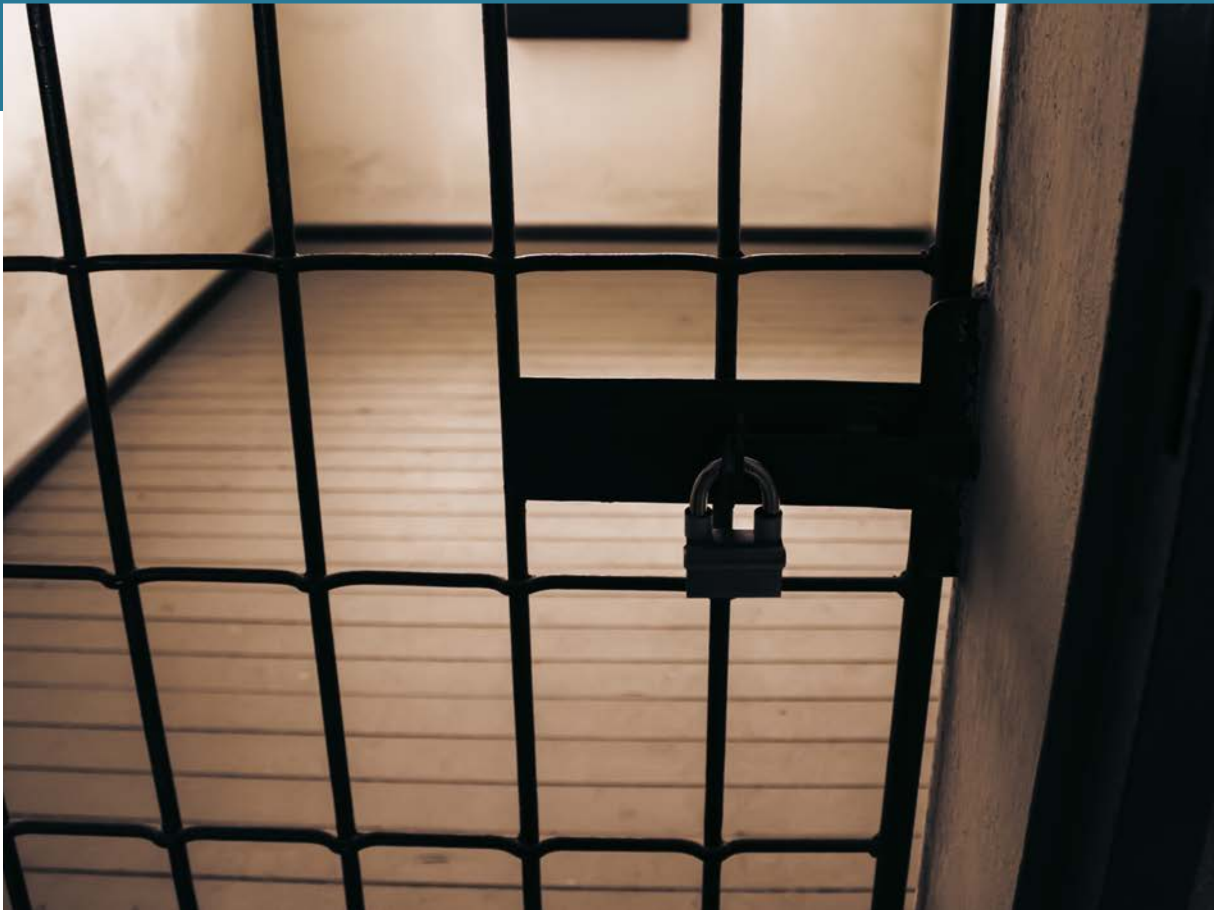
SUICIDE IN NORTH CAROLINA JAILS

SUICIDE RATES REACH RECORD HIGHS IN NC JAILS AS SHERIFFS BLOCK REFORM



DISABILITY RIGHTS NORTH CAROLINA
2019 JAIL SUICIDE REPORT

INTRODUCTION TO THE REPORT

As suicides and other deaths in North Carolina jails continue to rise, the need for suicide prevention programs, routine mental health care, adequate screening and inmate observation remains dire. The NC Department of Health and Human Services (DHHS) recently approved updates to the now decades-old Jail Rules that could significantly reduce the number of suicide and overdose deaths in NC jails. The Sheriff's Association, however, has used an administrative mechanism to delay the implementation of these updates. The Rule updates are now in limbo, while pending action from the state legislature could cancel the DHHS-approved Rules and allow deadly jail conditions to continue harming North Carolinians.

Disability Rights North Carolina (DRNC), the Protection and Advocacy (P&A) agency dedicated to advancing the legal rights of all people with disabilities statewide, asserts that steps must be taken to prevent or reduce these avoidable jail deaths. On any given day there are over 18,000 individuals in jails across the state. Many are disabled, and most are awaiting their day in court. They are endangered by unsafe conditions and lack of health care for mental health disabilities and substance use disorders. Statistically, upon entering the jail, a person becomes twenty-five times more likely to die by suicide.

DRNC'S RESPONSE

SHERIFF'S DEPARTMENTS MUST NOT BE ALLOWED TO CONTINUE OPERATING UNSAFE JAILS UNDER OUTDATED RULES

Too many people with disabilities land in our jails. The Bureau of Justice Statistics reports that people behind bars in jails are four times more likely to report having a disability than the general population. Once in jail, without adequate screening and treatment, too many are dying. Disability Rights North Carolina (DRNC) has called for urgent responses by our jails to implement nationally recognized best practices. Our current Jail Rules are 30 years old and must be brought into the 21st century. NC DHHS has worked with stakeholders to create updates to the current Jail Rules that will improve dangerous conditions and implement programs to prevent suicides and other unnecessary deaths in NC jails. After years of review from multiple experts, these Rules were approved by NC DHHS, the Attorney General, and the Governor in 2019. However, because of objections from the Sheriff's Association, the updated Jail Rules are delayed and in jeopardy of being blocked.

Sheriff's Departments must not be allowed to continue operating unsafe jails under outdated Rules. Climbing death rates have illustrated that Sheriffs are unlikely to improve conditions in NC jails without the new requirements for humane treatment contained in the updated Jail Rules. Multiple Sheriff's Departments throughout the state have repeatedly failed to follow even the decades-old current Rules, and new state-wide regulations are necessary to ensure a minimum standard of care for people in NC jails.

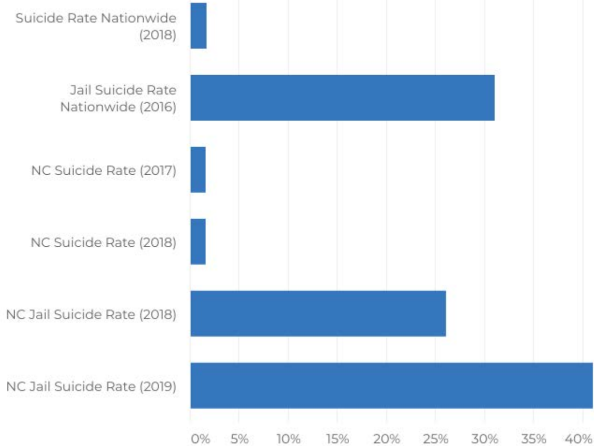
The updated Jail Rules require common-sense protections to ensure that people in NC jails are treated humanely. They include new requirements such as a suicide prevention program, routine medical care for people with disabilities, and increased protections against overcrowding. The fact that nearly two-thirds of suicide death investigations found that jail staff had not violated any of the current Jail Rules speaks to the inadequacy of those Rules to prevent suicides and other jail deaths.

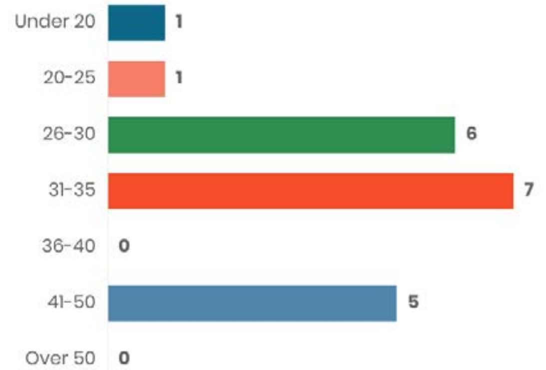
The updated Jail Rules will make jails safer for everyone – our communities, people in the jails, and those who operate and fund them. Years of death, mistreatment, failed inspections, and civil litigation have shown that the current Rules fall far short of creating safe conditions. The growing number of large monetary settlements stemming from civil lawsuits for wrongful deaths in NC jails shows that counties will face financial penalties for operating unsafe jails. We ask that counties proactively invest in the updates necessary to create safe jail environments, instead of retroactively paying a settlement when a preventable death occurs. Implementation of updated statewide Rules is the only way to bring all NC jails into compliance with everyone's goal of decency and safety.

DATA UPDATES 2019

SUICIDE AND DEATH RATES REACH NEW HEIGHTS

In 2019, more North Carolinians died by suicide in jail than in any year since 2013, when Disability Rights North Carolina (DRNC) began keeping data. Death rates in NC jails remain staggeringly high, and while the total deaths increased by 6% (from 46 to 49) between 2018 and 2019, jail suicides increased by 67% (from 12 to 20). In 2019, 41% of all jail deaths were deaths by suicide. This is far above the 2016 average national jail suicide rate of 31%.



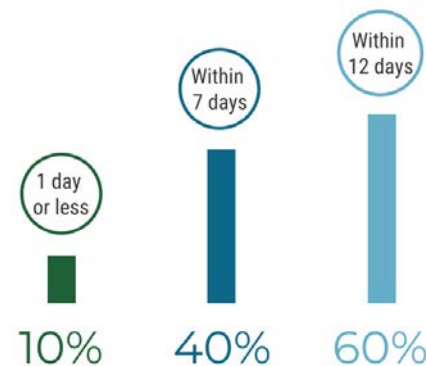


In 2019, the 20 suicide victims in NC jails were young, mostly between the ages of 26 and 35.

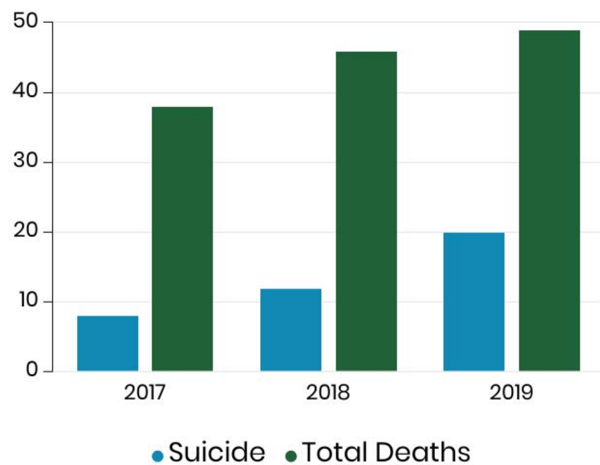
Well over half of suicide deaths happened within 12 days of arrest and incarceration; however, only 10% of suicide deaths occurred within 24 hours of the incarceration.

This indicates that a proper screening process and well-implemented suicide prevention program would have time to be effective and save lives before most suicides occur.

Average Time Incarcerated Before Suicide



2019 Percentage of all Suicides in NC Jails

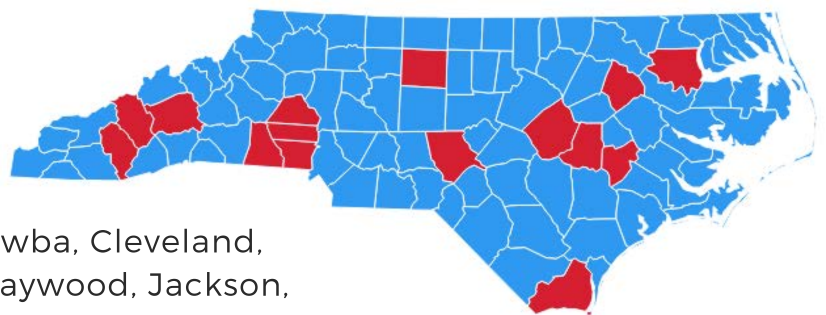


All but one of the twenty people who died by suicide in NC jails in 2019 **had not yet had their day in court.** All died from hanging, usually tying a bedsheet to a piece of furniture or wall fixture in their cells.

The Division of Health Service Regulation (DHSR), the NC DHHS division responsible for inspecting the jails to ensure compliance with the current Jail Rules, has completed death investigations for 19 of the 20 suicides that occurred in 2019. Thirty-six percent of those investigations found jail staff had not complied with current Jail Rules around the time of the person's death. Every instance of non-compliance related to a jail death involved staff failing to perform adequate supervision checks.

Had North Carolina Sheriffs not opposed the updated Jail Rules, they would have gone into effect on May 1, 2019. Since that date, at least 40 people have died in NC jails.

COUNTIES WHERE SUICIDES OCCURRED IN 2019



Bertie, Brunswick (2), Buncombe, Catawba, Cleveland, Edgecombe (2), Gaston (2), Guilford, Haywood, Jackson, Johnston, Lenoir, Lincoln (2), Moore, Wayne, Wilson

THE HUMAN COST OF INADEQUATE CARE

These accounts are of people who died by suicide or overdose while incarcerated in NC jails. They are representative of many similar stories that illustrate the widespread problems in jail policies and practices that unnecessarily put lives in danger and increase risk and liability for counties.

M.R.

MR, mother of three and grandmother, died by suicide in the Jackson County Detention Facility bond/attorney room in January 2019. MR was placed in booking earlier that day, and moved to the bond/attorney room to be served her charges by the magistrate. According to a lawsuit filed by MR's family, officers failed to place her on suicide watch despite the fact that she had attempted to light herself on fire in the back of a squad car while being driven to the detention center. After she was served her paperwork, MR was left alone in the bond/attorney room. Shortly thereafter, at 6:17pm, she began the 10 minute long process of committing suicide by wrapping a telephone cord around her neck. Her actions were caught by a camera inside the cell, which was being fed to a monitor located directly in front of the officer working the control room. Despite the camera coverage, no one noticed MR wrap the phone cord around her neck. During the hour MR was in the bond/attorney room, jail staff performed no supervision rounds. During a DHSR investigation, the detention officer working the booking area stated that "no one ever told [the officer] to make the rounds, and [the officer] never really thought about it because we can see them on the camera." While no official supervision rounds were recorded, a DHSR review of camera footage from outside the cell notes that an officer walked by the cell three times while MR was lying on the floor not moving. At no point did officers look into the cell. Fifty minutes after video footage shows MR first put the telephone cord around her neck, an officer entered the room at 7:07 pm and found her body. DHSR's investigation report includes statements from officers that MR was last checked at "6:30-6:45" and was "observed sitting on the table at 6:21". Video evidence shows MR began to hang herself with the phone cord at 6:17. At 6:21, her feet can be seen on the floor of the room. At 6:27, all movement stops. DHSR released a report on January 23, 2019 finding that the Sheriff was not in compliance with current Jail Rules.

C.M.

CM, age 35, was found hanging in the Wilson County Jail shower in September 2019. A DHSR investigation found that the jail failed to put CM on special watch (observation 4 times per hour) based on his positive answer to a mental health question during screening. The Sheriff responded that, despite CM's answer to that question and the clear rule requiring special watch, CM was not placed on special watch as the jail could not "confirm" his mental health history through records or prescription inquiries. Despite requirements to check on all people in jail twice every hour, CM had not been checked on for over an hour when he was found hanging, although staff statements about the time are inconsistent with jail paperwork. Further, the DHSR investigation found that jail staff had missed 80% of their observation rounds in the two days leading up to CM's death (81 of 101 rounds missed).

B.M.

BM died of complications from Percocet withdrawal at Vance County Detention Center in February 2019. A DHSR investigation found that "times between numerous rounds were excessive," and multiple missed supervision rounds around the time BM was found unresponsive. Another inmate found BM, and had to run to cell block door and bang on the door to get officers' attention as there was no way to contact officers from BM's block. The two-way communication system in BM's cell block had not worked for several months and the facility was "not utilizing direct supervision of inmates," so there were no officers stationed inside the housing areas. BM's autopsy stated that the intake screening had flagged BM as being in opioid withdrawal, but he was given no medication or care beyond some ibuprofen and drugs for nausea. The autopsy states that "shortly after incarceration he became sick, not eating, with nausea, vomiting, and diarrhea, and spent a large amount of time in the bathroom. On the morning of death, just slightly over 3-1/2 days after incarceration, he could not walk to get his breakfast tray, and it was brought to him. He attempted to return to his cell, but a video showed that he could not stand on his own and propped himself up against a wall. He was in his cell with his roommate who discovered him unresponsive." The autopsy states it was likely BM could not take his medications the morning of his death, and concludes that the cause of BM's death was "complications of opioid withdrawal ."

J.M.

JM, age 45, was found hanging in his Edgecombe County Detention Center cell in October 2019. Despite requirements that every person in jail be checked on twice every hour, no one had checked on JM for over two hours when a guard went to retrieve him for a visit and found him hanging. Investigating how many rounds were performed in days leading up to JM's hanging, a DHSR death investigation found that staff failed to perform half of the required checks in the days leading up to JM's death. A jail lieutenant acknowledged that officers were not actually making rounds and that officers were doing other activities. Medical records indicate that JM had been prescribed active medication assisted treatment but he did not receive that treatment for the month he was incarcerated prior to his death. Medical reports state that JM was not screened when entering the facility, but was "seen by medical." The DHSR investigation discovered that the day before JM's suicide, he was visited by a medical provider who described him as "paranoid, hearing voices, dishevelled with dirty clothes . . . refusing to bathe . . . thinks that staff and inmated are putting chemicals in vents and putting poison in food." JM was refusing medication, and the interviewer recommended hospitalization if this continued. The interviewer further recommended that JM be put in the "least isolated setting possible." After this interview, JM was returned to his segregation cell, where he was found hanging the next day after jail staff failed to check on him for over two hours .

Disability Rights North Carolina, a 501(c)(3) non-profit organization, is North Carolina's protection and advocacy system, mandated to advance the rights of people with disabilities state-wide. DRNC receives funding from the U.S. Department of Health and Human Services, Department of Education, Social Security Administration and other sources.