FOR IMMEDIATE RELEASE

HUMAN RIGHTS AUTHORITY – NORTHWEST REGION
REPORT 14-080-9009
WINNEBAGO COUNTY JAIL

INTRODUCTION

The Human Rights Authority (HRA) of the Illinois Guardianship & Advocacy Commission opened an investigation after receiving complaints of potential rights violations in the treatment provided to a detainee with disabilities in the Winnebago County Jail in Rockford. Allegations were that the detainee was stripped and tied to a chair for hours, guards taunted and provoked her into anger, said she was suicidal, and did not provide her with the necessary mental health care.

Substantiated findings would violate rights protected under the County Jail Standards (20 Ill. Admin. Code 701).

Per the Winnebago County Jail website, the Winnebago County Sheriff's Department operates the Winnebago County Jail. The local police department, as well as other police agencies in Winnebago County, use the jail to hold detainees. Their mission is to take responsibility for the care of inmates placed into the Sheriff's custody as a top priority and will maintain humane facilities to ensure their safety and the safety of the community. The website goes on to state that the Winnebago County Jail seeks to provide responsive, professional and caring law enforcement services to all people in Winnebago County.

To investigate the complaints the HRA team met at the facility where we interviewed the jail superintendent, a jail sergeant, officers and an attorney. Policies and a contract for mental health services were reviewed as were relevant sections from the detainee's records and surveillance videos of the alleged incidents with written authorization.

COMPLAINT SUMMARY

The complaint states that the detainee was stripped, hands and feet tied to a chair for hours because guards said she was suicidal. The complaint goes on to say that the guards provoked the detainee to anger, put a spit sock on her head and did not provide her with the necessary mental health care that she needed.

FINDINGS

Interviews

The sergeant states that upon admission of a detainee, they are taken to the medical window for an assessment, then to the property window and from there, to booking and classification. When someone comes in to the jail who is suicidal they are put in a Ferguson suit, which is made in such a way to prevent any attempts of a detainee from hurting themselves or others around them, typically of thick material and velcro straps. Detainees with mental health issues are housed in the mental health unit. Those with suicidal ideations are housed in the same

unit, but in cells that are also equipped with a camera. There is no policy regarding disrobing and a strip search is done only if there is a charge. The sergeant went on to say that the officer will immediately contact a community mental health agency, who will complete an assessment of the detainee within 24 hours. The suicidal detainee will not receive any jail services until the mental health agency completes its assessment. The sergeant or a higher authority of the jail will make the decision in the placement of the detainee in a restraint chair.

On 11/24/13, the detainee was taken through the process of admission. The officers state that the detainee is well known at the jail due to numerous arrests. The sergeant states that the detainee expressed suicidal ideations during the process of admission. The detainee was given a Ferguson suit to put on, was placed in the mental health unit that has a camera for constant monitoring, until the community agency came in to complete a mental health assessment. Per the officer, he and three other officers and the sergeant, brought the restraint chair to the detainee's cell, and placed and secured the detainee in the restraint chair due to her attempts to hurt herself and other detainees around her, including making threats and spitting on the officers. After being placed in the restraint chair, a spit sock was placed on the detainees head and she was left alone in the room. The officer went on to say that the nurse checks the initial restraints and conducts a physical recheck every 2 hours, and the officers check the detainee every 15 minutes.

On 11/24/13, the officer completed a Restraint Observation form with recordings of when the detainee was checked, which was every 15 minutes. The officer states that she did the checks by coming to the cell window to look at the detainee. She went on to say that it is standard procedure not to enter the room and not to open the door at all, but to only look through the small window on the door. The superintendent and other officers present agreed with this procedure as being the standard for the jail staff. They are unable to state how long the detainee was in the restraint chair on 11/24/13.

The officer stated that on 11/25/13, he and one male officer and two female officers (the sergeant was not present) went into the cell of the detainee and she is laying down on the bed, but they place her into the restraint chair because of her verbal suicidal threats. Both the superintendent and the officers stated that trained officers as well as untrained officers assisted in placing the detainee in the restraint chair.

The superintendent stated that on 11/25/13, the detainee was placed in a restraint chair with a sheet over her body, with no clothes on underneath the sheet. The superintendent went on to say that the detainee was told to put the Ferguson suit on, but the detainee refused to put it on and that is why she only has a sheet to cover her otherwise naked body. Officers stated that the detainee was placed in the restraint chair because she threatened to hurt herself. A spit sock was put over her head and she was left alone in the room.

The officers stated that they did not taunt or provoke the detainee, but on the contrary they state, the detainee was verbally abusive to them, including threats to injure them, name calling and spitting on them. The officers stated that the detainee attempted to hurt herself in several forms including hitting her head and banging her head, trying to cut herself with her fingernails, rubbing her neck along the side of the bed and threatening to hang herself with her Ferguson suit.

Per the superintendent, at the point of admission to the jail, a mental health referral was made to the community mental health agency for assessment. There is no psychiatric evaluation in the records that were provided to the HRA team, although they were previously requested. The superintendent explained that the detainee was asked to bring in her own medications by

contacting family or friends, which is common practice. But if a detainee's family or friends cannot bring the medicine to the detainee, the jail doctors and nurses will assist the detainee in getting the medications. The Superintendent went on to say that there is no waiting period between when the family or friends will bring the medicine in to the jail for the detainee, but she stated that the contracted doctors and nurses will move forward in their own attempt to obtain the detainee's medicine. The contracted team of doctors and nurses include a 24- hour registered nurse, a full-time nurse practitioner and monthly psychiatric consultations from a local medical university.

Per the jail superintendent, the officers receive extensive training in control tactics using various scenarios in the correct use of cuffs, shackles, including de-escalation techniques 2 hours per year, and restraint training 3 hours per month from a mental health agency and from a medical university. The jail superintendent also stated that in regard to the restraint chair policy, all officers can assist, but they prefer to use the officers who have been trained. One of the officers then clearly stated: "You will have to ask these guys…they are trained in that. Yes, I do help with putting them in the restraint chair but I have not received any training because I just help hold them in."

RECORDS

On 11/24/13, four officers wrote separate reports regarding the threats of physical harm, yelling of profanities and suicidal ideations from the detainee and placing her into a restraint chair. The Medical Referral form dated 11/24/13 states that the detainee was "dressed in a Ferguson suit" when "she said she was going to hit her head and cut herself." The jail video does not support this. The jail video does not show the detainee spitting, but does show the application of the spit sock. There is no documentation or video that supports how the officers took the Ferguson suit off of the detainee and gave her the sheet to put on. The jail video only shows the detainee already with the sheet on. Per the reports dated 11/24/13, there were 4 officers, not counting the sergeant, securing the detainee. On these reports, none of the officers record the detainee physically resisting as she was being placed and secured in the restraint chair. On the jail video dated 11/24/13, it is confirmed that the detainee was not physically resisting the officers in any regard to the restraint chair. The jail video for 11/24/13 covers only approximately a 2 hour time period. There is no sound on the jail video.

The Restraint Observation form dated 11/24/13 was completed by the officers from viewing the detainee from a window outside the cell and recording what they saw every 15 minutes. They did not physically enter the room. One officer records on the Restraint Observation form dated 11/24/13 that the detainee was scratching herself with her fingernails and one officer records that the detainee threatened to spit on him. The time listed on the form that the detainee was placed in the restraint chair is 8:05. The time of release from the restraint chair documented on the form is 12:15. There is no a.m. or p.m. listed on the form with the time.

The Restraint Observation form dated 11/25/13 was completed by the officers from viewing the detainee from a window outside the cell recording what they saw every 15 minutes. One officer records that he in fact, did enter the room to release the detainee at 9:21 to take her for a 9 minute walk and then returned the detainee to the chair at 9:30. The time listed on the form that the detainee was placed in the restraint chair is 7:35. The time of release from the restraint chair documented on the form is 11:24. There is no a.m. or p.m. listed on the form with the time.

On 11/25/13, the jail video shows the detainee laying down on the bed with a sheet over her and she has no clothes underneath the sheet and appearing to be calm, when one male officer and two female officers (not including the sergeant) enter the room and pull her up and begin placing her in the restraint chair and her sheet falls exposing her upper body. The jail superintendent stated that the detainee refused to put the Ferguson suit on. The officers stated that the detainee threatened to hang herself with the Ferguson suit. The jail video does not depict the detainee being offered the Ferguson suit. The jail video shows that the detainee was not resisting the officers. The detainee did not spit or attempt to spit on the officers per the jail video. A spit sock was put over the head of the detainee and she was left in the room alone. On 11/25/13, four officers have written separate reports regarding the suicidal ideations from the detainee and placing her into a restraint chair. For the exact day and time that the officers wrote their reports, the jail video for the exact day and time has been provided, but what the officers report in writing, is not on the video. One officer wrote that the detainee was "rubbing her neck on the side of the bed." Another officer documented that "he secured the restraint chair to the bunk due to the detainee trying to bang her head and attempting to move the restraint chair." One officer wrote that "he fixed the chair to the bed with belly shackles to ensure she would remain stationary." And yet another reported that "she was trying to cut her throat on the edge of the bunk". None of the aforementioned reports in writing were depicted on the jail video. The jail video dated 11/25/13 is only one and a half hours in length. When questioned what happened after this, the superintendent replied that the video is "shot in incidents".

The written reports by the officers dated 11/24/13 and 11/25/13 state that the detainee made threats, cursing and did name calling not only to the officers, but also to the fellow detainees.

The superintendent stated that at the point of admission, the detainee was taken to the medical window where the jail nurse assessed her. This is supported by the progress notes written by the jail nurse dated 11/24/13. The superintendent went on to say that a community mental health agency came to the jail within 24 hours of admission and completed a mental assessment. There is no psychiatric evaluation in the records that were provided to the HRA team, although they were previously requested. Progress notes dated 11/24/13 by the jail nurse state to "encourage detainee to have her own meds brought in". Per the progress notes by the jail nurse written later in the day on 11/24/13, and the medication administration record dated 11/25/13, the medications for the detainee were located and obtained from two different local pharmacies and administered to the detainee. Reports written by the officers on 11/24/13 and 11/25/13, both depict the suicidal ideations of the detainee. On the report dated 11/24/13 the "detainee kept hitting her head, tried to cut herself with her fingernails, and threatened to hang herself with her Ferguson suit." On the report dated 11/25/13 the detainee was "rubbing her neck along the side of the bed" and kept "banging her head". These alleged actions were not supported by the jail video.

The jail has a contract with a local college of medicine, which states that the college "…shall promptly provide, at its expense, all reasonably necessary mental health services which are required by any inmate and are of a type that can be reasonably rendered on-site. The mental health services shall be provided on-site at the jail to the extent reasonably possible." The contracted team of doctors and nurses include a 24-hour registered nurse, a full-time nurse practitioner and monthly psychiatric consultations.

CONCLUSION

The Winnebago County Jail Restraint Chair policy #5-620.15 states that "Only staff trained in the use of the restraint chair shall place an inmate in such."

The same policy states that "The supervisor authorizing and 2 officers will participate in the placing of a subject in the chair." It goes on to state what the same officers will do once the subject is in the chair.

The jail restraint chair policy addresses the monitoring of the detainee as follows: "Once occupied, the restraint chair shall be placed in an area that is under constant visual monitoring." And "use of the restraint chair shall be limited to no more than two hour intervals." It also states that "restraint chairs shall only be used to temporarily hold or transport inmates who present a danger to themselves or others, display aggressive behavior which results in the destruction of property and makes overt attempts to assault staff or other inmates."

The Suicide Watch/Prevention policy states that strong indicators of potential suicide include "recent attempts or a history of suicide attempts, suicidal threats and/or a specific plan to commit suicide, and writing a suicide note or a will and putting personal affairs in order."

The Mentally Ill Inmate policy states that "inmates exhibiting questionable behavior will be placed in the designated medical area; if suicidal, the inmate will be under watch by at least one corrections officer and monitored via camera at all times".

Also, in regard to the monitoring of the detainee, the jail restraint chair policy states that "the subject shall have their restraints physically checked a minimum of once every hour by medical staff and every 15 minutes by corrections staff."

The jail restraint chair policy states that "the spit sock may only be applied when the subject is attempting to spit." It goes on to say that "the hood shall be removed and thrown away as soon as the detainee stops spitting". During the site visit meeting, when the HRA team inquired why the spit sock was left on the detainee when no one else was in the room, the jail superintendent stated with all the officers agreeing, that it is the correct procedure to leave the spit sock on even when the detainee is alone, because the detainee had previously spit. The jail restraint policy also states that "whenever possible, subjects will be fully clothed when placed in the restraint chair." "Use of the restraint chair shall be limited to no more than two hour intervals."

The Mentally Ill Inmates policy #5-612-6 states that "it shall be the policy of the Winnebago County Corrections Bureau to provide specialized treatment, services and housing for inmates who display or have been diagnosed as having mental health issues. On admission, medical personnel will evaluate each inmate with regard to signs of mental illness. The facility physician or designee will review all intake medical screening forms to ascertain mental status information and will obtain any necessary specialty evaluations for inmates who records reveal a history of psychiatric illness. When staff suspects an inmate is mentally impaired, they will contact medical staff, who may make a referral for a mental health examination. The initial mental health evaluation by facility mental health staff is to determine whether the inmate requires further evaluation, continuing mental health treatment or emergency hospitalization." The medical progress notes by the jail nurse dated 11/24/13 address the suicidal precautions regarding the detainee, including her history of mental illness and a referral for a mental health examination by a mental health agency.

The jail policy also states that "Ferguson suits and/or blankets may be substituted for normal facility clothing, if necessary. Any such action shall be recorded." The Medical Referral form completed by the sergeant states that the detainee was "dressed in a Ferguson suit" when "she said she was going to hit her head and cut herself."

In regard to crisis intervention/staff training, the Mentally Ill Inmates policy states that "the officers and other personnel primarily assigned to correctional duties shall be trained annually by mental health professionals on suicide prevention and mental health issues. Staff will be trained to be alert to possible indicators of potentially suicidal inmates such as past history of suicide attempts, active discussion of suicide plans, a sudden drastic change in eating, sleeping or other personal habits and recent crisis in personal events, such as sentencing." Per the jail superintendent, the officers receive extensive training in control tactics using various scenarios in the correct use of cuffs, shackles, including de-escalation techniques 2 hours per year, and restraint training 3 hours per month from a mental health agency and from a medical university.

The local college of medicine Health Services Agreement states that "the college shall promptly deliver on-site at the jail, and at the college's expense all reasonably necessary medical, dental, and psychological health care services needed by any individual under the custody and control of the Winnebago County Sheriff and incarcerated at the jail." The contracted team of doctors and nurses include a 24- hour registered nurse, a full-time nurse practitioner and monthly psychiatric consultations.

According to regulations that govern the Department of Corrections, County Jail Standards (20 Ill. Adm. Code 701.70):

a) Classification Information

Each facility shall have written guidelines for the classification of detainees that specify criteria and procedures for determining and changing the status, assignment, or security of a detainee. To determine each detainee's degree of security, housing, programs, and assignments, the following items of information, to the extent available, shall be considered, among other matters:

5) Past criminal history, including known prior institutional history…

7) Medical condition and treatment needs.

8) Mental and emotional condition and needs.

9) History of substance abuse…

13) Detainee's attitudes regarding him or herself and his or her future….

6) Mentally Ill, Developmentally Disabled, Dually Diagnosed, or Emotionally Disturbed

A) Detainees who are mentally ill, developmentally disabled, dually diagnosed, or emotionally disturbed shall be housed or tiered and maintained under supervision as recommended by a mental health professional.

B) Action shall be taken to transfer detainees who have been determined by mental health professionals to be severely mentally ill, developmentally disabled, or emotionally disturbed to an appropriate facility.

Under section 701.90 Medical and Mental Health Care:

a) Medical and Mental Health Services

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.

6) Environmental health inspections.
7) Supervision of special treatment programs, as for alcohol and other drug dependent detainees.
8) Administration of medications.
9) Maintenance and confidentiality of accurate medical and mental health records.
10) Maintenance of detailed records of medical supplies, particularly of narcotics, barbiturates, amphetamines, and other dangerous drugs.
b) Physician, Mental Health, and Dental Services
1) A medical doctor shall be available to attend the medical and mental health needs of detainees.
A) Arrangements shall be made for provisions of emergency dental care as determined necessary by a dentist or a physician.
B) 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.
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 such 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. A written record shall be kept of all detainees' special diets.
h) Mental Health Training
Annually, mental health professionals shall provide training to all jail officers and other personnel primarily assigned to correctional duties on suicide prevention and mental health issues.
1) Suicide prevention training shall include the nature and symptoms of suicide; the specifics of identification of suicidal individuals through the recognition of verbal and behavioral cues, situational stressors, evaluation of detainee coping skills, and other signs of potential risk; monitoring; evaluation; stabilization; and referral of suicidal individuals.
2) Mental health training shall include the nature of mental illness; symptoms; specifics of identification of mentally ill individuals through the recognition of verbal and behavioral cues symptoms of mental illness, situational stressors, evaluation of detainee coping skills, and other signs of potential risk; monitoring; evaluation; stabilization; and referral of the mentally ill detainee.
Under Section 701.160 Discipline:
j) Use of Restraints
Restraint devices, such as handcuffs, waist chains, leg irons, leg braces, straitjackets, etc., shall not be applied as a penalty.
1) Such restraints may be used on a detainee:
A) As a precaution against escape during transportation.
B) On medical grounds by direction of the physician.
C) By order of the jail administrator in order to prevent a detainee from injuring others or to prevent a detainee from damaging or destroying property.
2) A written report shall be placed on file whenever restraint devices are applied in accordance with subsection (j)(1). Additionally, each individual case shall be reviewed at least once every 24 hours to determine the necessity for such restraints.

3) Psychotropic medicines shall not be used as a disciplinary device or control measure.
k) Use of Force by Staff
Limitations on the use of force do not prohibit self-defense, prevention of injury to another staff member or detainee, prevention of property damage, or efforts to subdue a recalcitrant or to thwart or prevent escape or attempt to escape. The least force necessary under the circumstances shall be employed.

Complaint: The detainee was stripped, hands and feet tied to a chair for hours and a spit sock put on her head because guards said she was suicidal. The sergeant stated that on 11/24/13 the detainee expressed suicidal ideations during the process of admission. She was given a Ferguson suit to put on and was placed in the mental health unit that has a camera for monitoring, until a mental health facility came in to complete an assessment. During the site visit when the HRA team asked why the jail video only shows 2 hours in length for each day of 11/24/13 and 11/25/13, the jail superintendent stated that the video is "only recorded in incidents". The jail restraint policy states that "the inmate will be under watch by at least one corrections officer and monitored via camera at all times." Jail policy states that the "use of the restraint chair shall be limited to no more than two hour intervals." The HRA team was not able to determine by the jail video or other specific documentation how long the detainee was in the restraint chair on 11/24/13; the jail staff were uncertain as well. Per the officer, he, being trained in restraint use, and three other officers (including one officer who was not trained in restraint use) and the sergeant, on 11/24/13 placed and secured the detainee in the restraint chair due to her attempts to hurt herself and other detainees around her, including making threats and spitting on the officers. The jail policy states that "only staff trained in the use of the restraint chair shall place an inmate in such." After being placed in the restraint chair, a spit sock was placed on the detainee's head and she was left alone in the room. The jail policy states that "the spit sock may only be applied when the subject is attempting to spit. The hood shall be removed and thrown away as soon as the detainee stops spitting." The officer went on to state that the nurse checks the initial restraints and conducts a physical recheck every 2 hours and the officers do not enter the cell to physically check, but view through the window of the cell door to check the restraints every 15 minutes. The jail policy states that "the subject shall have their restraints physically checked every 15 minutes by corrections staff and by medical staff a minimum of once every hour."

On 11/25/13, the jail video shows two male officers and two female officers going into the cell of the detainee, picking her up and placing her in the restraint chair. The jail policy states that "the restraint chair shall not be utilized as a punishment for inmates. The supervisor authorizing and 2 officers will participate in the placing of a subject in the chair." Officers state that the detainee was placed in the restraint chair because she threatened to hurt herself. But they did not provide evidence that they entered the room prior to this, and there is no sound on the jail video. The superintendent states that the detainee was placed in a restraint chair with a sheet over her body, with no clothes on underneath the sheet. The superintendent went on to say that the detainee was told to put the Ferguson suit on, but the detainee refused to put it on and that is why she only has a sheet to cover her otherwise naked body. Jail policy states that "whenever possible, subjects will be fully clothed when placed in the restraint chair." The jail policy goes on the state that "Ferguson suits and/or blankets may be substituted for normal facility clothing, if necessary. Any such action shall be recorded." The Medical Referral form dated 11/24/13 states that detainee was detainee was "dressed in a Ferguson suit" when "she said she was going to hit her head and cut herself." The jail video does not support this. There is no documentation

or video that supports when or how the officers took the Ferguson suit off of the detainee and gave her the sheet to put on. The jail video only shows the detainee already with the sheet on.
A spit sock was put over her head and she was left alone in the room. The jail policy states that "the spit sock may only be applied when the subject is attempting to spit. The hood shall be removed and thrown away as soon as the detainee stops spitting." Jail policy states that "use of the restraint chair shall be limited to no more than two hour intervals." The HRA team was not able to determine by the jail video or other specific documentation how long the detainee was in the restraint chair on 11/25/13. Substantiations of the complaint come in violations of jail policies and procedures: having multiple and untrained staff assisting in restraint chair use, the failure to make physical checks every 15 minutes and medical checks every hour, the failure to document when and how all manner of clothing was removed from the detainee and when/why the detainee was given a sheet to cover herself, the failure to clearly document time frames with a.m./p.m., exceeding the 2 hour time limit for restraint chair use, and the failure to remove the spit sock once the detainee stopped spitting.
Complaint: The guards provoked the detainee to anger. The officers state that they did not taunt or provoke the detainee, but in fact, they state that the detainee was verbally abusive to them, including threats to injure them, name calling and spitting on them. Written reports from the officers on 11/24/13 and 11/25/13 confirm the aforementioned. The jail video does not have sound on it to assist in the confirmation. Per the jail superintendent, the officers receive extensive training in control tactics using various scenarios, including de-escalation techniques 3 hours per month from a mental health facility and from a medical university. Jail policy states that staff are trained to be alert to possible indicators of potentially suicidal inmates such as past history of suicide attempts, active discussion of suicide plans, a sudden drastic change in eating, sleeping or other personal habits and recent crisis in personal events, such as sentencing." The complaint is not substantiated.
Complaint: The facility did not provide the detainee with the necessary mental health care that she needed. Per the superintendent, at the point of admission to the jail, a mental health referral was made to a community mental health facility for assessment. This is supported the progress notes by the jail nurse dated 11/24/13. There is no psychiatric evaluation included in the records that were provided to the HRA team, although they were previously requested. The superintendent explained, and progress notes dated 11/24/13 confirm, that the detainee was asked to bring in her own medications by contacting family or friends. But if a detainee's family or friends cannot bring the medicine to the detainee, the jail doctors and nurses will assist the detainee in getting the medications. The Superintendent went on to say that there is no waiting period between when the family or friends will bring the medicine to the jail for the detainee, but she states that the doctors and nurses will move forward in their own attempt to obtain the detainee's medicine. Per the progress notes by the jail nurse dated 11/24/13, and the medication administration record dated 11/25/13, the medications for the detainee were located and obtained from two different local pharmacies and administered to the detainee. The complaint is not substantiated.
RECOMMENDATIONS

1. Ensure adequate care and services of the patient by training all staff who apply or assist in restraints and restraint chair use.

2. Follow the jail restraint policy by having the sergeant and only 2 other officers participate in placing the detainee in a restraint chair instead of 4

or 5, which only escalates the situation and causes undue intimidation and fear to the detainee.

3. Follow the jail restraint policy by having officers physically check the restraints of detainees every 15 minutes and the medical staff physically check a minimum of once every hour.

4. Ensure that time frames for restraint chair use are clearly documented to confirm compliance with jail standards and policies.

5. Follow the jail restraint chair policy by assuring that the detainee is under watch by at least one officer and monitored via camera at all times.

6. Per the restraint chair policy, ensure that use of the restraint chair shall be limited to no more than two hour intervals.

7. Follow the jail restraint policy by removing the spit sock from a detainee and throwing it away as soon as the detainee stops spitting.

8. Clearly document the placement in or removal of the Ferguson suit or clothing.

SUGGESTIONS

1. Allow detainees to be clothed when placing them in the restraint chairs whenever possible as per policy.
2. HRA notes that a sheet provided to a suicidal detainee represents just as much of a suicidal risk as clothing.
3. Ensure that patients under watch are monitored by cameras at all times.

RESPONSE

Notice: The following page(s) contain the provider response. Due to technical requirements, some provider responses appear verbatim in retyped format.

Office of the Sheriff
Winnebago County

650 West State Street
Rockford, Illinois 61102
815/319-6400

Richard A. Meyers
Sheriff

October 9, 2014

Florence Sandberg, Chair
Human Rights Authority
Illinois Guardianship and Advocacy Commission
4302 N. Main St., Ste. #108
Rockford, Illinois 61103

Re: Report #14-080-9009
Winnebago County Jail

Dear Ms. Sandberg,

Please let this letter serve as the Winnebago County Jail's supplemental response to the Report and Recommendations of the Northwest Regional Human Right Authority of the Illinois Guardianship and Advocacy Commission. In your letter dated September 5, 2014, you indicated that the following four Recommendations contained in the original Report and Recommendations were not adequately addressed in the Jail's initial Response:

Recommendation #1.

In the Winnebago County Jail's initial response, I indicated that all Winnebago County corrections officers are trained in the use of restraints, including the restraint chair. You responded by pointing out that one of the officers admitted during the site visit meeting to having no restraint chair training.

All corrections officers when they are initially employed receive in-house training, which includes training in the appropriate use of restraints and the restraint chair. The Winnebago County Jail also has a group of corrections officers that receive additional training in order to better prepare for and handle emergencies that may arise in the Jail. Those officers are part of the Corrections Emergency Response Team (CERT) and those officers receive additional training in the use of the restraint chair.

In speaking to the corrections officer who allegedly made the referenced statement, she indicated that she believes her statement was taken out of context and that she thought it was clarified during the site meeting. She indicated that what she meant by her statement was that typically the CERT officers handle placement of the detainees into the restraint chairs as they have been trained more extensively. However, she acknowledged that use of the restraint chair was demonstrated during her initial training as a corrections officer.

Office of the Sheriff
Winnebago County

650 West State Street
Rockford, Illinois 61102
815/319-6400

Richard A. Meyers
Sheriff

Recommendation #2.

You have asked that the Winnebago County Jail provide verification that the specific detainee at issue in this matter was under watch by at least one officer and monitored via camera at all times. Corrections officers in Winnebago County work either 6:00 a.m. to 6:00 p.m. or 6:00 p.m. to 6:00 a.m., with two teams rotating on each shift. A-team and B-team cover the day shift and C-team and D-team cover the night shift. Copies of the rosters for the entire Jail for November 24, 2013 and November 25, 2013, are attached to this letter as Exhibit B.

Relevant to this matter are the Floor Control Officer for the 2nd Floor and the 2A Med/Ment Hlth Officer. The Floor Control Officer is the individual that monitors the various cameras on the second floor, including the camera that was located in the detainee's cell. The 2A Med/Ment Hlth Officer is the officer assigned to Pod 2A in the Jail, where the detainee was housed, and was the officer responsible for monitoring the detainee while in the restraint chair. The shift assignment rosters for November 24, 2013 and November 25, 2013, reflect that both positions were fully staffed on those dates, as they are every day of the year, 24 hours a day. These rosters provide the best evidence at the Jail's disposal to verify that the detainee was under watch by at least one officer and monitored via camera at all times while in the restraint chair.

Recommendation #6.

You have asked that the Jail provide a copy of the policy that provides, as stated in the response letter: "detainees are to be allowed out of the restraint chair after two hours, but if the supervisor finds that the detainee is still agitated and a suicide risk, the detainee may be placed in the restraint chair for an additional two hours."

If you will note, the cited phrase is not in quotes in the response letter because it is not contained in the policy. The policy provides: "Use of the restraint chair shall be limited to no more than two hour intervals." The Jail's interpretation of that policy and ongoing practice has been to allow the detainee out of the restraint chair after two hours, evaluate the detainee to determine if he or she continues to present a risk of harm to themselves, and place the detainee back in the chair if the determination is that they do present a further risk of harm. To satisfy this Recommendation, the restraint chair policy will be amended to reflect the current practice.

Recommendation #8.

You have asked that the Jail provide clear and concise documentation and/or video for all the placements in, and all the removals of, the Ferguson suit. The use of Ferguson suits and/or blankets is provided for in Winnebago County Sheriff's Department General Order No. 5-612-6, attached hereto as Exhibit C, which states on page 7 as it relates to suicide attempts: "Ferguson suits and/or blankets may be substituted for normal facility clothing, if necessary. Any such action will be recorded."

The detainee in this matter was initially placed in the Jail's general population. Therefore, as the video footage dated November 24, 2013 shows, the detainee was in a regular Jail jumpsuit. When the corrections officers determined that she presented a risk of harm to herself, she was placed in a restraint chair in the same jumpsuit. At

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Sheriff

that time, a Medical Referral Form was completed by the Sergeant, a copy of which is attached hereto as Exhibit D, which indicated that the detainee was to be dressed in a Ferguson suit until cleared by RWC (Rosecrance Ware Center). According to Jail practice, the Ferguson suit would have been substituted for the detainee's Jail jumpsuit once she was removed from the restraint chair. The detainee would remain in the Ferguson suit until cleared by a mental health professional.

On November 25, 2013, the detainee was not wearing the Ferguson suit, but that was her choice. The corrections officers would not have removed it from her, and, as the video footage shows on that date, the Ferguson suit is laying on the floor of the detainee's cell. The Jail has no way to determine when the detainee chose to remove the Ferguson or even if she put it on after it was given to her on November 24, 2013. As stated in the previous response, the corrections officers will not force a detainee to put on a Ferguson suit as this may result in a struggle, potentially causing injury to the detainee and/or the officers.

A copy of Exhibit A, General Order 5-620.38, which was inadvertently not included with the original response, is attached.

Thank you for your consideration in this matter.

Respectfully,

Andrea S. Tack

Andrea S. Tack
Winnebago County Jail Superintendent