PRISON SUICIDE IN WISCONSIN: BEYOND OBSERVATION

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November 24, 2026

When a person in a Wisconsin prison says they are suicidal, what happens next matters. Immediate protection matters. So do the conversations, treatment, and decisions that follow. This article examines Wisconsin's prison suicide statistics and the system's response to people in crisis, including my own experience. The available evidence supports serious attention both to the deaths and to the care delivered to those who survive.

I do not argue that the Wisconsin Department of Corrections (DOC) makes no attempt to help. It has psychological staff, treatment resources, and written suicide prevention procedures. My concern is whether a person who asks for help receives enough meaningful engagement to work through the crisis, rather than primarily being placed somewhere they can be watched.

The experience behind this examination

I write from personal experience. Between 1991 and my release in September 2019, I was housed in every maximum-security institution in Wisconsin, most of its medium-security institutions, and three minimum-security facilities. I was placed on observation at several of those prisons, including Green Bay Correctional Institution and Columbia Correctional Institution, and in county jails. These were separate experiences across those years, not one continuous placement. County jails are run by sheriffs under their own rules, so the DOC rule and policy discussed below never governed those placements. My account describes what I experienced; it does not establish that every institution or staff member responded the same way.

When I reported being suicidal, I experienced staff responses as dismissive. Before every one of these placements, I was in general population. Yet each time I was placed in an observation cell in a segregation unit, held under segregation status and given segregation treatment, in a cell with a glass front exposed to people passing through the hallway. I understood that I was being watched, but I felt displayed—like a zoo animal—at a time when I needed help.

Psychological staff came by every few days to check on me. Otherwise, my routine contact was with correctional officers delivering meals. Treatment consisted of photocopied materials to read and assignments to complete. Beyond those periodic checks, I received no sustained individual therapeutic engagement, and no one explained to me a clear plan for leaving observation status. No one ever discussed the results of an evaluation with me.

Written materials may be useful as part of treatment. In my experience, however, they did not provide the human engagement I needed. I wanted someone to listen, to discuss what was happening, and to help me understand a path forward. The observation cell made me visible. It did not make me feel heard.

The setting also affected what I was willing to say. On paper, observation is not punishment. But when reporting suicidal thoughts led to a segregation cell with segregation restrictions, it felt like punishment, and that kept me from being honest with staff. Sometimes I did not report my suicidal thoughts at all. Other times, once I was in observation, I told staff I was fine and all good so I could get out. A system that depends on people telling the truth about their own risk has to consider what that truth costs them.

What Wisconsin's numbers show

The federal Bureau of Justice Statistics (BJS) recorded 88 suicide deaths in Wisconsin state prisons from 2001 through 2019. Table 1 shows how the rate changed over that time. These prison figures are kept separate from county jail statistics, which BJS reports on their own.[1]

Table 1. Wisconsin prison suicide deaths and average annual rates, 2001–2019

Period	Wisconsin deaths	Wisconsin rate	U.S. state-prison rate
2001–2004	23	27	15
2005–2009	26	23	16
2010–2014	11	10	16
2015–2019	28	24	22
2001–2019 (all years)	88	21	—

Rates are deaths per 100,000 prisoners, using BJS's year-end custody population. The first period covers four years; the others cover five. BJS publishes rates rounded to whole numbers. The U.S. column covers state prisons only and excludes federal prisons.

From 2010–2014 to 2015–2019, deaths rose from 11 to 28, an increase of about 155 percent, and the rate more than doubled, from 10 to 24. Because the rate rose along with the count, population growth alone cannot explain the increase. The earlier periods also show that the trend was not a steady climb. These are crude rates, unadjusted for differences in who was incarcerated.

In 2015–2019, Wisconsin's rate of 24 exceeded both the national state-prison rate of 22 and the Midwest rate of 18. Neighboring Illinois, Iowa, Michigan, and Minnesota reported 17, 20, 13, and 11. About twenty states had higher rates than Wisconsin, though several of those estimates rest on ten or fewer deaths. Small counts and differences among prison systems limit rankings; BJS flagged the Iowa and Minnesota estimates for the same reason.[2]

These historical findings warrant examination, but they cannot establish where Wisconsin stands today. A current assessment requires comparable annual suicide counts and populations. All-cause prison deaths cannot stand in for suicide deaths, and observation placements cannot be treated as suicide attempts or deaths.

The institution matters, but rankings need care

The Legislative Audit Bureau identified 29 suicide deaths at 15 facilities from fiscal year 2003–04 through fiscal year 2007–08. Its table of locations is a useful starting point for examining differences among institutions.[3]

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[1]E. Ann Carson, Bureau of Just. Stat., U.S. Dep't of Just., NCJ 300731, *Suicide in Local Jails and State and Federal Prisons, 2000–2019—Statistical Tables* 20–21 tbl.10, 22–23 tbl.11 (2021), https://bjs.ojp.gov/sites/bjs/files/media/document/sljsfp0019st.pdf. BJS computes rates by dividing suicides by the December 31 custody population and multiplying by 100,000. *Id.*

[2]Carson, *supra* note 1, at 22–23 tbl.11. BJS flags estimates based on ten or fewer deaths with the instruction to interpret them with caution. *Id.* Some states operate combined jail-and-prison systems, which BJS includes in the prison comparison. The percentage change in deaths is the author's calculation from the published counts; because BJS publishes rates rounded to whole numbers, the rate change is described only approximately.

[3]Wis. Legis. Audit Bureau, Rep. No. 09-4, *An Evaluation: Inmate Mental Health Care, Department of Corrections, Department of Health Services* 68 tbl.37 (2009), https://www.wistatedocuments.org/digital/api/collection/p267601coll4/id/1574/download.

Combining that audit with the state's published average daily populations produces these rates per 100,000 incarcerated person-years: 64.9 at Waupun, 56.0 at Green Bay, 48.9 at Columbia, and 29.6 at Oshkosh. Green Bay and Oshkosh each recorded three deaths, yet their rates differed substantially because their populations differed.[4] Readers should know that two of these facilities, Green Bay and Columbia, are among the prisons where I was placed on observation.

These are descriptive comparisons, not proof of differences in the quality of care. With so few deaths, a single event can sharply change a facility's apparent position. Comparisons should also consider who is housed there, what treatment they need, and whether a death is attributed to the institution where the crisis occurred or to the hospital where the person later died.

The proper use of a higher observed rate is to prompt closer review. It should lead to questions about treatment, housing, and response practices, not to an unsupported declaration that one prison is the worst. A current facility-level analysis is still needed.

Resources and safeguards deserve an honest assessment

For most of my time in prison, observation was governed not only by DOC's internal policy but by a binding administrative rule, chapter DOC 311 of the Wisconsin Administrative Code. The rule took effect June 1, 1998, and remained in the Code until it was removed in November 2024. It described observation as a nonpunitive status. It required staff to observe and record the person's activities at least once every 15 minutes, and it required a clinician, crisis intervention worker, or physician to examine a person in a mental health placement at least every two working days. The person was to be told the findings orally within 24 hours or as soon as possible, and in writing within ten working days.[5]

Two points stand out. First, the examination requirement was a low floor. Because working days exclude weekends and holidays, an examination every two working days could lawfully mean a gap of four calendar days, or more over a holiday weekend. When I say psychological staff came by every few days, that may well have satisfied the rule. My concern is not only whether the rules were followed; it is that the rules asked for too little.

Second, the rule said that conditions, including privileges and property, should be the same “insofar as possible” as those in the status the person came from. It allowed staff to change those conditions for listed reasons, including self-harm risk and that privileges could not be offered because of the secured nature of the observation unit.[6] When observation cells sit inside segregation units, that last exception can swallow the rule: the location itself becomes the reason for segregation's restrictions. That matches my experience. I always came to observation from general population, and I was always held under segregation restrictions. I do not know what reasons, if any, staff recorded for those restrictions. I know only that a status the law called nonpunitive was, for me, extremely punitive.

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[4]Author's calculations using Wis. Legis. Audit Bureau, *supra* note 3, at 68 tbl.37; Wis. Legis. Reference Bureau, *State of Wisconsin Blue Book 2007–2008*, at 825 (2007), https://www.wistatedocuments.org/digital/api/collection/p267601coll4/id/26784/download; and Wis. Legis. Reference Bureau, *State of Wisconsin Blue Book 2009–2010*, at 831 (2009), https://www.wistatedocuments.org/digital/api/collection/p267601coll4/id/28734/download. Deaths were divided by the sum of each facility's annual average daily populations for fiscal years 2004 through 2008 and multiplied by 100,000. Denominators: Waupun 6,161; Green Bay 5,359; Columbia 4,091; Oshkosh 10,142. Each facility recorded only two to four deaths.

[5]Wis. Admin. Code DOC §§ 311.01, 311.05(3)–(4), 311.15(2) (Register Dec. 2014 No. 708) (removed by Register Nov. 2024 No. 827), https://docs.legis.wisconsin.gov/code/register/2024/827B/remove/doc311. The chapter in this form was created by Register May 1998 No. 509, effective June 1, 1998.

[6]*Id.* § 311.14(1).

DOC's own clinical observation policy has existed in some form since May 2007; the current version took effect July 13, 2021. It is more demanding than the old rule in some respects. It requires an initial evaluation by Psychological Services Unit (PSU) staff, later PSU evaluations at least every working day, close-observation checks at staggered intervals of no more than 15 minutes, and constant line-of-sight observation for people at high risk of imminent suicidal behavior. It also requires staff to tell the person the results of the initial evaluation and to interview the person the day after release from observation, with a second follow-up within seven days, subject to stated exceptions.[7]

Those provisions recognize a need for clinical involvement. They do not, however, require several psychological visits a day or private counseling sessions. Because "working day" excludes weekends and legal holidays, the policy's minimum still does not require a PSU evaluation on those days.[8] Nor does a documented evaluation establish the substance or length of a therapeutic conversation. I was in prison from before 2007 until September 2019, so the administrative rule and earlier versions of this policy governed some of my placements. A policy is only as meaningful as its follow-through. I cannot establish from memory whether every requirement was met in every placement. I can say that no one ever discussed evaluation results with me, although the rule required that the findings be shared orally and in writing. But the rule's own text shows that even full compliance could leave a person in segregation conditions, examined every few days, with little else.

A fair assessment must ask both whether required safeguards occur and whether the care is adequate for the person's needs. Staff contact, clinical evaluation, counseling, and treatment planning should be described precisely. Counting encounters without examining their content leaves an important part of the response unexamined.

An independent review raises related concerns

In October 2025, Falcon, Inc., a consultant DOC hired to review its adult prisons, reported that access to mental health care can be hindered by limited space, a lack of escorts for movement, and caseloads assigned by housing unit rather than clinical need. It counted approximately 2,500 observation placements in 2024, compared with a reported 1,200 to 1,500 a year previously; these are placements, not unique people or deaths. It also reported that people on observation status are not allowed therapeutic items, visits, phone calls, or recreation.[9]

Falcon recommended removing clinical observation placements from restrictive housing units and tailoring conditions and interventions to each individual. It cautioned that a watch-and-wait approach can produce isolation and shame that reduce engagement in treatment, and that restrictive responses can "exacerbate, rather than reduce suicide risk."[10] These findings give institutional context to concerns like mine, though they do not independently verify my individual experiences.

DOC reports that it signed a second contract with Falcon in February 2026 to continue implementation work at six facilities. Its stated objectives include improving the standards of observation placements, developing alternatives to restrictive housing for people with serious mental illness, and revising mental health

[7]Wis. Dep't of Corr., Div. of Adult Insts., Policy No. 500.70.24, *Clinical Observation* 1–4, 6 (eff. July 13, 2021) (original effective date May 1, 2007; superseding version of Apr. 20, 2018), https://doc.wi.gov/DepartmentPoliciesDAI/5007024.pdf.

[8]*Id.* at 2–3 (defining "working day" to exclude Saturdays, Sundays, and legal holidays, and requiring subsequent PSU evaluations at a minimum of every working day).

[9]Falcon, Inc., *Comprehensive Study of the Division of Adult Institutions Correctional, Mental Health, and Medical Practices with a Focus on Restrictive Housing* 82–84, 92 (2025), https://doc.wi.gov/Documents/AboutDOC/WIDOCFalconReport2025.pdf.

[10]*Id.* at 83.

classification codes. DOC reports that revised mental health designations have been approved, with implementation planned for early 2027, and that out-of-cell time in restrictive housing has increased at the participating sites.[11] These efforts deserve acknowledgment, and their results deserve evaluation.

A working explanation rather than a proven cause

The evidence supports investigating a mismatch between clinical need and the delivery of timely, sustained care. My working theory is that barriers to treatment, combined with observation conditions experienced as isolating or humiliating, may leave some people inadequately supported during a crisis. It is an explanation to test, not a demonstrated cause of the historical increase.

My account also raises a question about trust. In my case, the fact that observation looked and felt like segregation discouraged honest disclosure in both directions: it kept me from reporting suicidal thoughts, and it pushed me to say I was fine before I was. Falcon's caution about shame and disengagement suggests I may not be alone. If others respond the same way, segregation-style observation could hide the very risk it exists to detect, both by keeping people from asking for help and by moving them out of observation on the strength of statements made to escape it. How often that happens is a question for confidential interviews and records; my experience cannot measure it across the system.

Other explanations must be examined, including changes in prisoner characteristics, reporting and classification practices, clusters at particular institutions, and the natural fluctuation of small numbers. Falcon's 2025 findings cannot retrospectively prove what caused deaths years earlier. Responsible advocacy requires keeping that distinction intact.

What meaningful improvement should include

Observation should be housed outside segregation and should not carry segregation's restrictions unless a specific safety reason requires a particular restriction, consistent with Falcon's recommendation. I also advocate several psychological check-ins a day during an acute suicidal crisis, including weekends, with contact adjusted to clinical need, and meaningful one-on-one counseling in a setting that permits candid conversation while maintaining safety. This is my proposed improvement, not a claim that any universal clinical rule requires a particular number of visits.

People should receive a clear explanation of why observation is necessary, what treatment is being offered, how their condition is being assessed, and what will guide the next decision. A person should be able to understand and take part in the plan. Written assignments can support those conversations; they should not become the main substitute for them.

Dignity should be part of the design of care. The visibility needed for immediate safety should be reconciled with privacy and a therapeutic environment. Staff should take reports of suicidal thoughts seriously, explain their response respectfully, and avoid treating a request for help as a nuisance. Psychological staff and correctional officers both need the time, training, and resources to carry out their roles.

Wisconsin should also publish consistent annual suicide data by institution, with matching populations and clear definitions. Today, DOC does not publicly announce deaths in custody. Its mortality review committee counted 55 deaths in 2023, while DOC's public dashboard showed 54, and the department groups suicides with homicides and unexpected illness under the label “unanticipated.”[12] Reporting should state suicides separately and explain how hospital deaths, transfers, and later changes in classification are counted. Death reviews

[11]Wis. Dep't of Corr., *Falcon Initiative*, https://doc.wi.gov/Pages/AboutDOC/Falcon.aspx (last visited Nov. 24, 2026).

[12]Vanessa Swales, *What We Know About the 55 People Who Died Inside Wisconsin Prisons Last Year*, Milwaukee J. Sentinel (Apr. 23, 2024), https://www.yahoo.com/news/know-55-people-died-inside-110104690.html.

should produce public summaries of corrective action while protecting private medical information. Progress should be measured by treatment access, follow-up, and outcomes, not by announcements alone.

Beyond observation

The available evidence does not prove that Wisconsin's prisons are the nation's worst, or that every suicide could have been prevented. It does establish enough to justify a serious examination of how the system responds to people in crisis. That examination must include both the resources DOC provides and the barriers and conditions that may limit their benefit.

I survived those observation placements. What I remember is needing human engagement and receiving too little of it. My experience belongs alongside the statistics, with its limits stated honestly. Wisconsin should ask whether its response gives people the treatment, dignity, and understanding they need to move through a crisis. Keeping someone under observation should begin that work, not stand in for it.

If you or someone you love is in crisis, call or text 988 to reach the 988 Suicide & Crisis Lifeline. If you have a loved one in a Wisconsin prison who you believe is at risk, contact the institution right away and ask for the Psychological Services Unit.

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