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HUMAN RIGHTS AUTHORITY METRO EAST REGION

HRA CASE # 15-070-9010

MADISON COUNTY JAIL

INTRODUCTION

The Metro East Regional Human Rights Authority (HRA) received a complaint of possible rights violations at Madison County Jail. The jail, which services the Madison County area, has an average population of 280 detainees. The staff totals 57 members, including three nurses and one part-time physician. The jail contracts with a community mental health provider for crisis services but has no psychiatrist on staff and offers no one-on-one counseling.

The complaint alleges that a detainee with mental health needs did not receive adequate care for his diabetes and schizophrenia, resulting in dangerously high and low blood glucose levels as well as behaviors associated with the detainee's mental health needs. The allegation also states that the detainee was sent to the hospital five times in a two week period for hypoglycemia related to inadequate diabetic treatment. Additionally, the detainee was held without proper antipsychotic medication for 3 months during the latest time spent at the jail and has been without medication during previous stays at the jail.

If substantiated, the allegation would be a violation of Illinois County Jail Standards (20 IL ADC 701).

To investigate the allegation, an HRA team visited the jail facility and interviewed staff members. The team also reviewed documentation pertinent to the investigation.

METHODOLOGY

To pursue the investigation, The HRA team visited the jail facility and interviewed staff members. The team also reviewed documentation relevant to the investigation. During the interview, staff explained that the detainee has a history of going back and forth from the jail to state-operated mental health facilities. Having been found unfit to stand trial while in jail, the detainee was sent to a state-operated mental health facility for fitness restoration and subsequently ordered by the court to be returned to jail after being found fit. The individual's condition once again deteriorated while being detained in the jail and he was again returned to

the mental health facility for fitness restoration. Once fitness was again established, the individual was sent back to jail.

FINDINGS

Staff explained that a mental health questionnaire is completed for each detainee upon intake at the jail and all staff are made aware of his/her physical and mental health needs. This particular detainee had been at the facility previously and staff were familiar with his needs. The detainee was housed in the protective custody block, which is for sex offenders, people with uncontrollable behaviors, and people who may have conflicts in the general population. Staff explained that they monitored this detainee because they suspected he was not taking his medication in an effort to initiate behaviors that would result in his being transferred to a state-operated facility. In addition, staff moved his lunch area so he could be supervised while eating his diabetic meal to ensure that his blood sugar would not drop. They also monitored this individual to ensure he was not eating food that was not part of his diet. His blood glucose level was ordered to be checked twice daily. The detainee occasionally self-administers insulin injections under supervision of an officer but often refuses his diabetic and psychiatric medications, a pattern he established and has maintained during all his stays at the jail. Staff gave examples of times the individual would hide or cheek his medication in order to keep from taking it; these attempts were documented along with all refusals. Staff believe that the detainee's fluctuating blood glucose levels are from noncompliance of medication and not eating a diabetic diet.

Regarding staffing, nurses are at the jail between 6 or 6:30am until 2:30 or 3pm, seven days a week. A physician is present two days a week although staff have daily contact with the physician. There is no psychiatrist on staff. Madison County has tried to employ a psychiatrist in the past but has been unsuccessful at keeping them at the facility. There are no counselors employed by the jail. Staff explained that it is difficult to maintain their current contracted company, which employs social workers who come in at scheduled times each week. The social workers assess the detainees when it is deemed necessary and will respond in crisis situations. In addition, the social workers can refer the detainees to a local hospital for mental health treatment. At least 20 of the 57 officers employed at the jail have received Crisis Intervention Training (CIT), a 40-hour course that focuses on avoiding escalation. In addition, all officers must complete annual health and jail suicide training..

Officers distribute medications three times daily, at 8am, 4pm and 11pm, although under special circumstances medication can be provided outside of those times. The physician did not change the detainee's medications from those provided by the state-operated facility. The detainee had a defined schedule for taking his medication at the mental health facility and every effort was made to keep to that schedule. During his last time at the jail, the detainee was sent to the hospital for a problem with his ear, but not for diabetes or mental health issues. The detainee had

made makeshift ear plugs and attempted to use a pencil to remove the plugs. Staff said that a report is generated any time someone leaves the jail. There were no such reports from his previous stays, nor did the staff recall the detainee being sent to the hospital five times in a two week period as stated in the complaint.

Staff explained that detainees' initial health is determined at intake through a questionnaire completed by the guard. Each detainee is provided a copy of the rules and regulations which also includes contact information for a Captain. Detainees are also seen by a booking officer who asks additional questions. An intake form and two booking sheets are completed on each detainee upon arrival at the jail. The sheets are sent to the nurse for further review; the nurse performs an assessment of the detainee and relays that information to the physician. If an individual is detained at night, the information is reviewed by the nurse the next morning. If there is an immediate need, there is a nurse on call 24/7 and the physician can also be reached after hours. If the detainee is booked with medications, the pharmacy is contacted to verify that the medications are current. State-operated facilities usually send detainees with a supply of medication that lasts a couple of days. The detainee's family can bring in psychotropic medications that are then verified with the pharmacy. If a detainee is ill or needs mental health assistance while in jail, he/she fills out a "sick slip" that is forwarded to the nurse, physician or community mental health provider. The jail's infirmary has a stock of commonly used medications. If additional medication is required, it is obtained from a local pharmacy.

Staff indicated they had no knowledge of the detainee receiving any incorrect medications. During medication passes, the guard leaves the infirmary with medications that have been set up in individual cups and verified by a nurse. The medications include cards and the guard matches the cards with the detainee's wristbands. However, staff acknowledged that there could have been a misunderstanding during a medication pass, i.e., the detainee could have approached when another name was called. There is a numbered medication form associated with each detainee. The form lists the medication name, dosage, and times administered for all detainees. The nurses compile these forms. Medication refusals are sent back to the pharmacy. Although the medication pass date is documented, the name of the actual medication is documented only if the detainee refuses the medication.

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The HRA reviewed a prisoner intake information record dated 8/15/2014, the date on which the detainee was transferred from the state-operated mental health facility. Information on the form indicated that the detainee had special needs, i.e., "Medicine" and "Diabetic." The initial booking questionnaire, dated 8/14/2014, states that the detainee is diabetic and takes medication for epilepsy/seizures and high blood pressure. Another medical sheet, dated 8/15/2014, states that the detainee is diagnosed with diabetes mellitus, hypertension, and schizo-affective disorder, as well as chronic back issues and memory loss of the last year. A list of medications the detainee received at the state-operated facility includes: Geodon (twice a day, although conflicting dissemination instructions indicate that the medication should be taken both at 12pm and at night as well as at 8 and 11pm), and Ativan (to be taken every day). For diabetes, the detainee has Metformin (twice daily), Glipizide (every day), 25 units of Lantus in the morning, Humalog (daily, based on a sliding scale of sugar levels, and Desyrel (at night). It was later noted in a memorandum dated 10/29/2014, regarding the detainee keeping Prilosec under his tongue, and that the Geodon, Prilosec, Motrin, and Neurontin were discontinued.

The HRA reviewed blood glucose level records. According to The American Diabetes Association, the normal fasting blood glucose target range is 70-100 mg/dL, a fasting plasma glucose level (fingerstick) before a meal of 70–130 mg/dL, less than 180 mg/dL after a meal and 100-140 mg/dL at bedtime. Although the staff interview indicated that only refused medication was documented, the HRA obtained a log sheet indicating the detainee's blood sugar levels and the amount of Lantus/Regular insulin provided between 8/15/2014 and 12/5/2014 which showed the detainee's blood sugar level was above 200 on 52 occasions, and was recorded as high as 414, 456, 501, and 502. The detainee's blood sugar level dropped below 100 on 24 occasions during that time, and was recorded as being as low as 52, 49 and 60. The blood sugar was checked twice daily and often Lantus/Regular insulin was provided twice daily. There were four days when insulin was not provided with no reason documented. During that period, the HRA noted 12 times when insulin was only administered once in the day but the blood sugar was checked twice. Again, no reason was provided for this action. The sheet did not mention Humalog, only Lantus and Regular.

A memorandum dated 10/29/2014 reads "On October 29th, 2014 at 0820 hours I was handing out medication in cellblock C-South to Detainee # [number and name]. I placed [Detainee's] medication in his left hand; he then placed the medication into his mouth. I had [Detainee] open his mouth and one pill was sticking out the right underside of his tongue and the other pills were under his tongue. I told [Detainee] to swallow his medication he did not have any more water in his cup so he asked another detainee to put water in his cup. As [Detainee] turned around with his back to me he spit one of his pills in the Razor container. I told [Detainee] to hand me the Razor container and he refused. I was able to grab the container through the chuck hole and the pill was identified by nurse [Name] as his Prilosec; the pill was placed back onto the medication cart." Another memorandum on 9/3/2014 reads that the detainee was "… placed in an Attorney booth in order to eat his meal, which he ate everything. [Detainee] was searched before returning to cellblock C-South. In the bottom of his deck of cards I found a piece of aluminum foil wrapped up, from the top apple sauce." Another memorandum stated 8/31/2014 reads "At approximately 7:30am, I, [Deputy and Number], entered the infirmary and retrieved the cart that contained the 8:00am morning medication for the Dorm, while both [Nurses] were in the infirmary. I also picked up the insulin shots for [Detainee and Number], which had already been drawn out, placed in his 8:00am container, labeled with his name, and laying on the table across from the med cart. Morning medication was then completed, which included [Detainee] receiving his two insulin shots. When returning the medication cart to the infirmary, I was then advised by [Nurse] that [Detainee] was not to have received his two injections, because at approximately 6:30am, when his blood sugar was tested, the test showed that he would not need them."

In the record, there is also evidence in a radiology report, dated 10/15/2014, that the patient fell and went to the infirmary due to the fall. The record indicates that there was no fracture, dislocation or degenerative changes present due to the fall. The HRA was also provided with laboratory tests, dated 5/19/2014 from a hospital and x-rays were taken on the thoracic and lumbar spine, right shoulder, and left knee with no acute findings. There was documentation of an additional hospital visit on 11/4/2014 where the detainee had inserted paper tiles into his ear intentionally.

The HRA was also provided a letter that was written to a staff member from the detainee which reads "[Detainee] needs moved to Seg. 2 please. Without his psych medication can't communicate well with others over the Mike Brown [Ferguson, Mo.] decision its causing fights … If not could he sign an official grievance form and have it on file please."

The HRA reviewed a crisis intervention clinical assessment from the community mental health provider dated 8/18/2014 which reads "MCS infirmary staff requested an assessment. He is refusing to eat and refusing medical Tx. He has been found UFST [Unfit to Stand Trial] in the past. He claims that he is feeling ill. States 'My stomach is very upset.' He knows that he needs to eat and take his medications. He is over talkative. He has loose association, some difficulty with memory, some paranoid thoughts. Overall, I assess him to be low risk for harm to self or others. Very over talkative. Difficult to insert question or seek clarification. Don't know if this is due to MH symptoms or blood sugar." Another crisis intervention dated 10/9/2014 reads that there was an assessment of risks requested "due to reports that he is stressed and being bullied. There was concern for his safety. [Detainee] denied being suicidal. He doesn't know last thoughts of suicide. He didn't express any concern for his safety. He did state that there were a couple of guys on the block that threaten him for his food but he's dealing with it. He states 'I'm not giving my food away.' His biggest concern is that he doesn't think his insulin is right. He is also upset stating 'I just don't think I threatened a judge.' Most of his thoughts are focused on his mental health, physical health and legal issues. I assess him to be low risk. I staffed his case with staff that expressed concern." Another intervention narrative dated 10/15/2014 states that the detainee requested an assessment "due to an increase in symptoms. [Detainee] denies SI [serious illness]. He states he's not sleeping well. His blood sugar was very low this AM. He was argumentative with staff this AM. Currently he is very confused. He isn't making sense when he talks, jumping from one topic to the next. He states that he's hearing voices and given his response time to direct questions that is very likely. I assess hi risk to be low. I staffed his case with the infirmary to try to see if we should do something different. Currently they supervise the eating of his meals. They have to search him as he will try to bring food back on the block with him. He is supervised to take his medication. It appears he is probably just having a bad day that started with the low blood sugar."

An official incident field report, dated 10/15/2014, stated that the detainee was escorted to the infirmary to have his blood sugar checked. While leaving the cellblock, the detainee was verbally abusive towards staff and the detainee's blood sugar was found to be 52. The detainee stated that "I ain't eating anything" and "gently fell to the floor." Staff forcefully made the detainee enter the attorney booth and encouraged him to eat. Eventually, the detainee did eat and the blood sugar was checked again and it was at 80. A later check indicated it rose to 258.

The HRA was provided a copy of a duty logs that contained the detainee's name. On 3/26/2014 it reads that the nurse checked the detainee's blood sugar and it was down to 43. The detainee was given food to raise the blood sugar. The passage also reads that the detainee was "… also then placed in a male attorney booth to eat breakfast, and be better monitored." Later it said that the blood sugar was checked again and it was 160. A section on 4/9/2015 stated that the detainee wanted to speak with "CRISIS" and that he had "… a lot going on inside his head because of not receiving his medication." On 5/19/2014 the log states a nurse went to check the detainee's

blood sugar and he was found lying on his back outside of the shower and was taken by ambulance to the hospital. On 8/15/2014 it was determined that the detainee was to consume all of his meals in full view such as in the attorney or visitor's booth. On 8/18/2015 it was documented that the detainee refused to eat his meal. On 8/22/2014 a passage reads that the detainee "… attempted to hand this r/o back some of his medication. [Detainee] stated he would not take two pills because he did not know what they were. All medication was collected and will be given to medical staff and inform [Detainee] during nurse call what he is taking." Later that same day a note reads "… after the nursing staff advised he had refused his morning meds, tested high for blood sugar after lunch, and then cursed them for not allowing him to take his meds when he wanted them. He was advised that if he continues to be uncooperative with the medical staff he will end up back in SEG-1 so they can better monitor him. He said he understands." On 9/9/2014 there was another incident when the detainee said he was not going to eat and then the next day he met with a nurse regarding the situation. Much of the log was dedicated to documenting dates and times the detainee ate in the attorney booth.

The HRA reviewed the "Administration of Medication Policy and Procedure" which is the guideline for the administration of medications by correctional officers. The procedure defines medication pass times, and discusses responsibilities for the medication chart and the administration of medications. The policy reads that "E) At the end of each medication pass the correctional officer will sign the last page of the medication sheet and indicate the time of the pass. (See Attachment A). F) The correctional officer will indicate any refusals by the initial R and the time of the refusal placed on the line to the left of each medication. NOTE: each officer at the end of his medication pass must sign the medication sheet. A non-signature means the pass was not made and none of the inmates received their medications. <u>If it is not written it is not done!</u> … A) It is the responsibility of the correctional officer passing medications to see that each inmate takes his medication. If the inmate is refusing his medication the correctional officer will properly note on the medication sheet his refusal (See attachment B)." The policy states that the officer performing the medication passes must sign the sheet or it means that the medication was not provided. Another policy titled "Maintenance of Detainees on Medication Policy and Procedure" reads "Any detainee while being booked into the Madison County Jail who states he is on medication prescribed by a doctor outside the jail setting will have that information noted in the medical sheet of the booking form. The medical staff on the next sick call will review this information. At any time after the booking process the detainee makes this information known to any jail staff member the information will be passed on to the medical staff and reviewed with the detainee on the next sick call or at the medical staff's earliest opportunity."

The HRA requested the medical documentation mentioned in the interview (and below) which indicate that medication was refused but the facility stated that the records were stored offsite and obtaining them would be taxing on the facility staff. The facility requested that the HRA proceed without the records however, without the records, the HRA was unable to reach a sound conclusion regarding medication refusals and treatments.

The Illinois Administrative Code reads "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 … 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. 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 … 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. A written record shall be kept of all detainees' special diets" (20 Il Admin Code 701.90).

CONCLUSION

The 20 Il Admin Code 701.90 reads, "A written record shall be maintained, as a part of the detainee's personal file, of all treatment and medication prescribed, including the date and hour the treatment and medication is administered." According to the facility staff and the information provided for our review, this requirement is not being followed outside of the insulin care.

In addition, the HRA notes that there is no comprehensive record of the detainee's medications, such as a medication tracking sheet or up-to-date medication list. Instead there are medications listed in multiple areas of the chart. For example, the intake medical sheet indicates some medications while additional medications are listed on a sick call slip and on a memorandum. This is confusing and could cause adverse effects to a detainee's care while at the facility.

The HRA saw no evidence that the individual was hospitalized 5 times in a two week span due to inadequate treatment for diabetes. The HRA did see evidence that on 8/31/2014 he was provided two unnecessary insulin shots. Additionally, it was documented that his blood sugar levels rose or fell from targeted levels. Along with these changes in levels, there was indication that the individual refused to eat at times and the facility took measures to assure he was eating. The facility stated that they only document refusals during medication passes, but would not provide the documentation. This practice is supported by the jail policy. Consequently, the HRA determines that the complaint that the detainee was not provided adequate treatment is **substantiated.**

RECOMMENDATIONS

1. The HRA recommends that the facility conduct training with staff to assure that a detailed, written record of medical interventions is maintained as part of each detainee's file, as required in Illinois County jail standards (20 Ill. Admin. Code 701.90).

2. The HRA recommends that the jail policy be revised accordingly.

3. The HRA suggests that the facility implement a more comprehensive system for tracking detainee medications to ensure safety, accuracy and efficiency.