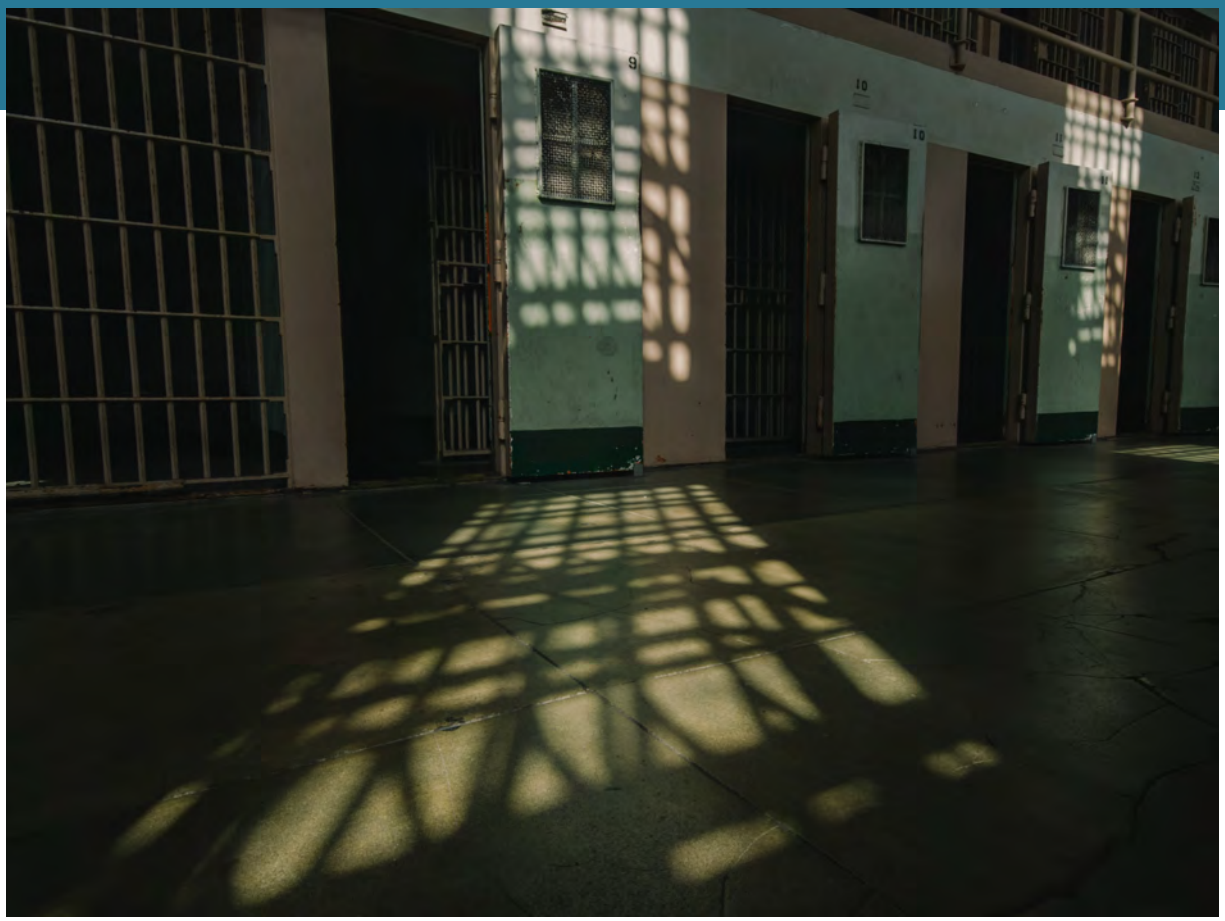
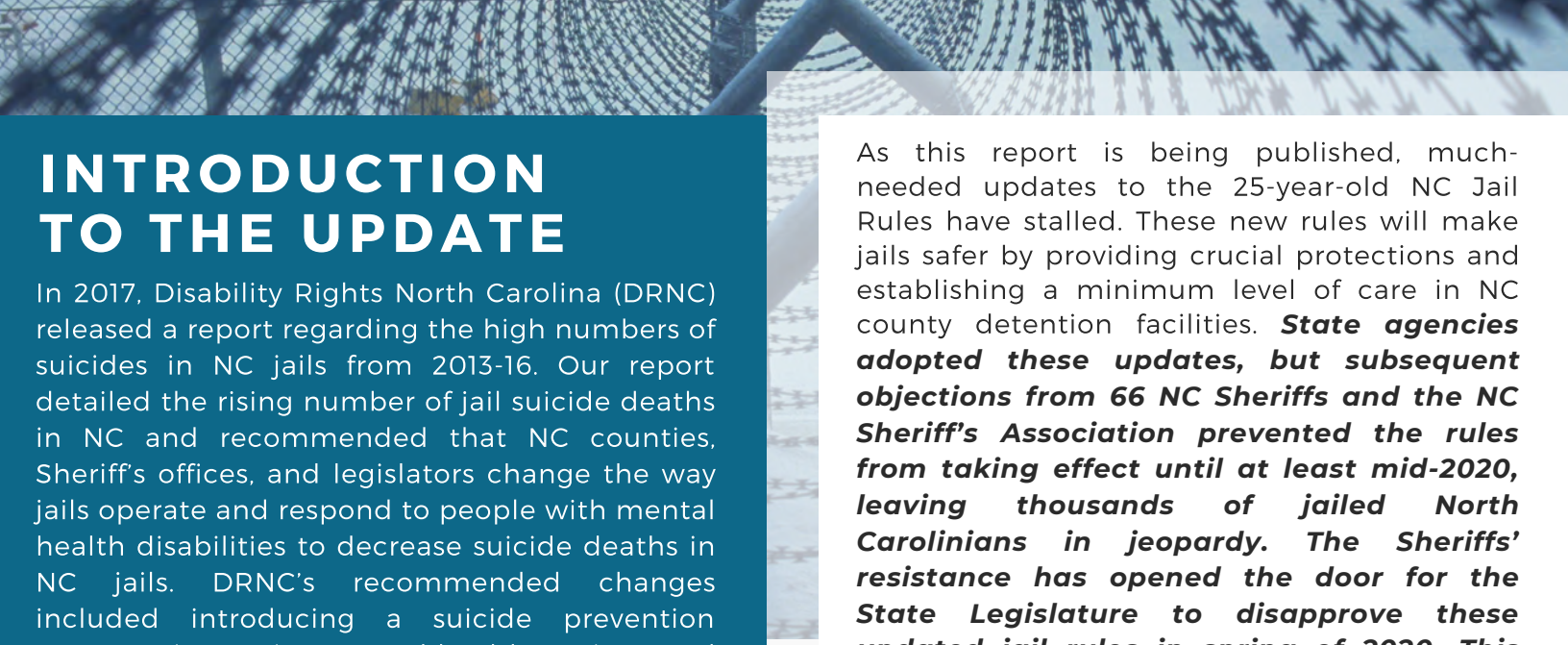
SUICIDE IN NORTH CAROLINA JAILS

HIGH SUICIDE AND OVERDOSE RATES REQUIRE URGENT JAIL REFORM ACTION



UPDATE TO DRNC'S
2013-2016 STUDY REPORT

Disability Rights North Carolina



INTRODUCTION TO THE UPDATE

In 2017, Disability Rights North Carolina (DRNC) released a report regarding the high numbers of suicides in NC jails from 2013-16. Our report detailed the rising number of jail suicide deaths in NC and recommended that NC counties, Sheriff's offices, and legislators change the way jails operate and respond to people with mental health disabilities to decrease suicide deaths in NC jails. DRNC's recommended changes included introducing a suicide prevention program, increasing mental health services, and improving screening for suicide risk. This update to our report provides the latest jail suicide information from 2017-18 and summarizes statistics on the increasing number of overdose deaths in NC jails. As the data shows, suicide levels in NC jails have not improved since DRNC's earlier report, and total jail deaths and overdoses continue to rise at an alarming rate. State agencies have not yet put any of our previous report's recommendations into effect, and an increasing number of North Carolinians continue to die in jail from preventable causes.

RECOMMENDATIONS

Disability Rights NC again recommends the adoption of active suicide prevention programs in all NC jails and detention facilities, as we did in 2017. We further recommend robust implementation of specific jail rules to improve intake screening and update policies regarding observational rounds.

Being arrested and jailed in North Carolina carries with it an unacceptably high risk of death or serious injury. Since our 2017 report, the number of jail suicides has not decreased and the number of jail overdoses has risen drastically. Since 2013, jail deaths are at an all-time high. The continuing rash of deaths and related lawsuits demonstrate the urgent need for changes to protect our jailed NC residents.

As this report is being published, much-needed updates to the 25-year-old NC Jail Rules have stalled. These new rules will make jails safer by providing crucial protections and establishing a minimum level of care in NC county detention facilities. ***State agencies adopted these updates, but subsequent objections from 66 NC Sheriffs and the NC Sheriff's Association prevented the rules from taking effect until at least mid-2020, leaving thousands of jailed North Carolinians in jeopardy. The Sheriffs' resistance has opened the door for the State Legislature to disapprove these updated jail rules in spring of 2020. This legislative intervention must not occur.***

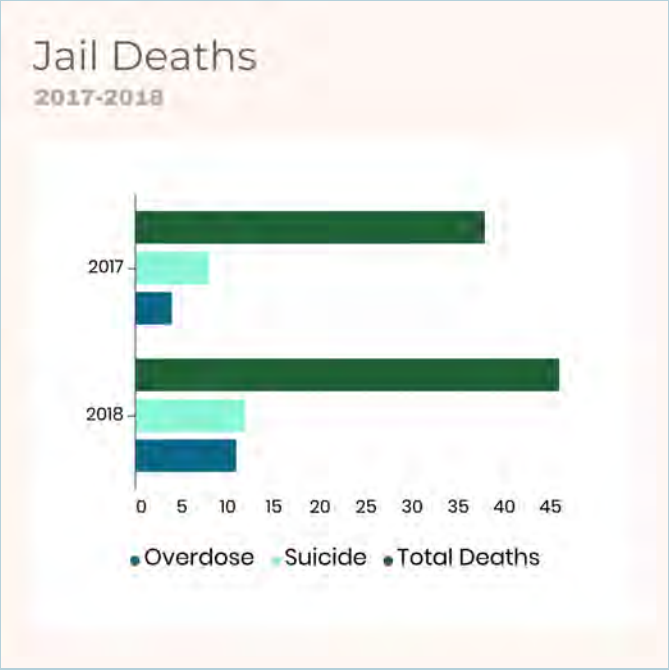
A number of local law enforcement agencies have recognized the dire need for mental health and substance use disorder services in local detention centers. Some county and state officials have made efforts to improve mental health services in their jails, including implementing Stepping Up programs, creating behavioral health units, and instituting pilot programs for providing substance use treatment in jails. These programs highlight the need for statewide action to improve mental health and substance use disorder treatment in NC jails, and illustrate that such programs can be affordably and effectively implemented.

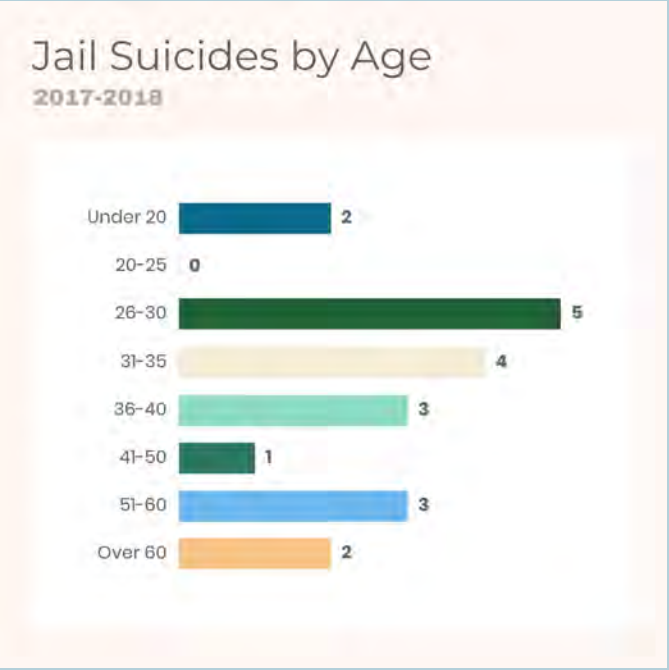
North Carolina cannot ignore the increasing number of residents suffering and dying in its jails. Any perceived savings from allowing the current lethal conditions to continue will likely be exhausted by future legal fees and penalties resulting from unnecessary in-custody deaths. Most of the fathers, mothers, sons and daughters of our NC communities dying in NC jails have not yet had their day in court. Many were allowed to suffer horrific deaths that could have been avoided had they been provided a minor amount of attention and care. Each death by suicide or overdose in a North Carolina jail represents a failure of the government to protect its residents. Action is needed to prevent future failures.

UPDATES FOR 2017-2018
SUICIDE RATES REMAIN HIGH

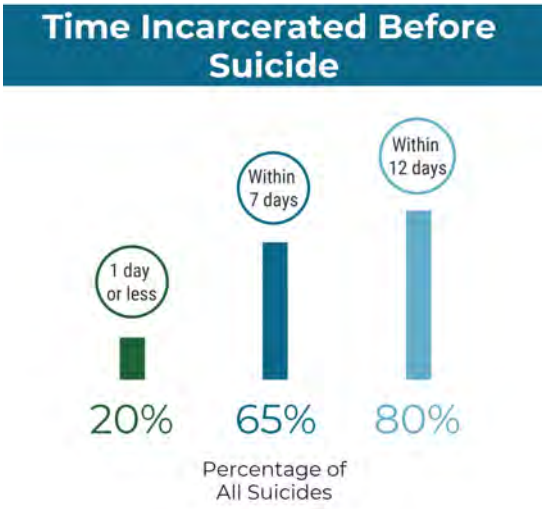
Although the total number of jail suicides decreased from 2016 to 2017 (from 12 to 8), they rose back to 2016 levels in 2018 (12). The percentage of suicides making up total jail deaths has only decreased because of the dramatic increase in overall jail deaths: 38 in 2017 and 46 in 2018, an increase of 77% from 2016 to 2018.

Seventy percent of the suicide victims in 2017-18 were 40 years of age or younger. The overwhelming majority of jail suicide victims (95%) had not been convicted and were being held in jail due to arrest or awaiting trial.





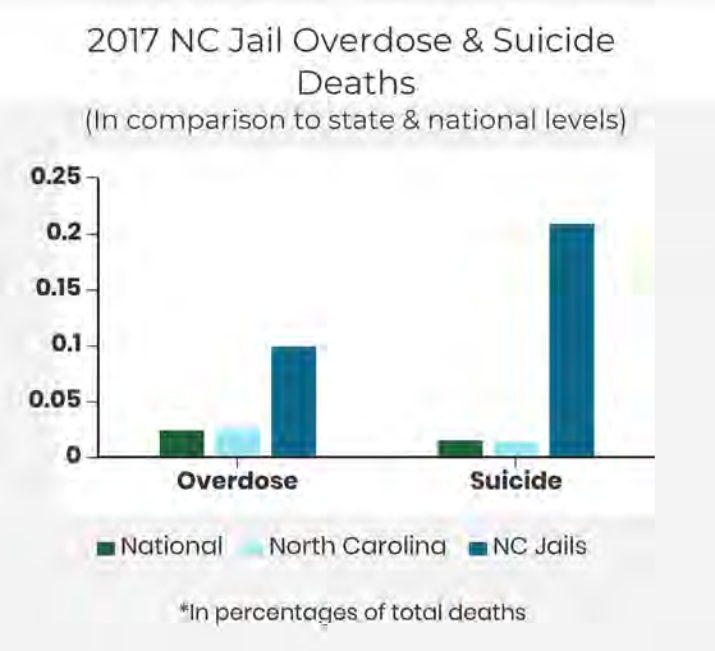
Most of the suicides in 2017-2018 occurred within a few days of admission to the jail. In 2017 and 2018, 20% of all jail suicides occurred within one day of the person entering the jail, 65% occurred within a week of entry, and 80% within 12 days. [1]

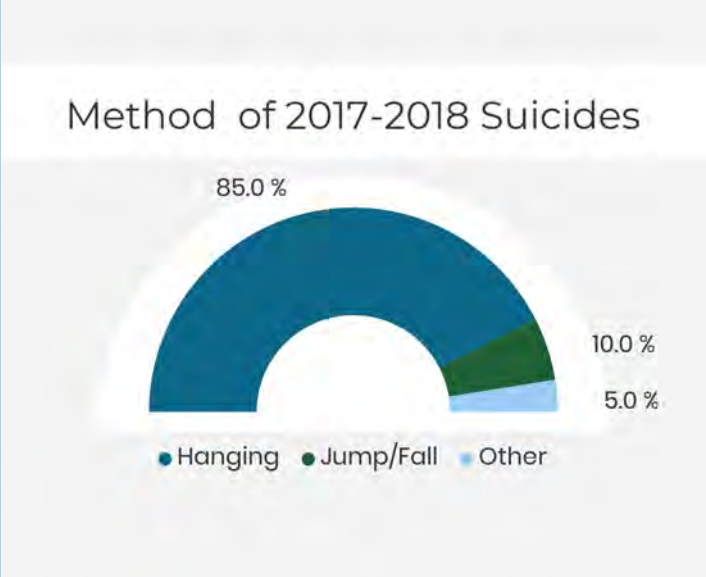


[1] These lengths are calculated from date of the person's entry into jail to the date the person suffered the injury that caused their death (e.g. the date of hanging or the date the fatal dose of drugs was ingested). These numbers do not include time spent in the hospital after the fatal injury but prior to death.

Jail suicide rates in North Carolina have far outpaced suicide rates among the NC and national populations. A resident incarcerated in an NC jail is fifteen times more likely to die from suicide than a free resident. Jail suicides in 2017-18 accounted for 24% of all jail deaths, while in the NC and nationwide populations, suicides accounted for 1.6% of total deaths in 2016 and 2017.

Of the 20 jail suicide victims in 2017-18, 85% died by hanging, 10% died from falls, and 5% suffered other causes of self-inflicted death. [2] Nine people hung themselves using a fixture or other permanent jail structure in 2017-2018. Many other deaths occurred when people hung themselves from furniture in their cells.





DRNC has received Division of Health Services Regulation (DHSR) investigation reports on all 20 2017-18 jail suicides. Nearly half of the suicide death investigations (45%) found that the jail was not in compliance with Department of Health and Human Services (DHHS) regulations regarding jail safety. Every DHSR suicide investigation that found jails had failed to comply with jail rules also found that jail staff had failed to follow proper procedures regarding the frequency and adequacy of observation rounds to ensure jail safety.

JAIL SUICIDES TO DATE IN 2019

As of October 2019, 17 of the 35 (49%) jail deaths known to DRNC this calendar year were reported as suicides. Seven of the people who died by suicide had been in the jail seven days or less. The suicide victims ranged from 20 to 49 years of age, with most in their 20s or 30s. None of the victims had been found guilty of the charges keeping them in jail. They were housed in detention facilities in fourteen different counties. Brunswick, Gaston, and Lincoln Counties have each had two deaths by suicide thus far in 2019.

Had NC Sheriffs not opposed the updates to the jail rules, the rules would have gone into effect on May 1, 2019. Twenty-one people have died in NC jails since May 1, 2019. Nine of those deaths were suicides.

[2] This 5% results from a man who committed suicide by swallowing a large amount of toilet paper while in solitary confinement.

OVERDOSES ON THE RISE

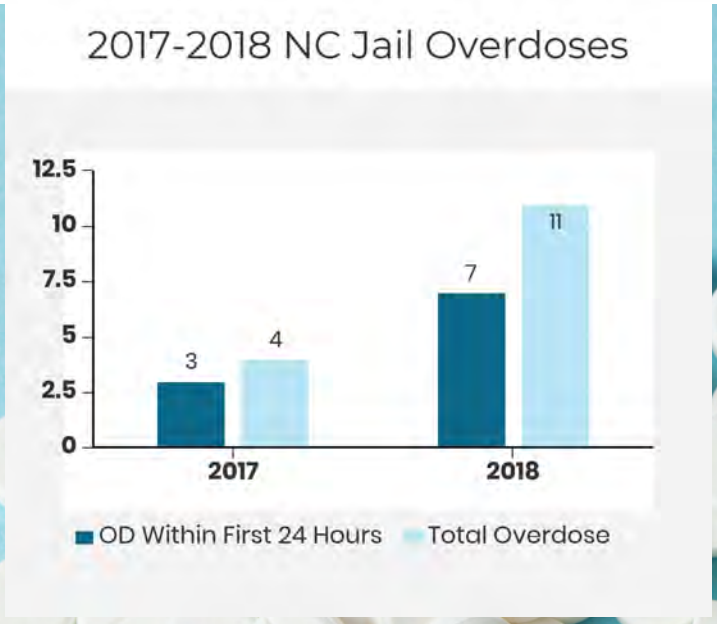
Jail deaths by overdose nearly tripled between 2017 and 2018, increasing by 175%. Overdoses are often preventable, and usually occur due to screening failures when people are first admitted into the jail. In many cases, jail staff failed to notice obvious signs of impending overdose and the person died without receiving proper medical attention. In some cases, jail staff ignored warning signs that included reports of ingesting large amounts of drugs. In 2017, there were four people who died of overdose, 3 of whom had been in the jail for 24 hours or less. In 2018, overdose deaths jumped to 11, with 7 of those people in jail for 24 hours or less. Jail overdoses in 2017 represented 10.5% of total jail deaths, far outpacing 2016-2017 overdoses on a national and statewide level, which averaged around 2.4% of total deaths. In 2018, overdoses accounted for roughly 24% of all NC jail deaths.

COUNTIES WHERE SUICIDES OCCURED 2017-2018

Alexander, Burke, Caldwell, Carteret, Cleveland, Columbus, Durham, Edgecombe (x2), Forsyth, Harnett, Mecklenburg (x3), Montgomery, Surry, Wake (x2), Watauga, Yadkin

COUNTIES WHERE OVERDOSES OCCURED 2017-2018

Buncombe (x2), Cabarrus, Cherokee, Cumberland, Davidson, Durham, Granville, Mecklenburg (x2), New Hanover, Surry, Swain, Union, Yadkin



SUICIDE AND OVERDOSE NARRATIVES
THE HUMAN COST OF INADEQUATE CARE

These stories of people who died by suicide or overdose while incarcerated in NC jails were chosen from many similar stories to illustrate widespread issues in jail policies and practices that unnecessarily put lives in danger and increase risk and liability for NC counties.

M.S., Mother of Six, Drug Overdosing Symptoms Ignored

M.S. died from a methamphetamine overdose shortly after being placed in the Buncombe County Detention Facility. M.S. repeatedly told jail staff, including officers and the nurse on duty, that she had ingested a large amount of methamphetamine in an effort to hide the drugs from her parole officer. Her behavior was erratic and she showed signs of overheating. Despite M.S. being clearly on the brink of an overdose, **jail staff refused to get her adequate medical care, instead locking her into a cell alone where she eventually fell unconscious**. M.S. was declared dead from an overdose at a local hospital a few hours later. An investigation into her death found that jail staff failed to put her on elevated observation.

S.N., Father & Grandfather, Observation Failure

S.N. died of suicide in 2018 while being held pre-trial in the Edgecombe County Detention Center. S.N. had attempted suicide that same day in the jail by beating his own chest in an attempt to have his pacemaker malfunction. **Jail staff strapped S.N. to a restraint chair and drugged him to keep him from harming himself.** Despite this earlier attempt, S.N. was not placed on special watch precautions that would have required the jail to observe him four times per hour to ensure he was not harming himself. Instead, S.N. remained on the standard observation schedule of two times per hour, and was found hanging from a ceiling vent just hours after his first suicide attempt.

D.K., Father of Two, Observation Failure

D.K. died by suicide in early 2019 at age 26 in the Brunswick County Detention Center. Despite indicating that he had suicidal ideations, D.K. was not on elevated observation standards of four checks per hour and was placed in a cell by himself. An investigation into D.K.'s death revealed that **jail staff marked his cell as checked without actually looking into D.K.'s cell as required by jail policy.** As D.K. attempted and, eventually, succeeded in committing suicide over a period of nearly 20 minutes, jail staff failed to make the required observation rounds and did not notice D.K.'s strange behavior, despite the camera in his cell that clearly showed D.K. making repeated attempts to harm himself. D.K. hung himself by opening his cell door and hanging himself from a bedsheet wedged between the top of the door and the doorframe.

A.C., Wife and Mother of Two, Medication Ignored

A.C. had been diagnosed with serious mental illness before entering the Wake County Detention Center on a charge of driving while impaired, and was on medication to help with her condition. After she was arrested, A.C.'s husband notified the jail of her mental health issues, and implored jail staff to give A.C. her prescribed medications that he brought to the jail. Jail staff refused to administer the medications, and over the next few weeks A.C. repeatedly complained to her husband about not receiving her proper medications. Despite her previous history of mental illness, **A.C. was not placed on elevated observation status**, and died by suicide after a month in Wake County Detention Center. An investigation into her death found that jail staff had failed to adequately observe A.C. twice every hour as required by jail policy.

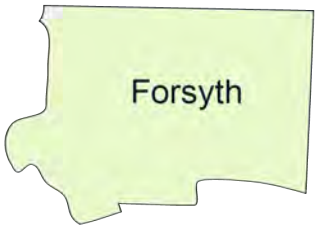
INCREASING SCRUTINY AND MOUNTING LAWSUITS

A number of settlements have been reached in civil suits that resulted from jail deaths.

Damages of **$650,000** to the estate of a 17-year-old to settle a lawsuit regarding her death by suicide in the Durham County Detention Facility. Durham also agreed to make significant changes to their jail facilities and policies as part of the suit, which was brought after an investigation found that jail staff were not compliant with required observation standards.

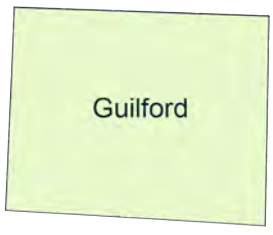
The Board of Commissioners approved an **$180,000** settlement with the estate of a person who died in the Forsyth County Detention Center due to lack of required medical care in 2013, and is still litigating a case stemming from a 2014 jail death.

The estates of two people who died in the jail brought separate lawsuits against the jail's healthcare provider, claiming that their deaths were caused by lack of adequate medical care.



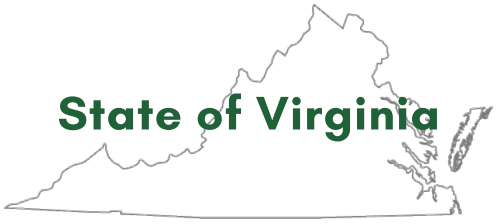
A lawsuit was filed seeking over **$25,000** in damages related to M.S.'s overdose death in Buncombe County Detention Center. Attorneys for the victim's family believe damages could be as high as $3 million.

Reached a **$105,000** settlement regarding the suicide death of a woman in Wilkes County Jail in 2012.



Settled a lawsuit related to a 2010 jail death in Guilford County Jail for **$475,000**, and settled another for an unspecified amount.

Awards to plaintiffs and settlements have been even higher in similar cases in other states.



State of Virginia

In 2019, a Virginia jail, the state, and the jail's former medical provider settled a suit over a 2015 jail death of an inmate with mental health problems for **$3 million**.

Milwaukee County, Wisconsin

Settled with the family of a man who died in 2016 of dehydration in their jail for **$6.75 million.**

Local and national news outlets are focused on the rising number of jail deaths and the need for improved care and treatment in our jails, particularly for individuals with disabilities.

An increase in lawsuits relating to jail conditions will lead to increased costs for counties that do not adjust their policies, facilities, and practices to stem the rising tide of preventable jail deaths in North Carolina.

These human rights abuses are disgraceful and DRNC urges counties to proactively invest in better care for incarcerated people in jails, rather than being forced to spend funds on settlements related to avoidable jail deaths.

Disability Rights North Carolina

Disability Rights North Carolina is a 501(c)(3) nonprofit organization headquartered in Raleigh. It is a federally mandated protection and advocacy system with funding from the U.S. Department of Health and Human Services, the U.S. Department of Education, and the Social Security Administration.