

Public Health behind Bars: Health Care for Jail Inmates

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In a recent year in North Carolina, local jails admitted more than 400,000 people. Some of them were admitted more than once, so this figure does not reflect the total number of individuals who spent time in North Carolina's jails that year. But it does suggest that the number was quite large. The vast majority of those who enter

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jails are released into the community shortly after entering—usually in less than two weeks.¹ Jail inmates are more likely than the general public to have health problems—including high rates of drug and alcohol abuse and communicable diseases such as tuberculosis and syphilis—so clearly their health can affect the overall health of a community. If their health needs are not addressed while they are in jail, any communicable conditions that they have may spread. Further, their chronic conditions may worsen, perhaps resulting in

a need for more costly care on their release, which may be borne by public clinics or hospitals.

Local governments that operate jails are legally obligated to make health care available to the inmates. As the number just reported suggests, this can be a daunting task. Providing health care is not a jail's primary mission, but it is a critical function that jails must perform, and under much more challenging circumstances than most health care providers face. In recent years, several trends have converged to make jail

health care more difficult—but also more important—than ever:

- **More inmates:** The number of people incarcerated in county jails in North Carolina more than quadrupled from the 1970s to the 1990s.² By 1998 the average daily population of inmates was about 13,250 statewide.³ The vast majority of inmates are “pretrial detainees”—people who have been charged with crimes but not yet tried and convicted.⁴
- **Sicker inmates:** Inmates are in poor health relative to the general population. In a 2002 report to Congress, the National Commission on Correctional Health Care noted that the prevalence of mental illness, chronic illness, and communicable disease is higher among inmates than among the general population.⁵ Some illnesses suffered by inmates, such as diabetes and hypertension, require complicated medication regimens. Other illnesses, such as active infectious tuberculosis, potentially pose risks to other inmates and jail personnel, if they are undetected or improperly managed.
- **Costlier care:** Health care costs have soared, and they continue to rise at a rate that exceeds the general rate of inflation. The National Commission for Correctional Health Care has asserted that, at the state level, expenditures for inmate medical care are increasing by about 10 percent each year.⁶

In addition to potentially threatening public health, lapses in jail medical care can be personally tragic. In recent years in North Carolina, there have been several inmate deaths related to unmet medical needs.⁷

Also, a number of inmates have committed suicide. Such incidents do not necessarily point to lapses in medical care, but they do demonstrate the importance of recognizing and attending to inmates’ mental health needs as well as their physical ones.

This article briefly reviews government’s legal duty to provide health care to inmates. It then describes the ways in which jail health care is provided in North Carolina and discusses some of the challenges that inmate medical care

creates for local governments that operate jails.

The Legal Duty to Provide Health Care to Inmates

North Carolina jails are legally obligated to provide health care to inmates. This requirement comes from both federal and state law.

Federal Constitutional Law: The “Deliberate Indifference” Standard

Nearly thirty years ago, in *Estelle v. Gamble*, the U.S. Supreme Court ruled that the government has an obligation to provide medical care to those whom it incarcerates, and that failure to provide such care may violate inmates’ constitutional rights. Jail medical care is considered a condition of confinement. When conditions of confinement are extremely severe or inadequate, they can amount to cruel and unusual punishment in violation of the Eighth Amendment. In *Estelle* the Court held that the Eighth Amendment can be violated by the failure to provide necessary medical care. The Court reasoned,

*An inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met. In the worst cases, such a failure may actually produce physical “torture or a lingering death,” the evils of most immediate concern to the drafters of the Amendment. In less serious cases, denial of medical care may result in pain and suffering which no one suggests would serve any penological purpose. The infliction of such unnecessary suffering is inconsistent with contemporary standards of decency . . .*⁸

The *Estelle* Court concluded that the Eighth Amendment is violated by a jail official’s “deliberate indifference [to an inmate’s] serious medical needs.”⁹

What constitutes “deliberate indif-

ference” under this ruling? The U.S. Supreme Court has held that a jail official is deliberately indifferent to an inmate’s serious medical needs only if the official *actually knows* that the inmate has a serious medical need and fails to take reasonable steps to deal with it.¹⁰ Deliberate indifference therefore is more than just negligence. An inmate may have a solid claim for medical malpractice or negligence under state laws but still not be able to show that the circumstances were so harsh or inadequate that they violated his or her constitutional rights. For example, in *Estelle* the inmate had a series of medical diagnoses, including hypertension and cardiac arrhythmia, and a long history of inter-

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actions with prison detention officers and medical staff regarding the care of those problems. The inmate acknowledged that he had received treatment but claimed that additional treatment options should have been pursued. The Court held that the

allegations were not sufficient to amount to a violation of the inmate’s constitutional rights. At most they stated a claim of medical malpractice that should be pursued in state court.¹¹

To establish the constitutional violation, an inmate also must show that the need the jail official disregarded was a “serious medical need.” Federal courts have held that a serious medical need is “one that has been diagnosed by a physician as mandating treatment or one that is so obvious that even a lay person would easily recognize the necessity for a doctor’s attention.”¹²

All jail staff members with some responsibility for medical care may potentially be held liable for deliberate indifference—from the medical staff who actually provide the care, to the detention staff who may be the first to become aware that an inmate is exhibiting a serious medical need, to the jail administrator who is responsible for jail health policies and staff training.¹³

People who are not employees of the jail also may be held liable for violating Eighth Amendment rights if they are

North Carolina Jail Medical Plans

Section 153A-225(a) of the North Carolina General Statutes requires all local government units that operate a jail to have a jail medical plan. The plan must meet the following criteria:

- Be designed to protect the health and welfare of the inmates and to avoid the spread of contagious diseases
- Provide for the medical supervision of inmates and for emergency medical care, to the extent necessary for inmates' health and welfare
- Provide for the detection, the examination, and the treatment of inmates who have tuberculosis or sexually transmitted diseases

State regulations, commonly known as the North Carolina Jail Health Standards, specify certain issues that the medical plan must address. It must describe the health services that are available to inmates, and include policies and procedures addressing each of the following:

- Health screening of inmates on admission
- Routine medical care for inmates
- Management of inmates with chronic illnesses or known communicable diseases or conditions
- Administration, dispensing, and control of prescription and nonprescription medications
- Management of emergency medical problems, including emergencies related to dental care, chemical dependency, and pregnancy¹
- Maintenance and confidentiality of medical records
- Privacy during medical examinations and conferences with qualified personnel

The regulations also specify that jails must have a sick-call procedure that allows inmates to communicate their health complaints each day. In addition, the regulations prohibit inmates from performing any medical functions in the jail, and require the jail medical plan to be reviewed annually.²

The regulations are enforced by the Jails and Detention Section of the Division of Facility Services, in the state's Department of Health and Human Services.

Notes

1. State regulations define "emergency medical problem" as "a serious medical need, including severe bleeding, unconsciousness, serious breathing difficulties, head injury, severe pain, suicidal behavior or severe burns, that requires immediate medical attention and that cannot be deferred until the next scheduled sick call or clinic." 10A NCAC 14J .0101(14).

2. 10A NCAC 14J .1001.

involved with inmate medical care. In a case that originated in a North Carolina prison, the U.S. Supreme Court held that a physician who provided medical services to prison inmates on a part-time, contractual basis could be held liable for such a constitutional violation.¹⁴

North Carolina Law: The Duty to Provide "Adequate" Care

Long before the U.S. Supreme Court issued its decision in *Estelle*, the North Carolina Supreme Court recognized the state's common law duty to provide

medical care to inmates. In a 1926 case, *Spicer v. Williamson*, the court wrote, "The prisoner by his arrest is deprived of his liberty for the protection of the public. It is but just that the public be required to care for the prisoner, who cannot, by reason of the deprivation of his liberty, care for himself."¹⁵ In 1992 the North Carolina Supreme Court reiterated this principle in *Medley v. North Carolina Department of Correction*. Drawing an analogy between the dependency of inmates on their custodians for medical care and the dependency of

children on their parents, the court concluded that the state has a nondelegable duty to provide adequate medical care for inmates.¹⁶

Although the court in *Medley* referred repeatedly to the duty to provide "adequate" medical care, it did not define the term or set standards for determining adequacy. However, the court's conclusion that the Department of Correction was liable for injuries that the inmate suffered as a result of a physician's negligence suggests that to be considered adequate, inmate health care in North Carolina must conform to the usually accepted standards of practice for health care providers.¹⁷

North Carolina law also requires local governments that operate jails to adopt jail medical plans that are "adequate" to protect inmates' health and welfare.¹⁸ The statute that imposes this requirement does not define "adequate," but it, along with regulations in the North Carolina Administrative Code, provides some guidance (see the sidebar on this page). The ultimate decision about whether a jail medical plan is adequate is made by the local health director. He or she must consult with the local mental health, substance abuse, and developmental disabilities authority and then approve the plan "if it is adequate to protect the health and welfare" of the inmates.¹⁹

Although they are not as straightforward as they might be, North Carolina statutes, regulations, and cases make clear that the state's standard for determining the sufficiency of the care provided to inmates is more stringent than the federal standard of deliberate indifference.

Jail Health Care in North Carolina

North Carolina jails meet their duty to provide routine medical care in several ways. Some hire their own health care provider, who becomes an employee of the jail or the sheriff's office. Others contract with a private health care provider or arrange for the local health department to provide services in the jail. Some jails use these methods in various combinations. For example, a jail might employ a nurse and also contract with a

private physician to direct and supervise the provision of care in the jail.

A small number of North Carolina jails have medical staff in the jails twenty-four hours a day, seven days a week. At the other end of the spectrum, a few jails have no health care provider on staff or on contract and must transport inmates to a local hospital or another community health care provider for any routine or emergency medical need.

State regulations require jails to have policies and procedures for responding to medical emergencies. Although all jails should be able to provide first aid or cardiopulmonary resuscitation around the clock, only rarely does a North Carolina jail have the equipment or the staff necessary to respond fully to a medical emergency.²⁰ As a result, most jails use emergency medical service agencies and hospital emergency departments for emergency care.

Challenges for North Carolina Jails

Inmate health care poses complicated challenges for North Carolina jails: Inmates are more likely than the general population to have serious medical problems, some of which may threaten the health of other inmates or jail personnel. Also, there is tension inherent in the jail's obligation to ensure adequate health care for inmates while maintaining the security of the facility. Further, the health care that inmates require can be extremely costly, but the resources available to pay for it may be quite limited.

The Nature of Inmates' Health Needs

There is ample evidence that inmates have more severe health problems than the general population. A 2002 report to Congress by the National Commission on Correctional Health Care compiled some of this evidence and reached the following conclusions:²¹

- Inmates are more likely to have serious communicable diseases than the general population. Between 13 and 19 percent of all HIV-positive people in the United States were incarcerated in 1997 (the year studied in the report). Inmates are five times more likely to have AIDS

than noninmates. Tuberculosis is at least four times more common among inmates than among noninmates, and the figure may be higher. Nearly a third of all people with hepatitis C were incarcerated at some point during 1997, as were as many as 15 percent of all people with hepatitis B.

- Many inmates suffer from chronic diseases that require management during their incarceration. During the years studied in the report, 8–9 percent of inmates had asthma, 5 percent had diabetes, and 18 percent had hypertension.
- Large percentages of inmates suffer from mental illnesses. The report considered jail and prison inmates separately and found that in jails alone, up to 20 percent had anxiety disorders and up to 15 percent suffered from major depression. Between 4 and 9 percent had posttraumatic stress disorder, between 1 and 3 percent had bipolar disorder, and about 1 percent suffered from schizophrenia or another severe form of psychosis.²²

Jails' ability to deal with the rising numbers of inmates with serious health problems varies. For example, some North Carolina jails have special "negative pressure" rooms that allow them to isolate inmates with tuberculosis from the general population, but many jails do not have such facilities.²³ Local jails sometimes can transfer inmates with medical needs beyond the jail's capacity to the state prison system.²⁴

The Nature of the Jail Environment

The primary mission of local jails is to detain potentially dangerous people in a secure setting. The provision of health care to inmates is a necessary function of jails, but it is not their sole function or even their most important one. Jail

detention staff and health care providers alike must attend to inmates' well-being and the facility's security simultaneously. The need to preserve security can create tremendous challenges for health care in jails.

For example, jails in North Carolina are required to have policies and procedures regarding privacy during medical examinations and conferences with medical personnel.²⁵ The regulation that imposes this requirement does not elaborate on how it is to be achieved. National standards for accrediting jail health programs urge jail health care providers to conduct clinical encounters in private whenever possible and to permit detention officers to observe or listen to the encounter only if the inmate "poses a probable risk to the safety of the health care provider or others."²⁶ The purpose of protecting privacy is the same in the jail as it is in any other health care setting—to encourage honest and complete communications so that the patient can receive the most appropriate care. At the same time, a greater security risk undeniably exists

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when trained security personnel are not present: medical equipment can become a weapon, or a health care provider can become a hostage. Jail administrators may feel caught between two liability risks: the risk of providing inadequate medical care and the risk of inadequately protecting jail employees and other inmates.

Detention officers must escort inmates to health care providers. This requirement can lead to delays in inmates receiving care. In routine situations, delays may be unavoidable and reasonable, but in emergency circumstances, delays may be life- or health-threatening.

When inmates must leave the facility for care, a greater risk of escape exists. Some North Carolina jails make a point of not telling inmates the times and the dates of their medical appointments outside the jail so that the inmates cannot notify friends or family members

who might assist them in an escape attempt. Following the same rationale, jail officials often keep inmates in the dark about when they will be transferred from one jail to another, or from jail to prison. A frequent complaint of jail medical staff is that they too are not notified when inmates are to be transferred. This oversight can cause serious disruptions in an inmate's care if it deprives medical staff of the opportunity to prepare necessary medical records and medications to send with the inmate.

Finally, jails rarely have medical staff present around the clock, but inmates can become ill at any time. North Carolina jails are legally obligated to obtain emergency medical care for inmates when it is needed.²⁷ A state regulation defines "emergency medical problem" and includes in the definition any medical need that cannot be deferred to the next regularly scheduled sick call or clinic.²⁸ Whether or not to defer a medical need—a decision that can be difficult for health care providers—often is decided by detention officers.²⁹ An error in either direction has its costs. Failure to obtain care may threaten the inmate's life or health.

On the other hand, emergency care usually comes with a hefty price tag for the county, so jails do not want to use it

unnecessarily. Making a decision about whether a situation constitutes an emergency is further complicated when detention officers have reason to believe that an inmate may be exaggerating or even inventing symptoms.

The Scope of Legal Obligations

Jails unquestionably have a legal obligation to provide inmate medical care, but numerous questions about the scope of that duty are unanswered. For example, many inmates spend a very short time in jail.³⁰ When, if ever, is it permissible for a jail officer to defer medical care for an inmate until the inmate's release? There is no clear legal answer to this question. Probably it is reasonable to defer care in some circumstances but not in others.

For example, suppose that before being incarcerated, an inmate made an appointment to have a dental cavity filled in two weeks. He expects to be out of jail within one week. Deferring care of the cavity until the scheduled appointment seems reasonable unless an emergency—such as an abscess—develops in the meantime. On the other hand, an inmate with symptoms of strep throat who expects to be out of jail

within a week should be treated at the next scheduled time for routine health care (again, sooner if the inmate is very ill or an emergency develops).³¹

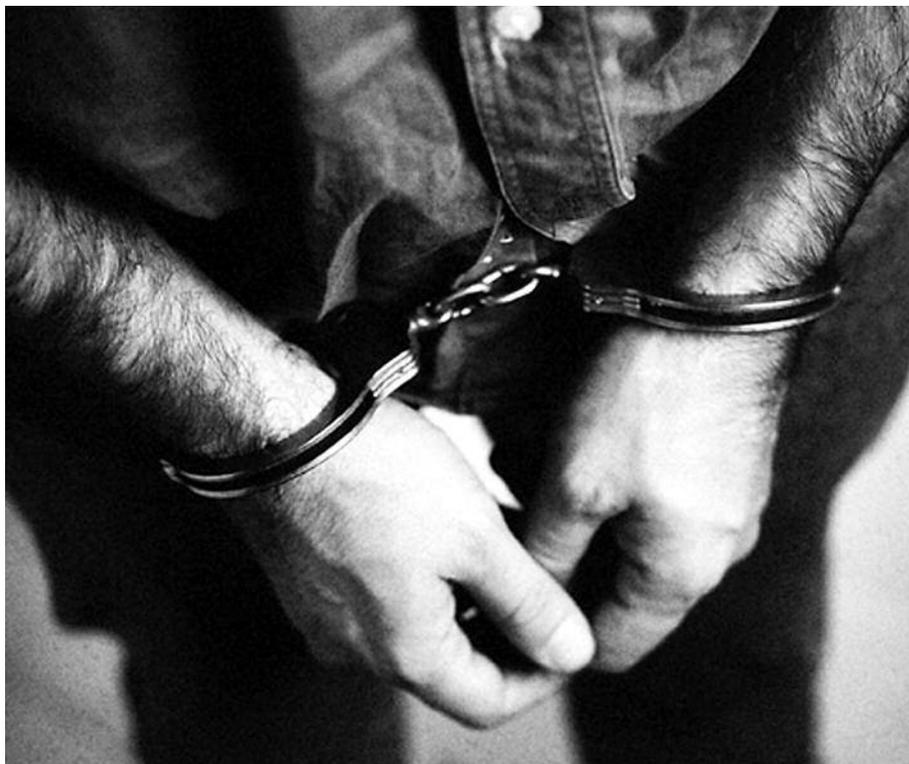
For another example, suppose a person is a "revolving-door" inmate—one who is in and out of jail regularly—and jail health care providers suspect her of failing to attend to her health needs when she is not in jail. If she then insists on medical care while incarcerated, can the jail refuse to provide it? This question has an easy legal answer, but it sometimes frustrates anyone with an interest in the county's budget. The jail's legal duty to provide adequate medical care to the inmate while she is incarcerated is unaffected by her failure to obtain care when she is on her own, even if the care she needs while in jail is costlier than it would have been if she had taken care of herself while in the community.

Financing of Jail Health Care

The cost of health care in the United States continues to rise at a rate that outpaces inflation.³² Jails are not immune to this phenomenon. Indeed, jails may suffer more from increasing costs than other settings do, for inmates as a group are poorer, sicker, and more likely to need substance abuse or mental health services than the general population.³³ In addition, in recent years the number of inmates held in local jails increased, and some evidence indicates that jail inmates may be getting older.³⁴ Both of these facts contribute to increasing health care costs for jails.³⁵

In North Carolina, counties bear most of the costs of health care. North Carolina jail administrators and health care providers often perceive—probably correctly—that many (if not most) jail inmates lack private medical insurance.³⁶ Inmates with public insurance, such as Medicaid, lose their eligibility for it upon incarceration (not conviction).³⁷ In the absence of third-party payers, the county becomes responsible for routine and emergency medical costs.

North Carolina law permits local jails to charge inmates a fee for routine medical care. The fee may not exceed \$10 per incident and must be waived for indigent inmates.³⁸ The county must pay any remaining costs.





State law also requires the county to pay the cost of emergency medical services unless the inmate has third-party insurance. If the inmate has such insurance and it has not terminated upon incarceration, the law requires the emergency medical services provider to bill the insurer first, and makes the county liable only for any costs that are not reimbursed by the insurer. It also permits the county to attempt to recover those costs from the inmate.³⁹ The county is required to pay only for emergency medical care that is provided while the inmate is in its custody. Efforts to avoid this responsibility by releasing the inmate are likely to be unavailing.⁴⁰

The state Department of Correction pays jails a portion of the cost of inmate health care if the inmate has extraordinary medical expenses, has been convicted (and thus is not a pretrial detainee), and fits into one of the following categories: is serving a sentence of thirty days or more, has been sentenced to state prison but been held in the local jail for more than five days, or is a parolee or postrelease supervisee awaiting return to state prison and has been

held in the jail for more than five days. “Extraordinary medical expenses” are defined as expenses associated with hospitalization, outpatient care expenses that exceed \$35 per occurrence or illness, or the cost of replacing broken eyeglasses or dental prosthetic devices, provided that they are broken while the inmate is incarcerated.⁴¹

The high cost of medical care may tempt jails to engage in what one legal commentator has described as “creative early release programs.”⁴² Although the temptation may be understandable, it is not legally defensible. In the only reported North Carolina case on this issue, the N.C. Court of Appeals held that a county was not relieved from financial responsibility when it arranged to have an unconscious inmate released from custody after he was hospitalized for meningitis.⁴³ Federal courts in other jurisdictions have found jails deliberately indifferent to inmates’ serious medical needs when they have released inmates rather than provide needed medical care.⁴⁴ Release of a medically needy inmate also may run afoul of penological objectives, if an inmate’s

medical condition becomes a more important consideration than public safety in deciding whether an arrestee should be granted pretrial release.

Conclusion

Some North Carolina jails take on the responsibility and bear the costs of inmate health care because the law says they must. Others may view it as a moral or ethical obligation. A third view posits that inmate health care ultimately is beneficial to society as a whole because the vast majority of inmates will return to the community and it is better if they return free of infectious diseases that could spread to others. Moreover, preventing or treating their chronic conditions while they are incarcerated may be more cost-effective than not treating or undertreating those conditions, with the result of worse medical problems that require costlier care.

Whatever the underlying rationale, the bottom line is clear: Counties that operate jails must provide inmate medical care and are probably going to pay most of the costs of it. Furthermore,

failure to provide adequate care could result not only in adverse health consequences for inmates but in liability for the county. Provision of care occurs in an environment that poses unique challenges for all involved, from detention officers who must decide whether they are witnessing a true medical emergency to the jail health care providers who must constantly strike the balance between protecting their patients' privacy and protecting their own safety. Therefore, everyone with a stake in the county jail would be wise to learn more about local inmates' health care needs and the county's legal duties for jail medical care, and to consider how the county can meet those obligations in a way that is both fiscally responsible and protective of public health and safety.

Notes

1. In 1998, the most recent year for which data are available, about 407,000 inmates were admitted to local jails in North Carolina, and about 395,000 were released. Some were admitted and/or released more than once; therefore they are counted more than once in these totals. The average stay in jail in 1998 was twelve days. MICHAEL BERRY, SCREENING FOR SYPHILIS AND HIV IN NORTH CAROLINA'S JAILS: ASSESSING THE BENEFITS AND BARRIERS (Raleigh: N.C. Div. of Public Health, 2000) (citing data provided by the North Carolina Association of County Commissioners).

2. STEVENS H. CLARKE, INTRODUCTION TO THE COUNTY JAIL 7 (Chapel Hill, N.C.: Inst. of Gov't, Univ. of N.C. at Chapel Hill, 1999). For the sake of brevity, this article uses the term "county" to refer to the unit of local government that is responsible for the jail, for counties operate most North Carolina jails. However, the term should be read to include municipalities that operate jails and multi-county regional jails.

3. BERRY, SCREENING FOR SYPHILIS AND HIV. Data about inmate populations are collected monthly by the North Carolina Division of Facility Services, but they are not routinely compiled. In December 2004, average daily population was computed and was found to be 16,270. Personal communication from Kristi Wall, Office Assistant, Jails & Detention Section, N.C. Div. of Facility Services, to author (Aug. 19, 2005) (on file with author). However, this figure represents only that one month. An annualized average daily population figure might be higher or lower.

4. CLARKE, INTRODUCTION, at 7.

5. 1 NAT'L COMM'N ON CORRECTIONAL HEALTH CARE, THE HEALTH STATUS OF SOON-

TO-BE-RELEASED INMATES: A REPORT TO CONGRESS (Chicago: the Commission, 2002).

6. This assertion appears on the commission's website, at www.ncchc.org/supplier/index.html.

7. See, e.g., Luann Laubscher, *No Jail Health Plan a Misdemeanor*, SHELBY (N.C.) STAR, Sept. 9, 2002 (reporting a Cleveland County inmate's death from appendicitis); Jon Ostendorff, *Answers Required in Death of Inmate at Jail in Murphy*, ASHEVILLE (N.C.) CITIZEN-TIMES, Sept. 17, 2002 (reporting a Cherokee County inmate's death from diabetes).

8. *Estelle v. Gamble*, 429 U.S. 97, 103, 97 S. Ct. 285, 290 (1976) (citations omitted).

9. *Id.* at 106, 97 S. Ct. at 292. Strictly speaking, the Eighth Amendment's prohibition against cruel and unusual punishment does not apply to pretrial detainees and arrestees because they have not been convicted of anything and therefore are not supposed to be punished at all. However, federal courts have held that the Due Process clauses of the Fifth and Fourteenth amendments make the standard of deliberate indifference applicable to these people. See *Bell v. Wolfish*, 441 U.S. 520, 99 S. Ct. 1861 (1979) (holding that conditions of confinement can amount to punishment of unconvicted detainee, in violation of detainee's right to due process of law); *Brown v. Harris*, 240 F.3d 383 (4th Cir. 2001) (holding that, in area of medical care, standard for determining whether there has been violation of pretrial detainee's due process rights is same standard of deliberate indifference that is applied to determine whether there has been violation of convicted inmate's Eighth Amendment rights); *Young v. City of Mount Ranier*, 238 F.3d 567 (4th Cir. 2001) (applying standard of deliberate indifference to arrestees). The terms "arrestee" and "pretrial detainee" do not have precise legal definitions, but they are commonly understood to refer to people who are at different stages in the criminal justice process. An arrestee is a person who has been taken into custody by a law enforcement official but has not yet had a first appearance before a judicial official to determine whether the person will be charged with a crime, and if charged, whether the person will be released or detained before trial. A pretrial detainee is a person who has had a first appearance before a judicial official, has been charged, and is being detained pending trial, either because the person is ineligible for release or because the person is unable to post bail.

10. *Farmer v. Brennan*, 511 U.S. 825, 847, 114 S. Ct. 1970, 1984 (1994).

11. *Estelle*, 429 U.S. at 107, 97 S. Ct. at 292-93.

12. See, e.g., *Farrow v. West*, 320 F.3d 1235, 1243 (11th Cir. 2003).

13. See *Estelle*, 429 U.S. at 104-05, 97 S. Ct. at 291 (holding that deliberate indifference can be "manifested by prison

doctors in their response to the prisoner's needs or by prison guards in intentionally denying or delaying access to medical care or intentionally interfering with the treatment once prescribed") (footnotes omitted).

14. *West v. Atkins*, 487 U.S. 42, 108 S. Ct. 2250 (1988) ("Contracting out prison medical care does not relieve the State of its constitutional duty to provide adequate medical treatment to those in its custody, and does not deprive the State's prisoners of the means to vindicate their Eighth Amendment rights"); see also *Medley v. N.C. Dep't of Correction*, 330 N.C. 837, 412 S.E.2d 654 (1992) (holding Department of Correction liable for malpractice of part-time contracted physician).

15. *Spicer v. Williamson*, 191 N.C. 487, 490, 132 S.E. 291, 293 (1926). In *Estelle* the U.S. Supreme Court quoted approvingly from *Spicer* in reaching its conclusion that modern standards of decency require correctional institutions to attend to inmates' serious medical needs. *Estelle*, 429 U.S. at 104, 97 S. Ct. at 291.

16. The court wrote, "Just as a minor child is, relative to his adult parents, less able to care for himself, so is a prison inmate who is prevented from seeking medical care outside the prison less able to care for himself than are his custodians." *Medley*, 330 N.C. at 842, 412 S.E.2d at 657. The principal issue in *Medley* was whether the Department of Correction was liable under the State Tort Claims Act for the malpractice of a physician who was an independent contractor. This required the court to consider whether the department owed a duty to the inmate and, if so, whether that duty was nondelegable. *Id.* at 844, 412 S.E.2d at 659.

17. This is consistent with the U.S. Supreme Court's statement in *Estelle* that a jail official who avoided liability under Section 1983 of Title 42 of the U.S. Code could still be found liable under state negligence law. See note 11 and accompanying text.

18. N.C. GEN. STAT. § 153A-225(a) (hereinafter G.S.).

19. After the local health director determines the plan to be adequate, the local governing body (usually a county board of commissioners) must adopt the plan. North Carolina law does not establish clear legal standards for determining whether a plan is adequate. However, the N.C. Jail Health Standards require the plan to include policies and procedures addressing certain issues (see the sidebar on page 18). Thus, at a minimum the plan must include those policies and procedures. Furthermore, G.S. 153A-225(a) identifies three goals that the plan must address: (1) "protect the health and welfare of the prisoners and . . . avoid the spread of contagious disease," (2) "provide for medical supervision of prisoners and emergency medical care for prisoners to the extent

necessary for their health and welfare,” and (3) “provide for the detection, examination and treatment of prisoners who are infected with tuberculosis or venereal diseases.”

A local health director may refuse to approve a plan if he or she thinks that the plan does not adequately address these statutory goals.

20. Within one year of their appointment, detention officers in North Carolina are required to complete general detention officer training (12 NCAC 10B .0602(a)), which includes ten hours of first aid and cardiopulmonary resuscitation (12 NCAC 10B .0601(b)). Some of the state’s largest jails have X-ray or other equipment, as well as the necessary staff and supplies to respond fully to some types of emergencies, such as bone fractures.

21. These conclusions present national estimates. Data on inmate health status are not routinely compiled in North Carolina.

22. 1 NAT’L COMM’N, HEALTH STATUS.

23. A “negative pressure room” is engineered to prevent air from flowing out of the room into adjacent rooms or corridors.

24. State regulations require a jail that is unable to provide for medical isolation when it is needed, to transfer the inmate to another facility. 10A NCAC 14J .1003; *see also* G.S. 162-39(d) (authorizing a superior or district court judge to order an inmate transferred to the Department of Correction “[w]henver a prisoner held in a county jail requires medical or mental health treatment that the county decides can best be provided by the Department of Correction”). An inmate who is transferred to the state prison system because of medical needs is called a “safekeeper.”

25. 10A NCAC 14J .1001(b)(7).

26. NAT’L COMM’N ON CORRECTIONAL HEALTH CARE, *Standard J-A-09*, in *STANDARDS FOR HEALTH SERVICES IN JAILS 16–17* (Chicago: the Commission, 2003).

27. G.S. 153A-224(b).

28. 10A NCAC 14J .0101(14).

29. As noted earlier, in North Carolina, detention officers receive ten hours of training in first aid and cardiopulmonary resuscitation. They receive an additional five hours of training on medical care in the jail. 12 NCAC 10B .0601(b).

30. In conducting interviews for a profile of jail inmates in 2002, the Bureau of Justice Statistics found that 23 percent of the inmates interviewed had been in jail for fourteen days or less, and more than half of those, for less than a week. DORIS J. JAMES, *PROFILE OF JAIL INMATES, 2002*, Bureau of Justice Statistics Special Report (Washington, D.C.: Bureau of Justice Statistics, U.S. Dep’t of Justice, July 2004).

31. For more on the potential liability associated with delaying or deferring health care, *see Jails and Delayed Medical Care: A Calculated (?) Liability Risk*, CORRECTIONAL

LAW REPORTER, Oct./Nov. 2000, at 38 (cautioning against “creative early release programs,” in which inmates are released sooner than they might have been, to avoid medical costs); *see also* Univ. of N.C. v. Hill, 96 N.C. App. 673, 396 S.E.2d 323 (1990) (holding that county may not avoid its obligation to pay for emergency care by releasing unconscious inmate from custody).

32. *See, e.g.*, BRADLEY C. STRUNK ET AL., *TRACKING HEALTH CARE COSTS: SPENDING GROWTH STABILIZES AT HIGH RATE IN 2004* (Washington, D.C.: Center for Studying Health System Change, Data Bulletin No. 29, June 2005), available at www.hschange.org/CONTENT/745/.

33. *See* 1 NAT’L COMM’N, HEALTH STATUS; *see also* note 22 and accompanying text.

34. About 714,000 people were incarcerated in local jails at mid-year 2004, compared with about 691,000 at mid-year 2003. PAIGE M. HARRISON AND ALLEN J. BECK, *PRISON AND JAIL INMATES AT MID-YEAR 2004* (Washington, D.C.: Bureau of Justice Statistics, U.S. Dep’t of Justice, Apr. 2005). In 2002, 38 percent of jail inmates were thirty-five years of age or older, compared with 32 percent in 1996. JAMES, *PROFILE OF JAIL INMATES*.

35. *See* B. JAYE ANNO ET AL., *CORRECTIONAL HEALTH CARE: ADDRESSING THE NEEDS OF ELDERLY, CHRONICALLY ILL, AND TERMINALLY ILL INMATES* (Washington, D.C.: Nat’l Inst. of Corrections, Feb. 2004), available at www.nicic.org/Library/018735.

36. Inmates are disproportionately poor and unemployed—two characteristics that are associated with lacking health insurance. *See* CARMEN DENAVAS-WALT ET AL., *INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2003* (Washington, D.C.: Census Bureau, 2004).

37. 42 C.F.R. § 435.1008. The loss of public insurance occurs upon incarceration, not conviction. Pretrial detainees—the bulk of the jail population in North Carolina—are ineligible for Medicaid and Medicare, depriving jails of one potential source of payment for inmate health care.

38. G.S. 153A-225(a).

39. G.S. 153A-224(b).

40. *See* notes 42–44 and accompanying text.

41. G.S. 148-32.1(a). The statute further specifies that the Department of Correction will reimburse the jail for replacing broken eyeglasses or dental prosthetics only if the inmate was using the eyeglasses or the dental devices at the time of his or her commitment and the jail seeks and receives the Department of Correction’s written consent before replacing them.

42. *Jails and Delayed Medical Care*, CORRECTIONAL LAW REPORTER.

43. Univ. of N.C. v. Hill, 96 N.C. App. 673, 396 S.E.2d 323 (1990).

44. *See, e.g.*, Marsh v. Butler County, Ala., 212 F.3d 1318 (11th Cir. 2000).



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