FOR IMMEDIATE RELEASE

Egyptian Human Rights Authority
Report of Findings
Franklin County Jail
Case #24-110-9003
September 20, 2024

The Human Rights Authority (HRA) opened an investigation after receiving complaints of possible rights violations involving Franklin County Jail. The allegations were as follows:

- **Inadequate Care and Treatment**
- **Improper Restraint**

If found substantiated, the allegations would violate County Jail Standards (20 Ill. Admin. Code 701.40).

To investigate the allegations, the HRA reviewed the detainee's records, with consent, interviewed jail staff and examined pertinent policies and mandates.

COMPLAINT STATEMENT

The complaint alleges that at least four recipients received inadequate medical and mental health care as well as improper restraint use while being held at Franklin County Jail.

FINDINGS

Recipient 1 [June 2023]: This recipient was admitted to the jail in the Spring of 2022, and released the end of the year but returned to jail the beginning of 2023. He tried to commit suicide while out of jail and had self-harm incidents while in the jail. He was evaluated for placement in a state operated facility and was awaiting transfer at the time of the investigation. The jail transported the recipient to the hospital after self-harm incidents, but he was reportedly released back to the jail without a mental health assessment being done. The recipient was placed in a restraint chair for approximately 36 consecutive hours upon return from the hospital. Allegedly the recipient was not allowed out of the restraint chair to use the restroom. A family member reported that other detainees had contacted the recipient's family reporting that the recipient was reportedly placed in a jail holding cell in the dark for 30 days. It was also reported that a nurse at the jail prescribed a medicine that the Department of Human Services Evaluator said was the wrong medication for post-traumatic stress disorder (PTSD.)

Sheriff Jail Staff [August 2023]: The jail can house 103 people and, at the time of the interview, there were 85 detainees housed at the jail with 20 being Federal detainees. There are 6 Holding cells that allow staff to monitor detainees easier. They are on camera and can communicate and monitor with them more frequently. In the day room there is a button in the common area and also a kiosk to request treatment. The rolling kiosk is also taken to the holding cell area. The facility camera is on a loop and recordings are held for 60 days, approximately. If there is an incident, the detectives have access to camera systems and can access and save pertinent information.

The restraint policy requires that 15-minute checks occur to look for any discoloration or distress and to loosen cuffs if anything is found. Every 2 hours the detainee must be released to use the restroom, release limbs, or

move about, depending on the level of danger displayed. The restraint chair is used when a detainee is a threat to themselves or others. If a detainee is unmanageable or violent while waiting for assessment professionals to arrive, they are placed in restraints to keep them from banging their heads or grabbing items that could harm them. They do not use the chair often as extreme behaviors occur rarely. During these situations, the mental health crisis worker usually comes within an hour or two. There is a logbook that documents the restraint checks. The restraint chair is in camera view at all times. Per policy, they can keep detainees in a restraint chair no longer than 2 hours, unless there are extenuating circumstances. Staff are trained at the Police Academy on restraint chair use. Annual training updates include placement of restraints and injuries. Annually, a message is sent to staff letting them know to look over the new policy within 2 weeks and staff sign that they have completed the policy review. Sometimes a Sergeant talks to staff and reviews the policy informally, and they also have hands on training. Staff are also trained on mental illness and developmental disabilities annually for suicide prevention and how to handle situations that occur with those populations.

The Sheriff explained that they have partnered with "Take Action Today" since August 2022 to provide community behavioral health services as part of a reentry support program. This program places a trained and state certified peer recovery specialist in the jail on a full-time basis. The liaison is also trained in crisis intervention. The 30-day curriculum provides programming 3 hours a day for 4 days per week. Within jail settings, detainees have the opportunity to meet with a community behavioral health specialist (CBHS) to assess needs such as substance use treatment, mental health treatment, housing/shelter options, peer support services and more. The CBHS can facilitate a person's transfer directly from jail to a detox facility, treatment center, homeless shelter, or other safe environment. After release, the CBHS will follow up with them to ensure they were able to engage in the referrals that were made and help them adjust to any problems encountered in the process. A program is also offered for individuals who remain in custody. The program addresses the many facets of life that have led or could lead to a higher risk of reoffending. Curriculum covers things such as recovery planning, relapse prevention, recovery pathways, job readiness, continuing education, parenting, trauma, healthy relationships, understanding victim impact, personal accountability, and resource utilization.

A copy of the "Take Action Today" [TAT] program agreement was provided which outlines the roles of the mental health liaison and jail. The liaison is an employe of TAT and will adhere to the policies of TAT and the Sheriff's Office. The liaison will assist detainees being released in locating and obtaining mental health or substance abuse treatment services; provide peer support to detainees within the jail; and, provide information concerning resources on substance abuse or mental health treatment and overall recovery.

Regarding recipient 1: The community mental health agency was called and completed a mental health assessment. The recipient was court-ordered to complete a fitness evaluation which was completed in January 2023. This resulted in a recommendation for mental health treatment in the Department of Human Services (DHS). He was in holding cell for 2 days, then another holding for 8 days, then moved to general population. He was in the general population when he left for DHS placement in July 2023. He was found unfit to stand trial and sent for mental health treatment and has returned and is doing well, currently. The DHS facility prescribed the recipient Seroquel for mood and anxiety and Prazosin for nightmares. The jail doctor had prescribed Celexa, Prazocin, Hydroxazine Pamoate, and Haloperidol. According to the website drugs.com, Celexa is used to treat major depressive disorder. The website documents that Prazocin uses include treating nightmares, PTSD, anxiety and stress. Hydroxazine Pamoate is used to treat anxiety and Seroquel, that the DHS doctor prescribed, is used to treat schizophrenia and bipolar disorder.

Jail Documentation for Recipient 1: Restraint Logs: Upon review of the records, the restraint episode referenced in this complaint occurred in May 2022. The restraint log for this time frame begins on Wednesday, 5/11/22 at 6:45 pm when the recipient was placed in the restraint chair. There was documentation of restraint checks every 15 minutes as required. The first note for restraints being released for restroom use was around 9:00 pm. One hand was released around 11:00 pm for the recipient to eat and again around 1:00 am (5/12/22). There was documentation that the recipient's legs being released to stretch at 3:00 am and placed back on at 3:30 am. A jail incident report from 3:58 am on this date documented that the recipient refused to answer when

asked if he was "going to behave when he gets out of the chair" and simply replied he did not want to lie. He also stated he swallowed a piece of metal but then said he was just joking, but due to these actions, the officer felt it was necessary to keep him in the restraint chair and to notify administration upon their arrival. At 5:15 am the belly strap was released so the recipient could stretch and it was placed back on 5 minutes later. One hand was freed to eat at 8:00 am and the recipient was taken out of the restraint chair to stretch and walk at 8:15 until 8:30. The crisis worker came at 10:30 am to do an evaluation which lasted until 11:15 am. The crisis screening on May 12, 2022 (no time listed), documented the recipient could be taken out of the restraint chair and placed in a cell by himself. The recipient was released from the chair to walk and stretch at 11:30 am and placed back in the chair at 11:45 am, but was allowed to have one hand released at noon to eat. The nurse checked him at 1:15 pm and he was released to stretch at 1:45 pm. A restroom break was documented at 3:00 pm and the recipient showered and was placed back in the chair at 3:38 pm. The next release of one hand was at 4:50 pm to eat and replaced at 5:10 pm. There is documentation after that the recipient made threats that he will "knock out" a staff and that they will be back at the hospital with him that evening. At 6:40 pm he was released from the chair to stretch and was placed back in 15 minutes later. Around 7:30 pm the recipient stated he stabbed himself with a screw because he wanted to go to the hospital. An hour later threats to "knock out" staff were made. The recipient was released to use the restroom at 9:00 pm and placed back in restraints but it does not say he was placed in the chair at this time just that restraints were back on. At 9:45 pm it was documented that the recipient was lying on a bench sleeping. At this point he had been in the restraint chair for approximately 27 hours. He was allowed 3 restroom breaks (11 pm, 3 pm & 9 pm) during this time and was released to walk 4 times, so it is possible there was one more restroom break at 8 am that was not documented as anything other than a walk. The recipient's limbs were released to stretch or eat every 2-3 hours. A second restraint episode occurred on 5/16/22 from 10:00 pm until 5/17/22 at 9:00 am. During this episode it was documented the recipient made a statement that "after he gets out of chair he promises it will be more severe and he won't make it back to chair" and that he will "eat anything he gets his hands on."

Incident reports: On 5/1/22 it was documented that per video footage, the recipient stood on his bunk, placed a blanket over the light and repeatedly struck it until the glass broke. He then grabbed a piece of glass from the light fixture and put it in his mouth. The officer drew the taser and ordered the recipient to spit out the glass and get off the bunk to which he complied. Hand restraints were applied, and he was placed in the restraint chair. Later that day, the recipient was out of restraint chair to use the restroom and then refused to go back in the chair and refused to follow commands. With the help of 2 other officers, they were able to place him in the chair. At which point he refused to put his hand in the restraints so one officer utilized the taser and "dry stunned him." The recipient complied after one cycle of the taser. On 5/4/22 it was documented that the recipient made a statement while hospitalized that he does not want to hurt himself but does want to get out of jail so he will keep ingesting items until he is released from jail. The recipient stated he learned this from a peer in a different jail. There were several reports of the recipient making threats that he would be back in the hospital if the jail released him from restrictions but then would recant and say he was joking. 6/12/22 the recipient was placed in the restraint chair after hitting the window with his "sleeping boat" and breaking the glass. On 1/21/23 the recipient stuck a staple in his neck and refused to leave the unit, so a wheelchair had to be utilized to wheel him off the unit and onto the observation bench, where he was placed in handcuffs to prevent further injury to himself or others. The staple was removed, and he was placed in the restraint chair for safety.

There was another crisis screening from June 2023 which recommended psychiatric care and medication for nightmares, depression, anxiety, and insomnia. It was indicated the recipient could "return to general population." When questioned, the jail administrator advised that they had no records of a restraint episode for this recipient in June 2023. The medication reconciliation sheet showed the recipient was on Seroquel for mood and anxiety, Vistaril for anxiety, Prazosin for anxiety and Celexa for depression in June. A nursing note dated June 21st documented a complaint of being unable to sleep and mind racing. It was noted he was currently taking Haldol and Benztropine. The note stated to call the nurse practitioner for orders to discontinue the Haldol/Benztropine and refer the patient for psychiatric consult for medication recommendations. Telephone orders were received by the nurse practitioner and the note was signed by the nurse. The physician signed it a

month later. The recipient was transferred to a state operated facility a couple of weeks later for fitness restoration.

The Discharge/Transition Record from the Department of Human Services listed the reason for inpatient admission was due to a "number of episodes of self-injurious behavior while in jail, mainly swallowing things that would result in hospitalizations. He denies that these were suicide attempts and says he has never attempted suicide. He manipulated the system knowing that the county would not want to pay for his hospitalizations, so he said he would swallow something to get taken to the hospital and then they would release him from there. When asked why he did not engage in these behaviors at the jail over the past few months before coming to [facility], he stated that he had no bond, so he could not be released even if he did injure himself by swallowing something." The recipient received inpatient treatment at the state facility for approximately 6 weeks.

Recipient 2 [June 2023]: Reportedly, the recipient had approximately 8 incidents of self-harm in 2 months while at the jail. The recipient swallowed paperclips, glass and batteries. The recipient asked for a mental health screening but reportedly did not receive any mental health treatment or an evaluation. When he swallowed glass, the recipient was allegedly placed in a restraint chair rather than being taken to the hospital. The nurse documented that she recommended he be taken to the hospital. The recipient was in the restraint chair following the hospital visit reportedly for 72 hours and was allegedly only checked on 1-2 times all weekend. Allegedly, after 60 hours in the chair, the jail contacted the community crisis agency and only after a friend of the recipient threatened to sue the jail if they did not get the recipient help. The crisis worker recommended inpatient treatment but reportedly did not assist with placement.

The Sheriff & Jail Staff stated the recipient was in restraints for ingesting many items such as; glass, toothbrush, medicine cup, and pen. The recipient was at a hospital for 11 days for swallowing a carabiner and was in arm restraints during the entire hospital stay. Upon returning from the hospital on Friday evening 2/4/22, he went into the restraint chair for his own safety. He had staples in his stomach from surgery to remove the carabiner. The jail staff were afraid he would pull them out and ingest them if he was not restrained. The community mental health agency was called at 7:50 am to complete a mental health assessment on Monday 2/7/22 and arrived at 9:33. The recipient remained in the restraint chair for the mental health evaluation. The mental health worker told the jail staff to keep him in the restraint chair for a while. The recipient was released every 2 hours for bathroom breaks, to eat on a napkin, no utensils were given due to his history of ingesting items. The mental health agency will not come unless the detainees are calm enough to talk. The jail Nurse made a recommendation to remove the recipient from the restraint chair due to the prolonged restraint episode. They prepared a holding cell and removed all hazards. He knocked the glass out of the light and ate the glass. It took 7 Correctional Officers to get him back in his cell after the nurse finished the medical check.

It was believed these self-harm incidents may have been for release rather than suicide attempts. The recipient told staff he would do whatever he has to do to get out of jail. The recipient was flown to a hospital in Indiana once for ingesting items. He ingested a medicine bottle that was given to him with toothpaste to use his finger to clean his teeth. He had cut off his finger in another jail and was released for treatment, but instead of going for treatment, he shot his finger off for $50. He ate a needle from an IV line at another hospital. The Sheriff stated there are no other circumstances except this one where someone should be in the restraint chair that long. However, anytime he was given any freedom he would self-harm. The recipient was in the general population for months this year with no incidents after being found not guilty on other charges. Reportedly, the recipient knew he could beat those charges and there were no behaviors. When he had charges he knew he could not beat, the behaviors began.

Typically, if the detainee swallows an object, they call the doctor who gives direction on whether to call an ambulance, transport, or to give him a drink and monitor. When sent to the hospital, the hospital does not typically request a mental health assessment before releasing detainees; they just return them to jail. When an assessment is done, and if it documents that the Department of Human Services (DHS) placement is needed, it

typically takes 8 months from the assessment to when placement within DHS occurs. The jail is not equipped to handle a detainee with these significant behaviors as per jail staff.

Crisis Screening 2/7/22 documented the recipient was seen in a four-point restraint chair and was "rolled out into the hallway". The recipient reported that he had been in the restraint chair for over 60 hours with no availability to get up and move around. The recipient admitted to swallowing objects in jail but stated he had never eaten things before in his life; this was reported by the patient as being situational. The recipient explained that he does not believe he needs to be in jail and figured out that if he gets himself hurt or eats something, he will be sent to the hospital and out of the jail. The recipient wants to be in his cell to sleep and stated that there is nothing in there to eat. He denied self-harm, suicidal or homicidal ideation. It was documented the recipient was oriented and his mood and affect were within normal limits. The recipient displayed irritation about being in the chair. No psychosis was observed. The recipient's judgment, memory, impulse control, decision making abilities and thought processes were within normal limits. The recipient can complete their activities of daily living and has fair insight toward his behavioral and mental health as per the crisis screening.

The crisis worker interviewed the lieutenant who provided a summary of the self-injurious behavior since being detained. These included, slamming his finger in door, as well as swallowing glass, paperclips, metal part of a chair, e-cigarettes, metal for a mask, a carabineer, a pen and an IV needle. He has been in the hospital four times for removal of the foreign objects. The carabineer was still in his abdomen at the time of the assessment because the surgery to remove it was unsuccessful. The lieutenant stated that if the recipient is not restrained he will rip out his 13 staples across his stomach and eat them. He stated the client is a risk to himself and should not be let out of restraints due to the risk of consuming other inanimate objects. The lieutenant believes the recipient would benefit from inpatient hospitalization at a psychiatric hospital as per the crisis screening.

The crisis worker recommended inpatient hospitalization but noted "due to client being incarcerated, recommendation will go to jail to be given to state attorney to help the judge make the decision."

Jail Documentation for Recipient 2: Upon review of the records, the restraint episode occurred Friday 2/4/22 through Monday 2/7/22. Documentation showed that the recipient was placed in the restraint chair for his own protection at 7:08 pm on 2/4/22. He was out of the chair at 8:40 to use the restroom and was given dinner. He was back in the chair at 9:24 pm. The recipient was released to use the restroom and walk at 10:34 pm and back in at 11:00 pm. Throughout the night, every 2-3 hours the recipient was released to move around for approximately 20 minutes each time and documentation showed 15-minute checks were also completed. On Saturday 2/5/22 every 2-4 hours the recipient was released from the chair and 15-minute checks were completed. There was also documentation beginning Saturday evening around 7:00 pm where he was released after an hour to toilet or move around. On Sunday the recipient was released every 2 hours and at 2:30 he was released for 30 minutes to shower. The 2-hour releases continued throughout the overnight hours on Sunday/Monday. At 7:50 am on Monday the crisis agency was contacted concerning the recipient. The 2-hour releases continued throughout the morning, and he was released at 10:30 to shower. The recipient was with the nurse at 2:00 pm and made phone calls. At 3:12 pm it was documented that the recipient was taken back to his unit and was argumentative. At 3:37 it was documented that he was out of the chair and there were instructions to monitor him every 5 minutes. Documentation showed he was checked every 5 minutes after that. The recipient was in the restraint chair for a total of 68 hours with releases every few hours to walk, eat or use the restroom for 10-20 minutes.

The HRA reviewed a grievance he filed with the sheriff for "cruel and unusual punishment while in custody." The basis was the length of restraint and not being allowed to sleep or rest. The recipient stated he was placed in a cell without a mattress while having a fresh wound with staples from stomach surgery. The recipient also stated he was denied pain medication and "anything practical to sleep on." The HRA found no response to this grievance. Jail staff reported that it is possible someone spoke to the recipient, but no written response was found.

Jail incident reports: On 1/19/22 a note documented that the recipient swallowed a piece of metal off a blue mask and stated he also swallowed a toothbrush and a flex pen. The recipient was removed from the unit and placed in the restraint chair "for his physical well-being." The recipient told jail staff that he would keep costing the jail money if they do not let him out. His vitals were taken, and the doctor was called. The doctor said to monitor him for symptoms. Within a half hour the restraints were checked and it "appeared [recipient] was spitting up blood." The doctor was called a second time and she "suggested an emergency room visit was warranted. CO [names] escorted [recipient] to the er. [Recipient's] holding cell was stripped of all materials."

The HRA reviewed a grievance filed by the recipient regarding another similar incident earlier that month. The grievance documented that after he swallowed 2 e-cigarettes, including the batteries and wiring, and requested medical assistance, he was instead placed in a restraint chair and on suicide watch. The doctor was called and stated he would simply pass these foreign objects. The recipient documented that he had experienced bleeding in his stool, headaches, nausea, vomiting with blood and pain in his chest and stomach. The recipient reported this to staff daily, but reportedly, no medical attention had been received 5 days after swallowing the objects. There was a handwritten response on this grievance signed by the doctor on 1/12/22 which stated the doctor was told he swallowed the e-cigarette batteries not the entire e-cigarette. An X-ray was done which showed no blockage or impaction, but the foreign bodies were in the colon. The doctor recommended a GI referral to see if the foreign bodies would need to be surgically removed.

On 2/4/22 at 10:50 am it was documented that while at the hospital, the recipient was given a pen by medical staff to sign documents for the hospital and while he had the pen he "tore it apart and put the cartridge in his mouth attempting to swallow it." The recipient refused the Officer's orders to spit it out and was restrained while waiting on medical staff assistance. The medical staff were able to sedate the recipient and retrieve the cartridge from his body without further injury. Medical staff were informed not to leave anything near him or give him anything that could possibly be used in self-harm or harm of others. At 7:08 pm the recipient returned from the hospital and was placed in the restraint chair for his own safety. He had been at the hospital for swallowing a metal carabiner the previous week and it was noted this was not his first time swallowing an object at the jail since his booking date. At 8:40 pm it was documented that the lieutenant was contacted regarding the detainee sleeping and the response was that the detainee was to sleep in the restraint chair until his staples are removed from his abdomen to prevent him from causing any kind of bodily harm to himself, so he was placed back in the restraint chair at approximately 9:30pm after being released to use the restroom, take medication and eat dinner. On 2/5/22 at 2:20 pm it was reported that after being let out of the chair, the detainee became verbally combative and "moved towards" the officers. The officer threatened to use the taser if the recipient did not stop resisting, so he complied with being placed back into the chair. The 2/7/22 report documented that at 4:00 pm the recipient was removed from the chair to see the nurse. After seeing the nurse, he was taken into the room to use the phone. While using the phone he struck the wall with the phone a few times. After his calls were completed he was escorted back to the restraint chair, and he refused to go into the chair. Officers were advised to remove the chair and cuffs from the cell. Administration ordered officers to monitor the recipient every 5 minutes. On 2/8/22 around 11:30 am, the recipient was taken back to his holding cell after a new camera had been installed. The recipient refused to go back in his cell and became "very disruptive and started fighting with the officers involved." Once he was sat down in his cell and officers began to leave, the recipient stood up and appeared to be going after staff again. One officer utilized Pepper Spray to prevent injury to staff. Fifteen minutes later the recipient was taken to the shower to decontaminate and placed back into his cell. On 2/8/22 around 8:00 pm, the recipient motioned an officer to his cell and showed the officer several of the staples from his incision in his hand and stated he had flushed some as well.

A medical note dated 2/7/22 signed by the doctor and nurse documented that 1 staple was missing from his stomach and noted some redness to the incision with drainage. The recipient had an abdominal binder in place. The recipient was upset about not receiving Ultram which was a short-term pain medication and was informed Tylenol is available if needed. The recipient was also upset about the chair and it was explained that restraint

chair use was not a medical decision but a security decision. It was noted he had good blood flow in restraints but complained about poor sleep in the chair.

A nursing note on 2/7/22 documented that the nurse was notified that the recipient had been in the restraint chair since Friday 2/4/22 upon return from the hospital post-surgery. The nurse told the lieutenant her concern for the extended periods of time the detainee was in the restraint chair and recommended he not be in the chair but remain in the smock if staff are concerned with his safety. The nurse also suggested to the lieutenant that if the recipient needed to be sent to the hospital for increased risk to self, the nurse can assist with arrangements, but the lieutenant declined. The nurse provided a restraint checklist to the officers. The lieutenant notified the Sheriff of the nurse's concerns with the recipient being in the restraint chair and he gave orders to keep him in the chair for security reasons due to his history of self-harm.

A medical progress note dated 6/2/23 showed the recipient had complaints of anxiety and not sleeping well. A call to the Nurse Practitioner (NP) resulted in the NP stating he needs to let the medication get in his system to start working; no new orders were given. It was noted that patient education on deep breathing exercises was given. Another note dated 6/21/23 showed the recipient had complaints of night terrors resulting from PTSD. A call to the NP resulted in orders for Seroquel twice daily, and an increase in Prazosin. A Crisis Screening dated 6/22/23 stated the recipient would benefit from psychiatric treatment as he "may be exhibiting traits of PTSD and would benefit from therapy if this service is available." The Progress note after this documented that the results were given to the NP who did not give any new orders except to continue with medications prescribed on 6/21/23. On 7/2/23 the Seroquel morning dosage was discontinued, and a note was made to refer the detainee to mental health. On 7/17/23 the Celexa was discontinued due to patient reports that it is not working and a referral for a psychiatric evaluation was made. The recipient was released in July of 2023.

Recipient 3 [July 2023]: The recipient has a history of heart attacks and has teeth that need to be pulled. Since being in jail, the recipient has been taken by ambulance to the hospital for heart issues which showed that one of his stents has begun closing up and they discovered an aneurism. He also stated his blood pressure is high and uncontrolled. The hospital physician contacted the jail physician because, reportedly, the jail physician was refusing to give the recipient his nitroglycerin for chest pain. The recipient also reported a high turnover of medical providers contracted by the jail. The recipient reported no follow up appointments being completed as required by the hospital physician for his heart issues. The heart surgery could not be completed until his teeth are removed which needed to happen right away. The day of his tooth extraction the recipient was reportedly told the paperwork was done incorrectly and the procedure could not be completed. Reportedly, the jail physician is not giving him pain medication for his tooth issues and no antibiotics for infection.

The Sheriff & Jail Staff explained that due to the nature of the charges, the recipient has become a federal detainee. When that happens, any medical procedure has to be approved by the Marshall service and then the jail facilitates the completion of the procedure. If he is already at a hospital, necessary treatment occurs. For follow up appointments the Marshall service has to also approve. That is generally not an issue. They may recommend another physician for follow-up but typically will just use the detainee's physician. It is primarily done this way for billing purposes, so that it is the Federal government that is billed rather than the county. He still sees the nurse and physician at the jail. Their medical contract just does not apply. For the August oral surgeon appointment, the Marshalls approved the oral surgeon, but the surgeon refused to see him because he was an detainee. He is scheduled to see a different oral surgeon. A local dental office pulled 4 teeth. They were not aware of any heart appointments the recipient missed. A Nitroglycerin patch cannot be administered in jail for safety reasons, so they provide pills instead of the patch. Detainees will take a patch and put it in water to extract higher doses of nitro glycerin which they use improperly (to get high). Also, they can no longer use e-cigarettes for the same reason. The recipient received the nitroglycerin pill when the doctor prescribed it.

Jail Documentation for Recipient 3: The medication administration record (MAR) for April 2023 showed the recipient was receiving Penicillin, Lipitor, Celexa for depression, 2 high blood pressure medications – Coreg and Lisinopril, Isosorbide Mononitrate for chest pain, Spiriva and Symbicort for breathing assistance, and

Norco for pain; there was an order for Nitroglycerin tablets that were administered three times. There was an order for Ibuprofen that was discontinued.

An After Visit Summary dated April 1-5, 2023, documented the aftercare instructions from a hospital stay which included following up with cardiology in two weeks and listed some new medications to begin: Alprazolam (Xanax) for anxiety or sleep (as needed) and Norco for pain (as needed). The Norco was given for 6 days in April following this discharge, but the Alprazolam was not listed on the MAR for April.

The recipient was admitted to the hospital on April 11 for chest pain. The discharge instructions included continuing the medication he was prescribed, which included ticagrelor blood thinner, but this was not listed on the MAR for April.

The recipient was seen on 5/17/23 for chest pain and hyperglycemia. Labs were drawn and an EKG was performed. The discharge instructions included following-up with his cardiologist in 2 days.

An after-visit summary dated 5/25/23 was reviewed documenting the recipient met with a Nurse Practitioner for hypertension, lightheadedness, and chest pain. A blood glucose assessment was done as well as a continuous pulse oximetry. It was documented that there were no upcoming appointments scheduled. There was documentation from the US department of Justice which showed a cardiology consultation was scheduled for 10/12/23.

Recipient 4 [June 2023]: This recipient had 2 heart attacks and 2 stents put in since being in the jail and reportedly no follow-up appointments had occurred. During a third ER visit he was instructed to have a stress test and cardiac rehabilitation. A week later he had severe chest pain and went to another hospital's emergency department where he was told to see a cardiologist within 2 days, which reportedly has not occurred. Since then, he had passed out 3 times and allegedly, he was placed in segregation to monitor. The recipient does not know when his appointments are ahead of time but stated knew he was supposed to have cardiac rehabilitation, a stress test and physical therapy appointments following his procedures which reportedly had not occurred.

Another issue was that a family member who is the recipient's Power of Attorney agent was not informed of dates for appointments or procedures so they could be there or be available if needed. This included procedures for stents in his heart and kidney stone surgery. This was also discussed with The Jail Standards division who explained that, in their experience, notification to a Power of Attorney regarding medical trips is only shared if the detainee was in eminent threat of passing. This is due to the likelihood that escape risk or incidents would significantly increase and place staff and members of the community in danger. It was explained that Wardens and Sheriffs are legally responsible for providing for individuals in custody, similar to a "ward" of the state.

The Sheriff & Jail Staff [August 2023] explained that the recipient has been taken to hospitals in Indiana and Illinois and had 2 stents placed. They stated that there is no cardiac rehabilitation with stents. The recipient has been taken to specialists for urology, cardiology and dental within last 2 weeks. He has missed some appointments due to being hospitalized. The recipient signed himself out of the hospital once, prior to heart surgery, because he said he could not make arrangements he wanted to make, such as a will and other legal documents. The recipient wanted the family to come to the hospital to complete those documents, which is not typically allowed for safety reasons. The jail made accommodations to have a hospital attorney come to see him, but he refused. The jail contracts with retired Department of Corrections workers to transport individuals to hospitals/medical appointments. Jail staff monitor blood pressure especially if there are complaints about discomfort. If vitals are outside of parameters, they call a physician and typically, he is taken to hospital. They were not aware of the detainee ever passing out at jail.

The jail has a contract with Advanced Correctional Healthcare to provide medical care which includes an on-site nurse 20 hours per week on Monday, Tuesday, Thursday, and Friday for 5 hours each day. A physician or physician's assistant visits once per week and they have 24-hour access to the physician for medical call

protocols. Staff are able to transport detainees 24 hours a day to medical facilities at the direction of Advanced Correctional Healthcare.

The jail has a grievance policy and forms that are on the kiosks and can be emailed to Jail administrators and the Sheriff's assistant.

Jail Documentation for Recipient 4: Medical records from the jail documented that on 5/11/23 and 5/16/23 the recipient was sent to the emergency department for chest pain. On 5/19/23 the nurse followed up with the recipient following hospital stay for stent placement. He reported no more chest pain. Later that day, he complained of chest pain and the doctor's orders were to give medication and check again in an hour, at which time staff were advised to send him to the ER after taking vital signs. On 5/21/23 the recipient was given nitroglycerin and aspirin for chest pain with instructions to send him out if it is not better in 15 minutes. On 5/23/23 the recipient was given nitroglycerin again for high blood pressure and pain. The nurse practitioner for the jail followed up with him after the hospital visit and vitals were within normal limits. On 5/24/23 the recipient was given hydroxyzine for chest pressure. On 5/25/23 he was having chest pain and other symptoms and was given nitroglycerin. The nurse practitioner followed up after his hospital stay and his vitals were within normal limits. There was an order for Metoprolol for high blood pressure to be given in the evenings and Tylenol for pain. There was also a note to "keep appointment with cardiology." On 5/26/23 the nurse practitioner saw him again for heaviness on his chest. The pain reportedly went from a 5 to a 2 after taking nitroglycerin.

The HRA also reviewed records from several hospitals where the recipient was taken in the month of May. On 5/17/23 the recipient had surgery for stent placement due to heart attack. The discharge instructions documented that a follow up appointment with his cardiology physician should be arranged for 2 weeks later. On 5/21/23 the recipient was hospitalized for "unstable chest pain due to insufficient blood supply to heart." Upon discharge a referral was made to a local hospital for "cardiac rehabilitation phase II as directed." A referral was also made to urology with an appointment for 5/30/23. On 5/28/23 the recipient was examined at another hospital for chest pain. New medications to take included extra strength Tylenol every 8 hours as needed, children's aspirin, a cream for skin infection, and isosorbide mononitrate for chest pain; and, he was told to discontinue the nitroglycerin tablet. The discharge instructions said to follow up with cardiology on 6/4/23. There was a follow up appointment at the cardiologist on 7/27/23 and a stress test was ordered. A follow up appointment with cardiology was scheduled for 2/1/24.

STATUTES AND POLICIES

The Illinois Administrative Code (20 IL ADC 701.40) states in section i) regarding physical and mental health assessments for detainees that "*When a detainee shows signs of or reports unusual physical or mental distress, he or she shall be referred to health care personnel as soon as possible. A) Detainees exhibiting psychiatric symptoms, such as acute psychotic features or mood disturbances, or detainees who have a known psychiatric history shall be evaluated by a mental health professional.*
B) Detainees exhibiting suicidal behavior or ideations shall be placed in a reasonable level of care that provides for their safety and stability."

Regarding medical and mental health services, section 701.90 states: "*All jails shall provide a competent medical authority to ensure that the following documented medical and mental health services are available: (1) Collection and diagnosis of complaints. (2) Treatment of ailments. (3) Prescription of medications and special diets. (4) Arrangements for hospitalization. (5) Liaison with community medical facilities and resources…(8) Administration of medications, including emergency voluntary and involuntary administration of medication, including psychotropic medication, and distribution of medication when medical staff is not on site. (9) Maintenance and confidentiality of accurate medical and mental health records…b) A medical doctor shall be available to attend the medical and mental health needs of detainees… Professional mental health services may be secured through linkage agreements with local and regional providers or independent*

contracts. Linkage agreements and credentials of independent contractors shall be documented. 2) General medical physician services may be provided by: A) Staff physicians B) Contractual services; or C) A nearby hospital."

Additionally, it is noted that *"(1) A schedule shall be established for daily sick call. (2) The names of those detainees reporting to sick call shall be recorded in the medical log. (3) Detainees with emergency complaints shall receive attention as quickly as possible, regardless of the sick call schedule. (4) Non-medical jail staff may issue over-the-counter medication, providing the attending physician gives prior written approval to the facility for such issue and the issue is made at the request of the detainee. (e) Written Record or Log. A written record shall be maintained, as part of the detainee's personal file, of all treatment and medication prescribed, including the date and hour the treatment and medication is administered. A written record shall be maintained of over-the-counter medication, for example, aspirin, cough medicine, etc., issued by jail staff..."*

The Jail Policy on Attempted Suicide states that officers and jail personnel will take all actions necessary to provide necessary medical assistance and to preserve the scene, cooperating with all medical and investigative authorities. Regarding suicide threats, the policy states that any time an officer feels an individual is a potential suicide risk, all necessary precautions will be taken to ensure the safety of the individual. The detainee will be placed on 15-minute checks or more frequently based on a review from the shift supervisor. If a 24-hour watch is deemed more appropriate, the supervisor will make proper arrangements for personnel coverage. Any detainee placed in the Restraint Chair or in therapeutic restraints shall be done so "in accordance with the current SOP [standard operating procedure]." Regarding suicide attempts, the policy states all measures will be taken to secure the detainee and render appropriate first aid. All on-duty officers will provide a report of the incident to the shift supervisor and notify the jail administrator. When the detainee is returned to the jail, the detainee will be placed on 15 minute or more frequent checks based on review by the shift supervisor. Detainees on suicide watch will only be removed after review by the shift supervisor.

The Jail Policy on Restraint Chair use states it is the policy that the restraint chair may be used by staff to provide safe containment of a prisoner exhibiting violent or uncontrollable behavior and to prevent self-injury, injury to others or property damage when other control techniques are not effective. The policy states that the restraint chair will never be authorized as a form of punishment. The application guidelines in this policy state that correctional officers are to ensure a prisoner is kept in the restraint chair no longer than 2 hours unless exigent circumstances exist, i.e. prisoners continued violent behavior. In the event the prisoner is to remain in the chair for more than 2 hours, a member of the command staff is to be contacted. The prisoner is not to remain in the chair "more than 10 hours per manufacturers guidelines." Correctional officers will only place the prisoner in the restraint chair long enough for the prisoner to regain control of their behavior. The officer is to review the condition of the prisoner and use of the restraint chair once every 15 minutes. This includes talking with the prisoner, checking the restraints for comfort and security, developing an appropriate plan for release, checking the restraint chair monitoring log form for appropriate entries, and notifying EMS/Medical staff if signs of medical distress are noted.

The Jail Policy on Mental Health Referrals states that if a correctional officer thinks that a prisoner may need professional mental health services, a referral will be made to Franklin/Williamson Mental Health Services for emergency services. The officer is to remove all items that could be used by the prisoner to harm self from the holding cell. All instructions and information from the emergency mental health worker is to be recorded in the daily jail log, on the admission card and carried out by staff. If the mental health worker determines that the prisoner needs to be hospitalized, the ranking officer on duty will arrange to have necessary papers completed by the mental health worker and have the prisoner delivered to the hospital. The correctional officer will ensure that follow-up treatment is provided to detainee in need of mental health services.

The Jail Policy on "Special Management Inmates" which are defined as inmates placed in segregation or isolation from the general population, states that restraints are not to be used to replace supervision. Restraints are only used when necessary and in a manner that is secure, safe, and humane. The type of restraint should be

reduced to the least restrictive level which may include de-escalating an inmate by talking to them, placing an inmate in seclusion cell, and offering medication if ordered by a physician. This policy reiterated that restraints should not exceed 2 hours without authorization and consultation of a medical professional and no more than 4 hours without a face-to-face evaluation by a physician. Monitoring should occur every 15 minutes and every 30 minutes a healthcare staff or emergency medical technician will observe the inmate for signs of circulatory, respirator or other dysfunction, abrasion, irritation, or injury. Vital signs will be taken and recorded by nursing staff. Range of motion exercises should be performed every 2 hours unless the patient is too agitated or assaultive to remove restraints. The inmates will be provided bathroom privileges, hygiene requirements and exercise of limbs sufficient to ensure adequate circulation. Meals are to be provided to restrained inmates.

The Jail Policy on Medical History requires that the jail obtain medical histories for each prisoner in order to provide the on-call physician with medical information to meet the medical needs of prisoners. The officer will ensure that any medical problems for which a prisoner is presently under a doctor's care for is noted on the medical history form and verified by the physician caring for the prisoner. The officer will ensure that provisions are made to meet the prisoner's medical needs. Regarding medical emergency services, officers will notify the control room after first aid is applied. The control room will notify the hospital emergency room of the condition of the patient, write down instructions and transmit them to the officer. If an emergency room evaluation is required, the prisoner may be transported by squad car or ambulance. Officers will carry out all orders from the emergency room or attending physician pertaining to the care of the prisoner when returned to the jail. If further medical care is needed, the physician will be required to provide written instructions.

CONCLUSION

The complaints alleged inadequate medical or mental health care for four recipients housed in the jail as well as improper restraint use. Documentation showed that recipient 1 was in a restraint chair for approximately 27 hours and another restraint episode lasted approximately 11 hours for self-injurious behavior. The HRA reviewed documentation showing that the recipient was released to use the restroom 3 times and limbs were released to stretch every 2-3 hours. The jail policy states that the restraint chair can be used for self-injurious behavior. This policy also states that correctional officers are to ensure a detainee is kept in the restraint chair no longer than 2 hours unless emergency circumstances exist. In the event the detainee is to remain in the chair for more than 2 hours, a member of the command staff is to be contacted. The detainee is not to remain in the chair "more than 10 hours per manufacturers guidelines." Correctional officers will only place the detainee in the restraint chair long enough for the detainee to regain control of their behavior, as per policy. A crisis worker completed a screening approximately 15 hours after initiation of the restraint chair use. The crisis worker documented that the recipient could be returned to general population, but he remained in the chair for another 10 hours after that screening. The HRA found no documentation that command staff was contacted to extend the restraint chair usage, and, per policy, the restraint chair was used longer than the 10 hours allowed per manufacturer guidelines. Further, the "special management inmates" policy states that restraints are not to be used to replace supervision. Restraints are only used when necessary and in a manner that is secure, safe, and humane. The policy also stated that the type of restraint should be reduced to the least restrictive level, which may include de-escalating a detainee by talking to them, placing a detainee in a seclusion cell, and offering medication if ordered by a physician. The policy also requires that authorization and consultation of a medical professional is required for restraint chair usage beyond 2 hours and no more than 4 hours without a face-to-face evaluation by a physician.

Documentation for recipient 2 showed that he had several, significant episodes of self-injurious behavior resulting in surgical removal of objects swallowed. Upon returning to jail from one of the hospital stays, the recipient was placed in the restraint chair for his own safety because he had staples in his stomach from surgery. The jail administration was concerned he would pull those out and try to swallow them. This restraint episode lasted for 68 hours. The crisis worker was not contacted until Monday morning which was 60 hours after being placed in the restraint chair. The crisis worker recommended inpatient psychiatric hospitalization and stated the jail would have to provide that recommendation to the state's attorney to assist the judge in deciding on

placement. However, there was no documentation that the recommended action was taken. On Monday morning, when the nurse became aware that the recipient had been in the restraint chair since Friday evening, the nurse voiced concern to the lieutenant and recommended that he not be in the chair but remain in the smock if staff are concerned with his safety. The nurse also offered to assist with arrangements to take him to the hospital which the lieutenant declined. The lieutenant notified the Sheriff of the nurse's concerns, and he gave orders to keep him in the chair for safety reasons due to history of self-harm. Although there was documentation the recipient exhibited ongoing self-injurious behaviors, aggression towards officers, even requiring pepper spray to manage, there was no documentation of a physician consult or nursing checks during the extended restraint. There was no documentation that any other intervention was attempted such as enhanced supervision, safety smock or emergency department visit as recommended by the nurse. The HRA concludes that jail policies mentioned above were violated for both recipients. Therefore, this portion of the allegation which involved improper restraint use is **substantiated.**

The HRA recommends the following:

1. **Retrain correctional officers on the restraint chair usage and special management inmates policies. Administration should ensure completion of proper documentation that command staff are notified and whether orders are received to extend restraint chair usage beyond 2 hours. Staff should ensure that a physician orders any restraint chair usage beyond 2 hours and that no restraint chair usage occurs beyond 4 hours without a face-to-face evaluation by a physician as per these policies.**

2. **Follow the jail policy on restraint chair usage by not using the restraint chair for longer than the manufacturer's recommended 10 hours. If a detainee's behavior is not manageable after 10 hours in the restraint chair, other methods should be utilized as per the special management inmates policy, such as de-escalating a detainee by talking to them, placing a detainee in seclusion cell, or offering medication if ordered by a physician. Utilize the TAT staff and community mental health staff and/or take the detainee to the emergency department at a local hospital.**

3. **Ensure that grievances filed are addressed in a timely fashion and that there is documentation of the outcome. Retrain staff on the grievance process.**

4. **Provide the HRA with proof of retraining on the restraint chair policy and the grievance policy and procedures.**

The HRA also strongly suggests:

1. When a crisis worker recommends inpatient hospitalization for a detainee, jail administration should work with the State's Attorney and Judge to determine if a Detain and Evaluate Order is appropriate for immediate mental health treatment, or if an Order for a Mental Health Assessment for placement within the DHS is appropriate.

2. Ensure that a TAT staff and/or community mental health crisis worker is contacted in a timely fashion when there is concern of self-injurious behavior or other mental health needs which need to be addressed.

3. It was documented that when recipient 1 swallowed an object and the physician was contacted, the initial order was to monitor him. Shortly after that he began spitting up blood and when the physician was contacted again staff were instructed to take him to the emergency department. This delay prevented the recipient from obtaining necessary emergency medical treatment. Jail staff and administration should ensure that communication with the jail physician in emergency situations is thorough and complete.

The second portion of the allegation was inadequate medical care. Recipient 3 had heart issues and teeth that needed to be extracted. The heart doctors said the teeth had to be removed before the heart surgeries could be done. However, the recipient's condition declined, and emergency situations necessitated heart procedures which delayed teeth extractions initially. However, it was noted that a local dentist was able to remove 4 of his teeth. Another barrier was that the recipient became a federal detainee which changed how medical follow-up appointments could be scheduled. There was documentation that one appointment was rescheduled due to the recipient being hospitalized. Another appointment was rescheduled due to a paperwork issue when the recipient became a federal detainee. Other documentation showed that one physician refused to treat him due to being a detainee. Another issue was the recipient was allegedly not receiving Nitro Glycerin. The MAR showed he was receiving Nitro Glycerin tablets. The patch is prohibited in jail for safety reasons, which is the type of administration the recipient previously used. Any delays in medical treatment had justification documented which indicated that delays were beyond the control of the jail; therefore, the allegations involving recipient 3 are unsubstantiated.

Recipient 4 had heart issues and allegedly was not receiving the proper follow-up care. Documentation showed that the recipient had been taken to the hospital emergency department several times in May for chest pain and had a surgery to place two stents. The discharge instructions stated the recipient should have cardiac rehabilitation phase II as directed and a stress test was ordered. No documentation was found showing that cardiac rehabilitation or a stress test occurred. The jail's medical policy states that officers will carry out all orders from the emergency room or attending physician pertaining to the care of the detainee when returned to the jail. Therefore, this portion is **substantiated. The HRA recommends the following:**

1. **Administration should ensure that follow-up medical care ordered by physicians occurs in a timely fashion and remind staff accordingly. Provide the HRA with proof of the reminder to staff to provide required follow-up.**