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Egyptian Regional Human Rights Authority
Report of Findings
15-110-9004
Wabash County Jail
July 30, 2015

The Egyptian Regional Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission has completed its investigation concerning Wabash County Jail. The jail has 5 cells and can house 17 inmates. The census at the time of the investigation was 11. The specific allegations are as follows:

1. **Medical/mental health care was not provided – inadequate treatment**
2. **An inadequate discharge planning process was followed**

If substantiated, the allegation would violate protections under Illinois County Jail Standards (20 IL ADC 701.10; 701.90 & 701-210).

To investigate the allegation, the HRA Investigation Team consisting of two members and the HRA Coordinator conducted a site visit at the jail. During the visit, the team spoke with the recipient whose rights were alleged to have been violated, the Sheriff and staff members at the jail. Policies relevant to the complaints were also reviewed.

Allegation 1: Medical/mental health care was not provided – inadequate treatment.

I. Interviews:

A. Recipient: The recipient informed the HRA that he was initially in the county jail, then transferred to a maximum security state operated mental health facility to attain fitness and was eventually found fit and returned to the jail. He voiced concern over the lack of medical and psychiatric treatment he received while at the jail. The recipient stated that his wife delivered his medication to the jail until the prescription ran out. He stated that he had made multiple requests to go to the Veterans Administration's (VA) doctor or to see another medical doctor in order to get his medication refilled when the prescription expired and those requests received no responses. He stated that he had also requested to see a counselor multiple times but the jail did not respond to his requests. According to the recipient, after his court date in January, 2014, he "stashed glass" in his cell to cut his wrists and then changed his mind and told the jailer about it and asked for psychiatric treatment, but he was never given the paper to sign requesting the same. He stated he did not understand why because he is a veteran and his medical care and treatment should have been paid for if the jail had just made arrangements for him to see a

doctor. Since his prescriptions expired, he had no choice but to quit taking them. He stated that he also made requests to see the Sheriff to discuss it, but the Sheriff refused to see him. While he was at the state operated facility, he was prescribed medication for depression, insomnia, an antipsychotic medication and medication for his thyroid. However, he stated that he refused to take the medication because his treatment team had determined him to be fit to stand trial and he knew he would be returning to jail where he had previously been denied a consult with a medical doctor to obtain refills on his prescriptions. He was afraid that if he started the medications at the facility and was returned to the jail he would have to go off the medications again and he did not wish to experience that withdrawal for a second time.

B. Sheriff: The Sheriff informed the HRA that the recipient ended up in jail because the Judge had ordered the Sheriff to serve him an eviction notice after a domestic issue despite the fact that the Sheriff had asked the Judge not to evict the recipient. When the recipient learned of the eviction notice, he allegedly posted on social media that he would shoot anyone who tried to take him out of his home. Therefore, to be safe, the Sheriff took tactical team to serve him the eviction notice and even paid for a hotel room where he could stay. After his court date he was remanded into custody. The Sheriff stated that the VA was trying to get the recipient help but he would "undo everything they were trying to do." The recipient would contact the VA to renew his prescription and so would the jail which resulted in confusion and prescriptions not getting filled. The Sheriff stated that "he is his own worst enemy" and that the Sheriff had done nothing but tried to help and the recipient was resistant to everything he tried to do.

When questioned about mental health treatment while in jail, the Sheriff responded that there is a community agency that comes into the jail if the patient makes a request or if there are behavioral problems in jail. When an inmate is an imminent danger to self and is transported to the emergency room, crisis workers from that agency visit them at the hospital. He did not see a need to have a counselor come into the jail to see the recipient when he returned from the mental health facility because "that's what he went there for, to receive treatment." The Sheriff stated that they had not tried to contact the VA to provide treatment because there were no facilities close by.

For medical requests, inmates are required to complete a medical request form asking to see a doctor. The form is obtained from the corrections officers/guards and then given to the Sheriff for review. The Sheriff stated that it is a small jail with limited resources therefore, when someone is really sick, the Sheriff transports them to urgent care or to the emergency room. Otherwise, they monitor the inmate and respond accordingly. If an inmate is on prescription medications, they obtain their refills from a local pharmacy that delivers to the jail. The correctional officers/guards dispense the medications and when they are low, they get them refilled. In this case, the Sheriff stated that the recipient's wife brought in his medications due to them coming from the VA. However, the Sheriff also stated that the recipient refused medication when he was at the state operated facility and then when he came back to the jail he wanted them.

The Sheriff did concede that the recipient had requested to speak with him, however if he goes over to the jail to see one person, then everyone wants to talk to him, so he tries to communicate through the correctional officers/guards unless it is an emergency situation. He stated that he did

speak with the recipient a few times but then realized that it was "counter-productive" so he quit seeing him. He stated that the jail does have a grievance process that can be followed which requires the inmate to fill out a form stating their complaint. The Sheriff reviews the complaint and either takes action or monitors the situations. There is no other person who receives the grievance forms or oversees the process. The HRA requested to review the grievance forms that were completed by the recipient, but the Sheriff said that they do not keep copies of them due to lack of storage space in the office.

C. Veteran's Affairs (VA) Case Manager: The HRA spoke with the recipient's case manager via telephone. She stated that per Federal Regulations, the VA cannot go into jails to provide services because once the person is in jail, the jail is solely responsible for the client's care. The VA does have Outreach Coordinators that can attempt to assist clients in obtaining lesser consequences such as treatment instead of prison and one did visit with the recipient in jail. However, Outreach Coordinators can only assist those clients who have not been convicted of violent crimes. This recipient's last crime was considered a violent crime; therefore they could not help him. She informed the HRA that the VA also cannot provide medications to clients in jails. If a prescription expires, as in this case, the jail is responsible for bringing in a medical doctor to provide a new prescription and the pharmacy the jail uses would fill the medication. She stated that in this recipient's case, the jail would not arrange for a doctor to provide a consult with him in jail in order to get his medication refilled due to "being a small county jail with limited resources." Therefore, he was forced to go off of all his medications "cold turkey." She stated that she was given a name of a person who was supposed to provide counseling to the recipient in jail and she reached out to that person so she could provide a history but she could never get in touch with the counselor. The case manager also stated that she was trying to get the recipient into a program for PTSD [post-traumatic stress disorder] based out of state in case the recipient "got probation." In order to be considered for this program, an application had to be completed by the recipient's current provider; therefore she could not complete the application. She again tried to reach out to the counselor via email to complete the application. This time, the counselor responded by stating that he had not seen the recipient and that he did not have resources to complete the application on his behalf. The VA Case manager could not remember the counselor's name and had deleted the email.

II Chart Review:

The HRA reviewed the recipient's chart at the state operated facility where he was admitted. The Treatment Plan Reviews (TPRs) confirmed that medications were prescribed while he was at the facility and it was documented that he consistently refused the medication, therefore they were discontinued. It was also noted in the discussion section of the TPRs that the treatment team was of the unanimous opinion that he was fit to stand trial as soon as his 21 day review was held and the team notified him that he would be returning to court the following month.

Allegation 2. An inadequate discharge planning process was followed

I...Interviews:

A. Recipient: The recipient also was concerned over his prior transfer to the maximum security state operated mental health facility from the jail. The recipient stated that a doctor came to complete his pre-placement evaluation and stated that he would go to a state operated facility for treatment to attain fitness, but that he did not require a maximum facility because he had no aggressive behavior. After that, the recipient stated that the forensic coordinator at the receiving hospital sent a letter which stated that he had been accepted into the facility, but at that time there were no available beds. Therefore, he would have to remain in jail until a bed becomes available. However, the recipient stated that a short time later, he was informed that he would be going to the other state facility which was a maximum setting. When the recipient questioned the Sheriff about the change of plans, the Sheriff stated that he had to "call in favors" to get him into the facility because he cannot stay in the jail any longer. The recipient alleged that even the Court did not know where he was because a writ to appear in Court was sent to the facility he was originally scheduled to transfer to instead of the maximum facility where he went.

B. Sheriff: The Sheriff denied telling the recipient that he had "called in favors" to get him into the maximum secure facility and stated that DHS (Illinois Department of Human Services) makes the decision as to which facility a particular person is transported. The Sheriff stated that he did not recall transporting the recipient to the DHS facility but could not remember why and stated that he must have been off at the time and that a Deputy who was on duty at that time would have transported in the Sheriff's absence. The HRA later confirmed with the secretary and a guard on duty during the HRA's visit that the Sheriff was the one who logged the recipient out for transfer to the DHS facility.

C. State's Attorney: The HRA spoke with the State's Attorney regarding the Writ being sent to the original DHS facility instead of the maximum secure facility where the recipient was transported. The State's Attorney stated that the Writ should have been sent to the maximum secure facility that it was a clerical error but insisted that the Court knew where the recipient was. The HRA also asked for a copy of the letter or Order that authorized the recipient's transfer to the maximum secure facility and notified the Court as to where the recipient was being sent. The State's Attorney referred us to the Circuit Clerk who reviewed the court file and could not find any such documentation. The HRA was provided with a copy of the court docket on his case to review.

D. DHS Forensic Coordinator: The HRA contacted the Forensic Coordinator for DHS to inquire about this recipient's transfer and if there was documentation authorizing the transfer. The Forensic Coordinator informed the HRA that he had called the Sheriff and notified him that a bed had opened up at the maximum security hospital and told him to transport the recipient to that facility. However, he had been accepted onto that facility's new "medium unit" not on the maximum secure units.

E. Transfer Coordinator: The HRA contacted the Transfer Coordinator at the facility where the recipient was transferred. He confirmed that a medium unit had recently been opened to help with the lack of bed availability at state operated facilities and that is the unit that the recipient was housed on while at the facility. Regarding his transfer to the facility, he informed the HRA that there is usually a transport letter which authorizes transfer of patients to the facility. He agreed to look for that letter, but was not sure he could locate it. The HRA followed up with the

Transfer Coordinator two more times however, the letter was never located for the HRA to review.

II. Docket Review:

On 2/10/14 the recipient's attorney indicated he would file a Motion for Fitness Evaluation. On 2/14/14 another court date was held for the Motion to Determine Fitness of the recipient to stand trial. The recipient was not in court and it was indicated that he was in the County Jail at that time. An Order was issued for a fitness examination. On 4/3/14 an order finding the recipient Unfit to Stand Trial was entered. On 6/6/14 an Order of Habeas Corpus was returned as not served (wrong address) then on 7/1/14 it was returned as served. On 7/3/14 a Fitness Report was received. On 9/25/14 the recipient was found fit to stand trial. On 12/8/14 he was remanded to the custody of the Department of Corrections.

Statutes

The County Jail Standards (20 IL ADC 701.10) requires that *"1) All full-time jail officers shall be trained as provided by the Illinois Police Training Act [50 ILCS 705/8.1]. All personnel assigned jail duties shall be made familiar with these standards. The training shall include first aid, CPR and identification of signs and* ***management of detainees with a mental illness*** *or a developmental disability. 2) Jail officers and other personnel assigned to jail duty shall be trained in security measures and handling special incidents such as assaults, disturbances, fires, natural disasters, evacuation procedures, escapes, emergency medical response, communications, crime scene protection and* ***suicide prevention…****4) Jail officers and other personnel primarily assigned to correctional duties* ***shall receive annual training*** *by or approved by mental health professionals* **on suicide prevention and mental health issues.** 5) Documentation of staff training shall be maintained."

The County Jail Standards (20 IL ADC 701.90) states that *"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, such as alcohol and drug dependency.
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…
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… Sick Call 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."

County Jail Standards (20 IL ADC 701.210) also states *"Jails are encouraged to provide Social Service Programs and enlist volunteers, including groups such as Alcoholics Anonymous, Gamblers Anonymous, religious volunteers, and volunteer counselors or groups offering needed services, to participate in the jail programs."*

Conclusion

Allegation 1. Medical/mental health care was not provided – inadequate treatment

The recipient stated that he was not provided a counselor or a consult with a medical doctor to obtain medication refills when requested. The Sheriff stated that they would try to get medication refills from the VA but then the recipient would also call and undo everything they tried to do. However, the VA caseworker stated that the VA cannot provide services or medication for veterans who are in jail which lessened the credibility of the Sheriff's statement. The recipient was not on any medications when he was admitted to the mental health facility from the jail. When the recipient was returned to jail from the mental health facility, the Sheriff stated that he did not come with any prescriptions and since the recipient had refused medication at the facility, he did not see a need to have a consult with the doctor.

The Sheriff also stated that they have a contract with a community agency to provide mental health treatment if the inmate requests such. However, the recipient stated that he was never given the form to fill out to make the request even when he requested the same from the jail staff. He also stated he filed grievances which received no response. The Sheriff admitted to once visiting the recipient but then ceasing visits due to it being "counter-productive." When questioned about the grievance forms, the Sheriff stated that he had received some, but could not recall the specifics and did not keep the forms due to lack of space. The HRA finds the allegation of inadequate medical and mental health care is **substantiated.** The following **recommendations** are made:

1. The Sheriff and jail staff should ensure that proper medical and mental health care is being provided as required by the County Jail Standards (20 IL ADC 701.90) by responding in a timely fashion to requests from inmates to see medical and mental health professionals. The physician and/or therapist should be the person who determines if treatment is necessary not the Sheriff or jail staff.

2. County Jail Standards (20 IL ADC 701.90) require that *"detainees with emergency complaints shall receive attention as quickly as possible, regardless of the sick call schedule"* and Section 701.10 requires that *"jail officers and other personnel primarily*

assigned to correctional duties shall receive annual training by or approved by mental health professionals on suicide prevention and mental health issues" In this case, the recipient stated he had a plan to attempt suicide which he allegedly told jail staff about when he asked for a counselor. His request received no response. The Sheriff should ensure that jail staff are trained on mental health and suicide prevention and ensure that annual trainings are conducted as required and keep documentation of the same.

The following **suggestions** are also made:

1. The Sheriff should keep copies of grievance forms and how they were responded to either in a master file or in individual inmate's files to ensure all issues are responded to and resolved.

2. The Sheriff should make regular rounds at the jail to ensure compliance with County Jail Standards and address any issues that inmates may have to ensure that a breakdown in communication does not occur.

3. The Sheriff should coordinate with the community social service programs to enlist religious volunteers and other social services volunteers in order to provide services such as counseling and drug and alcohol groups to inmates as provided for in County Jail Standards (20 IL ADC 701.210).

Allegation 2. An inadequate discharge planning process was followed

The recipient stated that after his pre-placement evaluation, he was scheduled to go to a medium security state operated facility and instead, he was sent to a maximum security facility and that the Court did not know where he was as a writ for him to appear in court was sent to the original facility that he was scheduled to go to instead of where he was housed. He also alleged that the Sheriff stated he had to "called in favors" to get him sent to the facility because he could not stay at the jail any longer. The sheriff denied making such a statement and stated that when a person is ordered to the Department of Human Services (DHS) to attain fitness, the probation office and the State's Attorney coordinate the transfer. The DHS forensic coordinator informed the HRA that he contacted the Sheriff and authorized the transfer to the maximum security facility; however the recipient was to be housed on its medium unit not the maximum security side. The HRA confirmed with the state operated facility that the recipient was indeed housed on its medium unit due to lack of bed availability at the other facility. The State's Attorney confirmed that the Court knew where the recipient was and that the writ going to the wrong facility was a clerical error. Therefore, the allegation is **unsubstantiated**. The following **suggestion** is offered:

1. The HRA could find no paper trail in the jail file, the court file or at the mental health facility that authorized this recipient's transfer to that facility. The HRA suggests that in the future, if the Sheriff receives telephone authorization to transfer inmates, that some type of written correspondence be drafted to document the authorization. It could be in the form of a letter to the circuit clerk or a memo to the receiving facility or simply a memo to the inmate's file.