider creating and implementing a policy to conduct



body scans prior to admission to the psychiatric infirmary. It should also consider conducting a review to evaluate the policy's implementation.

Improved Management of Potentially Dangerous Items In the Psychiatric Infirmary Would Help Reduce Risk

UDC should consider reviewing its processes for managing commonplace items that inmates could use to self-harm. After reviewing incident reports and medical records for psychiatric infirmary residents, we found at least 16 cases of inmates appearing to use UDC-provided items to self-harm. The items used in these cases include articles of clothing, a paper utensil, and towels.⁶



In at least 16 cases, inmates used UDC-provided items to self-harm.

Notwithstanding the risks associated with these items, UDC custody staff have not adequately accounted for them. As a result, inmates have used these items to hurt themselves, as demonstrated in the following examples:

Safety Smock Example

An inmate housed in the psychiatric infirmary used a thread from a "safety smock" issued upon admission to the psychiatric infirmary to attempt to hang themselves.

Paper Spoon Example

An inmate housed in the psychiatric infirmary used a paper spoon to cut themselves.



UDC could benefit from paying special attention to materials such as safety smocks, towels, and similar materials to ensure they are not used to inflict self-harm.

UDC could benefit from paying special attention to materials such as safety smocks, towels, and similar materials to ensure they are not used to inflict self-harm. There is currently no policy regarding the monitoring of these materials, but UDC could identify appropriate methods and formalize them into policy. Afterward, UDC should take steps to ensure policy implementation. This will help establish expectations for staff and prevent additional use of these materials to self-harm.

⁶ Following admission to the psychiatric infirmary, inmates are only given finger food. However, at a provider's discretion, inmates who show signs of stabilization can be served cooked meals in Styrofoam containers that contain plastic wrappers and paper utensils.



Furthermore, UDC management could improve in accounting for trash in the psychiatric infirmary. Trash poses a potential sanitation and security concern. While we only identified one example of an inmate using leftover trash to self-harm (see “Paper Spoon Example”), UDC could benefit from greater oversight. UDC management posted an internal document in the psychiatric infirmary stating that inmates are required to return trash from previous meals prior to receiving a new one. However, we observed multiple trash items in several cells, suggesting that inmates have access to these items for an extended period. Examples are shown in the following photos:

Figure 2.1 Uncollected Trash Items Poses a Potential Safety Risk to Inmates Housed in the Psychiatric Infirmary. The audit team observed multiple instances of trash left in cells. These items often contain utensils which inmates could use to self-harm.



Source: Photo taken from auditor observations of the USCF psychiatric infirmary.

While no general policy exists on collecting trash from meals in the psychiatric infirmary, there is a policy related to a subset of the cells known as “dry cells.” The policy states that “any packaging or containers from the food or liquids are to be removed...as soon as possible.”⁷ UDC should consider expanding this policy to include the other cells in the psychiatric infirmary and monitoring its implementation. This will limit opportunities for inmates to self-harm.

⁷ A “dry cell” is a form of cell without access to plumbing which is used to monitor inmates who are suspected of ingesting a foreign object.



Overall, we are encouraged by many of UDC’s efforts to ensure the safety of suicidal inmates in the USCF psychiatric infirmary and mental health housing unit. Making additional improvements will help increase the safety of inmates housed in these sections. To accomplish these further improvements, UDC should conduct a review of current custody processes and incorporate best practices for suicidal inmates into policy. UDC should also monitor for implementation and evaluate its effectiveness. These measures will help ensure the safety of suicidal inmates as they receive treatment.



UDC has made efforts to ensure the safety of suicidal inmates but additional improvements can be made.

RECOMMENDATION 2.1

The Utah Department of Corrections (UDC) should conduct a review of current custody processes, including all issues identified in this report, and incorporate best practices for suicidal inmates into policy. UDC should then monitor implementation and evaluate its effectiveness. These measures will help enhance the safety of suicidal inmates.





Complete List of Audit Recommendations





Complete List of Audit Recommendations

This report made the following four recommendations. The numbering convention assigned to each recommendation consists of its chapter followed by a period and recommendation number within that chapter.

Recommendation 1.1

The Department of Corrections and the Division of Correctional Health Services should collaborate and revise their policies and procedures to include the same definitions of *frequent and close observation* for suicidal inmates. They should also monitor implementation following the revision. This change should improve outcomes of 15-minute checks and ultimately the outcomes of inmates in behavioral health treatment.

Recommendation 1.2

Department of Corrections leadership should ensure custody staff are adequately supervising suicidal inmates. Adequate supervision should help ensure inmates under suicide watch are not engaging in self-harming behavior.

Recommendation 1.3

The Department of Corrections should improve coordination on transfers from the Utah State Correctional Facility psychiatric infirmary to ensure inmates are discharged when appropriate in a timely manner.

Recommendation 2.1

The Utah Department of Corrections (UDC) should conduct a review of current custody processes, including all issues identified in this report, and incorporate best practices for suicidal inmates into policy. UDC should then monitor implementation and evaluate its effectiveness. These measures will help enhance the safety of suicidal inmates.





Appendix



A. Example of Safety Checklist for Environmental Suicide Risks



Environmental Risks for Suicide Assessment Checklist

This checklist includes questions to ask to assess environmental risks for suicide in nonbehavioral health units and emergency rooms as well as inpatient behavioral units. It can be used as a daily check or as a periodic check to see if changes need to be made. Answers to all questions should ideally be Y for Yes (unless they aren't applicable).

Organization: _____ Department/Unit: _____

Date of Review: _____ Reviewer: _____

Nonbehavioral Health Units and Emergency Rooms and Inpatient Behavioral Units*

General Facility Safety [CAH, HAP]	Y	N	N/A	If N (No), Note Changes Needed
Are plastic trash can liners absent in every space accessible to patients?				
Are all doors to all service and supply rooms locked when staff members are not physically present?				
Are all chemicals, including alcohol-based hand rub, kept under direct staff observation or within a locked room or area inaccessible by patients?				
Are telephones located in corridors or common spaces for patient use securely wall-mounted and have a nonremovable shielded cord (maximum length 14 inches)?				
Are disposable medium-weight bendable plastic cutlery used—and accounted for after meals so that patients cannot take it and use it to harm themselves or others?				
Ceilings, Walls, Windows, and Doors [CAH, HAP]	Y	N	N/A	If N (No), Note Changes Needed
Are the ceilings and walls solid and resistant to ligature attachment?				
Are all air vent covers or grills designed to resist ligature attachment and secured with tamper-resistant fasteners?				
Are window frames and sills designed to resist ligature attachment?				
If the outside window is operable, is it limited to no more than a 4–6-inch opening?				
Is window glass made of shatterproof material?				
Are door hinges, handles, and locks designed to resist ligature attachment?				
Are institutional sprinklers safely mounted to resist ligature attachment?				

*Some items may not apply to nonbehavioral health inpatient units; the organization should make that determination.

Lighting and Electrical Devices and Circuitry [CAH, HAP]	Y	N	N/A	If N (No), Note Changes Needed
Is glass in lighting fixtures shatterproof?				
Are light fixtures tamper-resistant and designed to resist ligature attachment?				
Are all electrical device cover plates secured with tamper-resistant fasteners?				
Are all electrical outlets GFCI (ground fault circuit interrupter) and tamper resistant?				
Are outlet covers nonconductive?				
Are electrical power cords on adjustable beds secured or replaced with removable cords? (Make sure bed can still be mechanically lowered for CPR positioning.)				
Are power cords to TVs and other electrical devices secured?				
Patient Rooms and Bathrooms [CAH, HAP]	Y	N	N/A	If N (No), Note Changes Needed
If electrically operable beds are used due to medical necessity, do they have reduced-length cords and other tamper-resistant features?				
Are closets designed safely, with all coat hooks, hangers, and poles removed?				
Are cubicle curtain tracks removed?				
If pull cords on nurse call or emergency call switches are provided, are they lightweight and no longer than 8 inches?				
Are mirrors and wall decorations made of shatterproof material?				
Are mirrors and wall decorations designed to resist ligature attachment, and mounted in a tamper-resistant manner?				
If soap or hand hygiene product dispensers are wall-mounted, are they tamper-resistant and designed to resist ligature attachment?				
Are grab bars and towel bars in patient bathrooms removed or designed to resist ligature attachment?				
Are toilets (including tanks and plumbing fixtures) tamper resistant and designed to resist ligature attachment?				
Are sinks (including faucets, valves, and plumbing fixtures) tamper resistant and designed to resist ligature attachment?				

Patient Rooms and Bathrooms (continued) [CAH, HAP]	Y	N	N/A	If N (No), Note Changes Needed
Are showers (including faucets and plumbing fixtures) tamper resistant and designed to resist ligature attachment?				
Are mounting brackets for TVs removed (to prevent use as a ligature point)?				
Are any cork bulletin boards with thumbtacks replaced with dry-mark boards?				

Inpatient Behavioral Units Only

Entrances and Exits [CAH, HAP]	Y	N	N/A	If N (No), Note Changes Needed
Are entrances and exits to the unit within the line of sight of a nursing station?				
Are nursing stations secured from unauthorized entry? Note: Walls around nursing stations should be substantial (not modular office furniture) and fixed in place. Doors should be capable of being locked. Counters should be tall and wide, if open above, to prevent patients from climbing over. Objects in the nursing station should be out of patients' reach.				
Do staff members take appropriate actions when individuals are entering or exiting the unit, in an effort to prevent unauthorized individuals from entering—and patients from exiting—the unit?				
Does each staff and medical staff member present on the unit have a key on his or her person at all times and can he or she rapidly unlock the egress doors in the event of an emergency?				
Panic Alarm and Response to an Event [CAH, HAP]	Y	N	N/A	If N (No), Note Changes Needed
Can staff members clearly describe the location of the panic button or alarm and the process for activating it?				
In the records for panic alarm testing, is the testing documented at the frequencies defined in the security management plan or policy?				
Do all staff—including nonclinical staff—know the response process to follow in case of a suicide?				
Are staff educated on the location and use of emergency equipment for suicide response?				

Fire Safety and Emergency Evacuation [CAH, HAP]	Y	N	N/A	If N (No), Note Changes Needed
Do the fire sprinklers have institutional heads that provide very little opportunity for attachment?				
Are the fire extinguishers and fire pull stations locked or secured to prevent unauthorized access?				
Does each staff member have a key on his or her person at all times with which he or she can rapidly unlock the fire extinguishers and the fire pull stations?				
When asked to describe or demonstrate actions to take in the event of a fire, can each staff member queried clearly describe the appropriate actions, per your organization's fire response plan?				
When asked to describe the response in the event of an emergency requiring evacuation, can each staff and medical staff member clearly describe required actions, per the Emergency Operations Plan?				
Circuit Breakers and Shutoff Valves [CAH, HAP]	Y	N	N/A	If N (No), Note Changes Needed
Are electrical circuit breakers, water shutoff valves, and medical gas shutoff valves locked?				
Do staff members have access to a key or device to unlock and access electrical circuit breakers, water shutoff valves, and medical gas shutoff valves in the event of an emergency?				
Seclusion Rooms [CAH, HAP]	Y	N	N/A	If N (No), Note Changes Needed
Are seclusion rooms free of blind spots in which staff cannot see patients without entering the room?				
Are seclusion rooms free of potential hazards to patients, including all those previously cited, plus the following? <ul style="list-style-type: none"> • Furniture is secured and free of separate pieces or parts. • The room is free of decorations. 				



Agency Response Plan





State of Utah

SPENCER J. COX
Governor

DEIDRE M. HENDERSON
Lieutenant Governor

Utah Department of Corrections Executive Office

JARED GARCIA
Executive Director

REBECCA BROWN
Deputy Executive Director

MIKE SCHOENFELD
Deputy Executive Director

MARIA SHIREY
Deputy Executive Director

SPENCER TURLEY
Deputy Executive Director

November 6, 2025

Kade R. Minchey
Legislative Auditor General
W315 House Building – State Capitol Complex
Salt Lake City, UT 84114

Mr. Minchey,

The Utah Department of Corrections (UDC) appreciates the comprehensive performance audit conducted by the Office of the Legislative Auditor General regarding our security operations for behavioral healthcare in state prisons. We concur with all four recommendations presented in the report and are committed to implementing the necessary changes to enhance safety and facilitate the care of inmates with severe mental illnesses within our facilities.

We recognize the critical importance of our role in providing security, monitoring, and housing for these vulnerable individuals and acknowledge the identified deficiencies. The UDC is dedicated to continuous improvement and will work diligently to address these findings.

Below is our response to each recommendation, outlining our concurrence and proposed action steps:

Recommendation 1.1: The Department of Corrections and the Division of Correctional Healthcare Services should collaborate and revise their policies and procedures to include the same definitions of frequent and close observation for suicidal inmates and monitor their implementation. This change should improve outcomes of 15-minute checks and ultimately the outcomes of inmates on behavioral health treatment.

Department Response: The Utah Department of Corrections (UDC) concurs with the recommendation that the Department of Corrections and the Division of Correctional Healthcare Services collaborate to revise their policies and procedures. This revision should standardize the definitions of constant and close observation for suicidal inmates and include monitoring of their implementation to improve the outcomes of 15-minute checks and overall behavioral health treatment for inmates.

- **What:** Harmonize definitions and expectations between UDC and CHS policies for constant and close observation of suicidal inmates to ensure a unified and effective approach to suicide watch.
- **How:**
 1. **Form a Joint Policy Review Committee:** UDC has taken a two phased approach to policy review. We have established an internal committee with our Policy Advisory Committee to review all policies that have overlap with the CHS Operations. We will then invite a joint review with representatives from UDC and CHS to review and revise existing policies and procedures related to constant and close observation for suicidal inmates. This committee includes staff with expertise in corrections, behavioral health, and policy development.
 2. **Develop Standardized Definitions:** The committee will develop clear, consistent, and specific definitions for "constant observation" and "close observation" that will be incorporated into both UDC and CHS policies. These definitions will explicitly outline the required actions and expectations for staff performing these observations, including elements such as visual contact, verification of safety, and monitoring of breathing, as highlighted in the audit.
 3. **Policy Revision and Approval:** The revised policies and procedures will undergo a thorough review process by both UDC and CHS leadership and legal counsel, with a target implementation date of Quarter 1 2026.
 4. **Staff Training:** Training will be developed and delivered to all relevant UDC and CHS staff (correctional officers, medical staff, supervisors) on the updated policies and standardized definitions. Training will emphasize the "why" behind the changes and provide practical demonstrations of quality 15-minute checks.
 5. **Ongoing Monitoring and Auditing:** UDC, in collaboration with CHS, will establish a routine monitoring and auditing process to ensure consistent implementation and adherence to the revised policies. This will include regular reviews of Q15 logs, camera reviews, scanner data, direct observation of staff performance and/or other applicable monitoring and auditing practices available within the facility.
- **Documentation:** Revised policies and procedures, training materials, Q15 logs, and audit reports.
- **Assigned Responsible Person:** Assistant Chief Nick Bricker, Deputy Warden Travis Knorr, Chief Tyler Johnson.
- **Current Status/Target Date for Completion:** Initial policy updates and training completed in Quarter 1, 2026. Broader policy updates may continue beyond this date. Training will be an ongoing measure as new staff rotate into their work assignments.

Recommendation 1.2: Department of Corrections leadership should ensure custody staff are adequately supervising suicidal inmates. Adequate supervision should help ensure inmates under suicide watch are not engaging in self-harming behavior.

Department Response: UDC concurs with this recommendation. The audit findings clearly demonstrate a need to strengthen oversight and accountability for custody staff performing suicide watch, particularly concerning the quality and frequency of Q15 checks.

- **What:** Strengthen oversight and accountability for custody staff performing suicide watch, particularly concerning the quality and frequency of Q15 checks, to prevent self-harming behavior.
- **How:**
 1. **Reinforce Supervisory Expectations:** Communicate reinforced expectations to supervisory staff regarding their responsibility for ensuring adequate supervision of suicidal inmates, including guidelines on monitoring Q15 checks and addressing non-compliance.
 2. **Implement Regular Supervisory Audits:** Supervisors will conduct frequent, unannounced audits of Q15 checks, including direct observation, camera review and/or review of log entries or other available information.
 3. **Utilize Technology for Enhanced Monitoring:** Explore and implement technological solutions like enhanced badge scanner systems or video surveillance (where appropriate) to improve monitoring of Q15 checks.
 4. **Performance Accountability:** Establish a clear disciplinary matrix for non-compliance with Q15 check protocols.
 5. **Ongoing Education and Refresher Training:** Provide annual training to custody staff on the importance of and conducting quality Q15 checks, identification of self-harming behaviors, and intervention strategies.
- **When:** Ongoing.
- **Documentation:** Supervisory guidelines, audit reports, any data reports, disciplinary matrix, and training records.
- **Assigned Responsible Person:** Chief Aimee Griffiths, Assistant Chief Nick Bricker, Warden Sharon D'Amico
- **Target Date for Completion:** Quarter 1, 2026

Recommendation 1.3: The Department of Corrections should improve coordination on transfers from the Utah State Correctional Facility psychiatric infirmary to ensure inmates are discharged when appropriate in a timely manner.

Department Response: The Utah Department of Corrections (UDC) concurs with the recommendation to improve coordination on transfers from the Utah State Correctional Facility psychiatric infirmary. The goal is to ensure timely and appropriate discharges of stabilized inmates to prevent prolonged isolation. This will be achieved by streamlining transfer protocols, implementing mandatory bed reservation procedures, enhancing communication through shared platforms, establishing regular interdepartmental meetings, and monitoring transfer timelines. As the prison population grows and available prison bed space reduces, there may be times when an alternative bed is not readily available to move an inmate into. In the event no other appropriate prison beds are available for an immediate transfer, once a bed becomes available, we will prioritize moving inmates out of the psychiatric infirmary ahead of other inmates who may also be waiting for a bed to open.

- **What:** Improve coordination to ensure timely and appropriate discharges of stabilized inmates from the psychiatric infirmary to prevent prolonged isolation.

- **How:**
 1. **Streamline Transfer Protocols:** Review and revise current transfer protocols, clarifying roles and responsibilities and establishing a clear, step-by-step process. Updating any policy and procedure necessary.
 2. **Mandatory Bed Reservation Procedures:** Implement a procedure for prison operations staff working in the psychiatric infirmary staff to place beds on "hold" in regular housing units upon discharge approval.
 3. **Enhanced Communication and Shared Platforms:** Improve communication channels between the psychiatric infirmary, Assignment Office, and regular housing units, potentially utilizing a shared electronic platform.
 4. **Regular Interdepartmental Meetings:** Establish regular meetings between psychiatric infirmary, Assignment Office, and regular housing unit leadership to review pending discharges and address barriers.
 5. **Monitor Transfer Timelines:** Establish metrics and regularly monitor the time taken for transfers from the psychiatric infirmary after a discharge order.
- **Documentation:** Revised transfer protocols, bed reservation procedures, communication platform usage, meeting minutes, transfer timeline data.
- **Assigned Responsible Person:** Chief Aimee Griffiths, Warden Sharon D'Amico, Assistant Chief Nick Bricker
- **Target Date for Completion:** Quarter 2, 2026

Recommendation 2.1: The Department of Corrections should conduct a review of current custody processes including all issues identified in this report and formalize best practices for suicidal inmates in policy. It should then monitor implementation and evaluate its effectiveness. This will help enhance the safety of suicidal inmates.

Department Response: UDC concurs with this recommendation. We acknowledge the need for a comprehensive review of our custody practices for suicidal inmates and the formalization of best practices into policy to proactively mitigate risks.

- **What:** Conduct a comprehensive review of custody practices for suicidal inmates, formalize best practices into policy, and monitor implementation to enhance inmate safety.
- **How:**
 1. **Establish a Custody Practices Review Team:** Form a team to review all current custody processes related to suicidal inmates, incorporating all identified issues.
 2. **Conduct Environmental Hazard Assessments:** The review team will conduct frequent, proactive environmental risk assessments of the USCF psychiatric infirmary and mental health housing units, incorporating the "Environmental Risks for Suicide Assessment Checklist."
 3. **Formalize Standardized Search Procedures:** Develop and formalize policy for standardized, thorough search procedures, including mandatory body scans, for all inmates prior to admission to the psychiatric infirmary.
 4. **Implement Enhanced Management of Dangerous Items:** Review processes for managing UDC-provided items that could be used for self-harm, developing policies for monitoring, accountability, and trash collection.

5. **Develop and Formalize Best Practices Policy:** Based on review findings, develop a comprehensive policy outlining best practices for working with suicidal inmates.
 6. **Continuous Monitoring and Effectiveness Evaluation:** Implement a robust monitoring program to ensure adherence to the new best practices policy and conduct regular evaluations.
- **Documentation:** Review team reports, environmental hazard assessment tool and reports, formalized search procedures policy, dangerous items management policy, best practices policy, monitoring program reports, evaluation reports.
 - **Assigned Responsible Person:** Chief Aimee Griffiths, Assistant Chief Nick Bricker, and Warden Sharon D'Amico
 - **Target Date for Completion:** Quarter 3, 2026

The Utah Department of Corrections is fully committed to implementing these recommendations and improving the safety and care provided to inmates with behavioral health concerns. We look forward to ongoing collaboration with the Office of the Legislative Auditor General and all stakeholders as we work to achieve these critical objectives.

Sincerely,



[Jared Garcia \(Nov 6, 2025 19:11:36 MST\)](#)

Jared Garcia
Executive Director







THE MISSION OF THE LEGISLATIVE AUDITOR GENERAL IS TO

AUDIT · LEAD · ACHIEVE

WE HELP ORGANIZATIONS IMPROVE
