

Mecklenburg County Sheriff's Office

700 East Fourth Street Charlotte, NC 28202

T (704) 336-2543 • F (704) 336-6118 www.mecksheriff.com GARRY L. MCFADDEN SHERIFF

TELISA E. WHITE CHIEF OF DETENTION

KEVIN D. CANTY CHIEF DEPUTY SHERIFF

MEDIA ALERT FOR IMMEDIATE RELEASE

February 27, 2024

CONTACT: Bradley Smith

MCSO Public Information Manager

Bradley.Smith@mecklenburgcountync.gov

O: (980) 314-5008

Mecklenburg County Sheriff Garry McFadden's Response to Concerns Regarding Inspections at the Mecklenburg County Detention Center-Central

(CHARLOTTE, NC) – In response to a recent news story concerning state safety inspections at Mecklenburg County Detention Center-Central (MCDCC): I acknowledge and share the concerns of the public regarding the safety and security of the facility and its residents.

As outlined in my memo to the Mecklenburg County Board of County Commissioners, my staff and I have expressed our concerns regarding the data that MCSO is asked to provide when we experience an in-custody death, and the criteria used by state inspectors to define a pod tour or round. I have urged the state inspectors to acknowledge these discrepancies and to provide clarity on their inspection processes, but they have thus far declined to do so. Moving forward, it is my hope and expectation that state inspectors will consider the operational realities of MCDCC so that accurate reporting can be provided.

Ensuring the well-being of MCDCC residents is one of my top priorities. That is why my staff and I have undergone a rigorous accreditation process with <u>CALEA</u>, <u>ACA</u> and the <u>NCCHC</u>. Thanks to our hard work, the Mecklenburg County Sheriff's Office (MCSO) was honored with the prestigious <u>Triple Crown Award</u>. As of 2022 only 71 of 3,081 sheriff's offices in the United States have received this honor. Furthermore, I am also pleased to say that during the most recent ACA audit, MCSO met all 62 mandatory standards as we have maintained this accreditation since 2003.

ACA's performance-based standards and expected practices encompass a wide array of services, programs, and essential operations necessary for effective management of a detention center. By achieving and maintaining this accreditation, MCSO ensures an environment that prioritizes the safety and well-being of the public, staff, and residents while also offering opportunities for education, work, religious services, and rehabilitation.



Mecklenburg County Sheriff's Office

700 East Fourth Street Charlotte, NC 28202

T (704) 336-2543 • F (704) 336-6118 www.mecksheriff.com GARRY L. MCFADDEN SHERIFF

TELISA E. WHITE CHIEF OF DETENTION

KEVIN D. CANTY CHIEF DEPUTY SHERIFF

February 27, 2024

To: Mecklenburg County Board of County Commissioners (BOCC)

From: Garry L. McFadden, Sheriff

Mecklenburg County

Re: State Inspectors Compliance Report for In Custody Deaths

Over the past couple of years, The Mecklenburg County Sheriff's Office has had some In Custody Deaths that would give the appearance based on the State Inspectors Compliance Report that POD tours were not completed in accordance with the guidelines set forth by the State of North Carolina. After several Plan of Corrections, MCSO took a deeper dive into each In Custody Death and began to discover that some of the State Inspectors Compliance Reports were not accurate in their deficiencies. This report explains those findings.

The Mecklenburg County Sheriff's Office (MCSO) acknowledges that NCAC 14J.0601 ("Code") states: "A jail shall have an officer make supervision rounds and observe each inmate at least two times within a 60-minute time period on an irregular basis with not more than 40 minutes between rounds". The Code does not require that every tour start at the same place in the POD. That practice defeats the requirement that tours should be as unpredictable as possible. If all tours on a shift start at the same point in the POD throughout the entire shift, residents (inmates) learn the precise pattern for every tour. MCSO aims to maintain unpredictability by ensuring that residents (inmates) cannot forecast tour starting points or anticipate the time intervals between said tours.

MCSO respectfully submits that time lapses between tours is more accurately measured by comparing the previous tour's actual completion time (regardless of the label on the button) to the next tour's start time (regardless of the label on that button,).

In the Statement of Deficiencies Report (SOD), the examiner selected a specific tour button and calculated the time between tours based on when that same button was pushed in the next tour, using this as the "start time" for the next tour. This assumes that all officers start a tour by pushing the same button at the start of every POD tour and follow the exact same order for pushing tour buttons every time. MCSO officers may start different tours at different buttons within the POD for the above-stated irregularity in the pattern of tours, so the tour patterns are as unpredictable as possible. For example, for the first tour of the shift, the officer may start the tour at button B. However, the officer may start the next tour at button C. Therefore, the correct time between tours should be calculated from the push of the last button pushed in the first tour to the first button pushed in the next tour. If the measurement for time

between tours is based upon the push of the same button each time, the time between conducting POD tours will not necessarily be accurate and could falsely indicate an officer's delay in starting a subsequent tour.

An example from the SOD is as follows.

SOD states that in POD 4900, the duration between pod tours recorded at 10:58 am and 11:39 am is 41 minutes apart, exceeding the 40-minute standard. This was measured based solely on pushes of 1 selected button, 4959C. However, when the time is measured based solely on the actual start and end time for this tour, rather than focusing solely on the pushes for the same button, the first tour ended at 10:59 and the next tour began at 11:31. This is an interval between these tours of 32 minutes, well within the Code requirement, as opposed to 41 minutes as indicated on the SOD.

MCSO's other concerns with the Statement of Deficiencies Report are the number of hours asked to be provided prior to the In Custody Death incident. Also, by rule, the North Carolina Administrative Code does not require more than one round in any specific hour on the clock.

An example from the SOD is as follows:

SOD states that only one round was conducted during the hours of 4:00am, 5:00am, 6:00am, and 10:00am on December 13, 2023. However, the North Carolina Administrative Code does not require more than one round in any specific hour on the clock (e.g., 4:00am to 4:59am being "the 4:00am hour"). Rather, 10A NCAC 14J .0601(a) requires that each inmate be observed "at least two times within a 60-minute time period on an irregular basis with not more than 40 minutes between rounds." As such, a resident could be observed at 3:55am, at 4:30am, and then at 5:05am with only one round in the 4:00am hour (at 4:30am), with no deficiency or violation of the code. The statement, therefore, doesn't indicate a deficiency based on the requirements of 10ANCAC 14J .0601. Nonetheless, in review of the circumstances surrounding this particular case, MCSO determined that on four separate occasions between 4:00am and 11:00am on December 13, 2023, pod officers did fail to make observations within 40 minutes after the previous observation. Specifically, a particular resident (inmate) was observed at 4:27am and next at 5:22am (a gap of 55 minutes), next at 6:05am (a gap of 43 minutes), next at 6:50am (a gap of 45 minutes); and, having observed the resident (inmate) at 9:55am. The resident (inmate) was next observed at 10:55am (a gap of 60 minutes). The resident (inmate) was found unresponsive at approximately 4:30am on December 14, 2023, more than 171/2 hours after the last gap of more than 40 minutes in his observation.

In other words, the resident (inmate) was observed in compliance with 10A NCAJ 14J .0601 at least two times within any 60-minute time period on an irregular basis with not more than 40 minutes between rounds from 10:55am on December 13, 2023, until he was found unresponsive at approximately 4:30am on December 14, 2023. At this time, MCSO has no reason to believe that excessive gaps more than 17½ hours earlier, excesses of 15 minutes, 3 minutes, 5 minutes, and 20 minutes, were significant factors in this incident.

The examples above have been explained to the examiner on multiple occasions. It is our hope that a true understanding of our (MCSO) POD tour system will be taking into consideration moving forward so that the citizens of Mecklenburg County have a better understanding and more accurate report.