



FOR IMMEDIATE RELEASE

**Egyptian Regional Human Rights Authority
Report of Findings
16-110-9004
Fayette County Jail**

The Egyptian Regional Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission has completed its investigation concerning Fayette County Jail. The jail has 70 cells. The census of detainees with mental illness or developmental disabilities at the time of the investigation was 3. The jail currently has 8 full time employees and 3 part time employees that were just added in 2016. The specific allegations are as follows:

- 1. An inmate with mental health needs was held in a restraint chair for an excessive amount of time resulting in injuries and health concerns.**
- 2. Staff were inadequately trained and failed to properly monitor an inmate with mental health needs.**

If substantiated, the allegation would violate protections under Illinois County Jail Standards (20 IL ADC 701.10; 701.90; 701.130; 701.140 & 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 and spoke with the Sheriff and the Jail Administrator. The HRA Team also spoke with the recipient whose rights were alleged to have been violated and reviewed relevant policies.

I. Interviews:

A. Recipient: The HRA investigation team spoke to the recipient about the allegations of the complaint. The recipient informed the team that he was at Fayette County Jail for approximately 2 months. He has a diagnosis of Bipolar Disorder and Schizoaffective Disorder. He stated that he was placed in the restraint chair due to “banging on the walls.” When in the chair, they placed handcuffs on his hands and his ankles and feet were strapped to the chair. He was in the restraint chair for approximately 8 hours and was not allowed to get up and as a result he developed blood clots in his lungs. He was not given food or water and stated that no one checked on him at all. He stated there was a camera on him and this should be easy to prove. When questioned further about no food being given, the recipient stated that he refused food due to going on “hunger strikes” because the food was bad. In addition to being in the restraint chair, the recipient stated that he was “tased” with a taser gun long enough to leave a mark. After the restraint chair, he was placed in a high security cell which was approximately 10x10 and had 2

bunks and stated that when both doors are locked it was hard to breathe in the room. He stated that when someone finally checked on him he was sent to the hospital. His mother informed him that he was in the hospital for 3 days. He stated that he did not remember anything about the hospital stay or why he was there just that he had developed blood clots in his lungs.

B. Social Worker: The HRA also spoke with the social worker at the state operated mental health facility that the recipient was transferred to from the local hospital. The Social Worker informed the team that the recipient was very physically ill on arrival and he had lost 20 pounds in the 4 months since he was previously discharged in March, 2015 from that facility. At that time, the recipient's discharge weight was 193 and upon admission this time in July, 2015, his weight was 173. A physician at the facility thought something was wrong medically because the recipient's oxygen saturation was low. He monitored the recipient and then sent him to a regional medical center for evaluation.

The staff at the state operated facility had also completed a wound assessment form upon admission which documented 3 scabbed areas on his buttocks approximately 5 x 2 cm in size and several stage 2 or 3 pressure ulcers. (The scale is stage 1 for minor and stage 4 for severe.) The scabbed area was also draining yellow indicating some type of infection. He was transferred to another community hospital for wound care. He spent 4-5 days there and multiple blood clots in his lungs (pleural emboli) were discovered as well as the multiple bed sores on his buttocks. A physician at the state operated facility had documented that the recipient's injuries correlated with his story that he was in restraints for multiple days. The recipient had reported to staff there that he was in the restraint chair approximately 13 days and was only out of it long enough for it to be cleaned. Upon return from the hospital he was on a blood thinner medication and the facility placed him on special observation for a week due to hemorrhage potential.

C. Sheriff and Jail Administrator: The HRA team met with the Sheriff and Jail Administrator at the same time and toured the jail including the restraint chair and high security cells. The HRA was informed that a psychiatrist comes weekly and they can call him in case of emergencies. In addition to the psychiatrist, there is a nurse that comes on Mondays and Wednesdays and a physician that comes on Mondays. The physician writes orders for medications if he feels that they can have that medication in the jail. When medication is running low, the officers contact the physician immediately and they pick up the refills at a local pharmacy. The nurse completes a "medicine check" with the physician and pharmacy for any prescriptions an inmate has. If there are current prescriptions, the jail can pick them up or get a formulary equivalent that the jail can provide. If there is an emergency, jail staff call the physician or psychiatrist and they can also call the State's Attorney and Judge to get the inmate released to a hospital if needed. There are no community counseling facilities close to the jail, but the local churches have volunteers that counsel detainees. The HRA was informed that the jail can ask for a bond for an inmate to be released on their own recognizance in order to go to the hospital by jail transport. The officers get help on the way and an officer sits with the inmate until a crisis worker arrives. Once a crisis worker arrives, the inmate can be released. They informed the HRA that they try to do this when someone really needs help because they do not want to stand in the way of someone getting the treatment they need.

The officers place the detainees in the safest spot for their individual situations. They have a padded cell and a high security cell that are both directly beside the “front desk” area where the officers are. The padded cell is used when harm to self is possible. The room has beds on each side and padded walls. The high security room has metal walls, a toilet/sink, bed and a secured chair and a “window” in the door that had a television just outside the cell where detainees could watch television while in the room. It is more of a seclusion type cell. The detainees in these two cells can be heard and seen at all times. There are cameras on the cells and screens that the officers monitor continuously and they also conduct 30 minute checks on all detainees. When making rounds, the officers carry a taser and each cell has a button that they push or scan with a wand when that cell is checked. They also have a suicide smock and blanket and a restraint chair that can be used to protect a hostile, uncooperative inmate from harming himself or others. The recipient in this case was placed in the restraint chair for hitting the walls continuously to the point that his hands were swollen. This recipient has been in the jail before. The Sheriff informed the HRA that he will be out for 1-2 years and then something happens and he returns to jail. The Sheriff stated that he was fine the last time he was at the jail but while waiting for his fitness evaluation this time his mental state declined significantly. He was yelling and hitting the walls continuously. When placed in the high security cell, the recipient pointed out ways he could hurt himself, specifically pointing out screws that had come through the wall and he also picked tile out of the floor. Therefore, he had to be moved to the padded cell. In this cell, he would not quit hitting the walls when prompted by staff and stated that he was going to continue to hit the walls until his hands were broken. Therefore, the staff placed him in the restraint chair with his hands cuffed behind his back/chair for his own protection. The recipient complied with going into the restraint chair and did not refuse or fight back in any way. He was not aggressive to others, just to himself. The jail’s policy states that an inmate should be in the chair a maximum of 2 hours before release, unless he is a continued threat to harm himself or others and when this recipient would be released from the chair, he would immediately go back to hitting the walls. While in the restraint chair, he “screamed and rubbed his arms violently and left marks.” He would go from the chair to the padded cell but almost immediately he would have to be put back in the restraint chair due to banging his hands on the walls. Staff would take him out of the chair to eat and he usually did ok with that but would return to self-injurious behavior (SIB) immediately. If an inmate in the restraint chair needs to use the restroom, they can ask and officers will let them out of the chair to use the restroom. Anytime the inmate comes out of the chair, officers will change the detainees clothing/covering and disinfect the chair. If calm enough, the inmate will be allowed a shower at that time as well. This recipient refused a covering while he was in the restraint chair.

The recipient would be in and out of the chair for a couple of days and be okay, but then would start banging his hands and screaming again. After a week of this, the nearest community counseling agency was contacted. The counseling agency informed the jail that the recipient needed to be seen by a crisis worker, but they could not see him in jail, he would have to be at the hospital. After that conversation, the Administrator contacted the State’s Attorney to get approval to release him to the hospital. The Judge signed the order on Friday morning. The crisis worker came Friday evening and the Administrator stayed until 1:00 a.m. with 2 officers then went down to 1 officer and then they released him from custody on Saturday when officers knew he had a placement come Monday. Officers were at the hospital for over 12 hours on Friday night and Saturday morning at 6 a.m. the crisis worker was still trying to find placement

for him. Around 11 a.m. on Saturday, the jail released him from custody once placement had been secured. The recipient stayed at the hospital emergency department until Monday morning when he was released to a state operated mental health facility.

The jail keeps daily log sheets when someone is placed in and out of the chair. However, the HRA was informed that the jail is transitioning to a new system that is computerized and can track inmate movement easier and staff can then print off reports that more accurately reflect when someone was in the high security cell, padded cell or restraint chair.

The Administrator informed the HRA that lightning had hit the jail's metal roof shortly after this recipient was housed there. This lightning hit destroyed their video recordings that were stored on their system therefore, no video recordings of the restraint episodes or cell checks were available for review.

When asked about staff training, the HRA was advised that the jail provides one day of staff training once per year on the mental health population. There is also staff training on proper restraint chair use initially, but no ongoing training. However, this restraint chair did not have instructions with it and the jail staff had to "figure it out on their own."

II Chart Review:

A. Jail Records: The HRA reviewed a jail management inmate report dated 7/12/15 at 03:46 am which stated that the recipient was in the padded cell area and punching the wall multiple times and was instructed to quit hurting himself. It also stated that the recipient "*could not control himself and his hand was becoming swollen from multiple punches to the wall. Inmate was placed in restraint chair at 1855 hrs and checked on every ½ hr. Inmate [name] was spoke to every 30 min and asked if he could restrain himself from punching the wall and not hurt himself and he continuously stated he would not quit punching the wall until his hand was broken. Inmate [name] agreed to comply at approximately 1255am and approximately 0345 hrs inmate [name] continuously punched the padded cell door and would not quit screaming. Inmate [name] was placed in high security chair until his actions changed for his safety.*" The HRA also reviewed the handwritten logs of jail staff showing the initial restraint chair placement of the recipient on 7/11/15 at 3:30 pm. He was released from the chair at 5:00 pm.

The following is the remaining documentation that the jail had regarding the restraint chair episodes. The paper documentation is kept for 2 time periods 6 am to 6 pm and then 6 pm to 6 am.

7/11/15 In the chair at 6:55 pm and out at 12:55 am [7/12/15]

7/12/15 In the chair at 3:45 am due to punching the wall and hurting himself. Released from the chair at 3:00 pm and placed back in the chair at 5:40 pm and released at 11:55 pm.

7/13/15 In the restraint chair at 10:05 am. There was no documentation on when he was released from the chair after being placed in it this time.

7/22/15 2:15 pm in the restraint chair. No documentation of being released.

The Administrator also provided the HRA with computer printouts dated 7/19/15 through 7/24/15 documenting the 30 minute cell checks as a result of the button push or scan for all of the “blocks” of the jail. There are no names listed just the block letters however, there is documentation that “padded cell” was checked and the Administrator advised the HRA that the recipient in this case was the only one who was occupying the cell during this time period.

7/19/15 3:36; 4:26; 9:28; 10:37; 11:28; 14:28; 15:28; 21:33; 23:30
7/20/15 02:29; 03:27; 05:28; 06:39; 07:34; 08:35; 09:01; 10:13; 14:29; 15:38
7/21/15 04:38; 06:47; 08:53; 09:59; 11:32; 13:55; 15:08; 16:25
7/22/15 15:32 [High Security Cell]
7/24/15 07:04; 07:34; 08:42; 09:03; 09:34; 10:08

The jail management medical intake report dated 5/11/15 documented an allergy to Haldol. The recipient answered yes to questions asking if he had mental health problems and if he had ever been hospitalized for the same. The form documented him as being restless, anxious, intellectual disability, irrational and mentally ill. There was no documentation that the recipient was physically examined by a nurse or physician upon the brief releases from the restraint chair.

A Mental Health Evaluation was done on 5/12/15 by a physician at the jail which showed no homicidal ideation, recipient reported feeling very agitated and anxious with racing thoughts. He was documented as being cooperative with a flat affect and having memory, orientation and sensorium intact. The diagnostic impression was GAD [generalized anxiety disorder] and the plan was to give Paxil once a day to treat the symptoms of anxiety, agitation and racing thoughts. Physician documentation showed that the recipient was seen on 5/19/15 for a follow up on Paxil medication. The “*offender states it seems to be working for him (thinks he’s on Ativan).*” He was seen in the “*isolation cell*” and was noted to have appropriate appearance, speech and mood with a flat affect. His thought form was documented as “*coherent for most part*” and appropriate thought content with some confusion. The plan was to continue on psychiatric intervention. And follow up with behavioral health provider in 7 days. Nursing Documentation while in jail showed that the nurse saw the recipient on 6/1/15 for back pain. The physician also saw the recipient on 6/1/15 as a follow up on Ativan. The recipient stated that “*it is working to manage his [illegible] now. No changes needed at this time.*” The plan was to continue medications and follow up in 7 days. On 6/4/15 he was seen again for a follow up to the 6/1/15 visit/note. He was oriented and had no suicidal ideation and it was noted that he was medication compliant. The plan was for a behavioral health follow up within 5 days and continue to follow on weekly basis. He was next seen on 6/9/15 for the follow up visit. The recipient was “*adjusted okay to present situation says he would like to try upstairs for a while.*” The physician was going to consult with the jail administrator regarding this request. On 6/15/15 he was seen for “*racing thoughts re: being homeless. Paxil now, wants Ativan back. Would like to have it at night.*” The intervention was for medications as appropriate and follow up within 7 days. No further documentation was provided on follow up visits. On 7/10/15 a medical progress note documented that the recipient was seen for agitation, anxiety and psychosis. The recipient refused to speak with the physician and was described as agitated with offensive language, no

acute distress, loud voice and having a past history of racing thoughts. The plan was to “consider psychiatry evaluation.” Medication Administration Records (MAR) show that the recipient was given Paxil once a day beginning 5/12/15 through his release date of 7/24/15. He was also given Ibuprofen twice a day for 10 days beginning 7/1/15.

B. County Hospital Records: The recipient was admitted on 7/25/15 and was discharged on 7/27/15. The hospital records state the chief complaint is “*brought from jail because of abnormal behavior.*” The relevant comments section stated that the patient “*is in jail and released with charges dropped, pt [patient] has been tied to a chair for the past 2 weeks urinating on self and other prisoners also defecating [sic] on self, speaks to people and about people that are not there*” Precautions in place listed “*handcuffs and sheriff deputys [sic] at bedside.*” The respiratory examination showed no abnormalities stating “*chest non-tender, no respiratory distress, breath sounds nml [normal].*” The skin examination stated that his color was normal and there was no rash and the recipient was medically cleared. The emergency department tried to transfer the patient to a psychiatric facility but was told there would not be any beds available for 2 days. Therefore, he was admitted for observation. His vital signs were normal upon admission. His lungs were clear and he was breathing easily without effort. It was noted that he had abrasions on his left foot anteriorly and over the Achilles area that were not infected. The recipient stated it was due to a poisonous snake biting him. He was given Ativan “now” and was started on Geodon every 12 hours. The plan was to observe and work on placement in a psychiatric facility. Nursing notes indicate that the Sheriff’s Deputy informed nursing staff that charges were dropped and they would no longer be able to provide any deputy to watch over the patient at 8:30 a.m. on 7/25/15. A crisis counselor was contacted and arrived to assess the recipient at 11:20 a.m. on 7/25/15. A progress note dated 7/26/15 stated that the combination of Ativan and Geodon seemed to be helping significantly with his agitation. His vital signs were normal with 95% oxygen on room air. Examination of the lower portions of the buttocks revealed pressure sores “*a smaller one approximately 2 cm in diameter is present on the left lower buttock and a 4-5 cm area is present on the right. This has a couple of blackened areas in it. There is no active drainage. There is no surrounding erythema [redness of skin]. Examination of the Achilles areas in the ankles reveals that the abrasions appear to be healing up.*” The treatment plan was to continue medications and apply dressings to the pressure sores on his buttocks to help protect the skin and encourage healing. The nursing assessment dated 7/26/15 stated that the recipient had “*several scattered scabs to bilateral feet as well as a large bruise and swelling to the inner portion of his right foot. He also has 2 large open sores to his buttocks. He has a ½ inch by 1 inch open sore to his right buttock and a 1 ½ inch by 2 ½ inch sore to his left buttock. This larger sore also has 3 dark/black areas within it...patient laying on his side. He states these sores were from the chair he was in at the jail.*” The nursing assessment by this same person on 7/25/15 just noted the sores/scabs on feet and lower legs and stated the patient denies any other sores, cuts or bruises. A progress note on 7/27/15 stated that he had been off his medications for 2-4 weeks according to report by his family. It noted that he was in jail and required frequent restraints since he was hitting himself and hitting walls and he has been making homicidal threats to his family repeatedly. He was noted to have been “unkind to staff with cursing and complaining.” His white blood cell count was elevated but he had no source of infection. His Discharge Summary reported his discharge diagnoses as “*Suicidal tendency, homicidal tendency, Schizophrenia, Hypokalemia [low potassium] and Leukocytosis [white blood cell increase].*” The hospital course was finding placement in a psychiatric hospital and

addressing the “one outstanding medical issue...elevated white count but he had no definite source of infection other than a few scabs on his right posterior ankle area which he felt was related to a copperhead snake bite, but was more likely related to picking and scab formation. There was no pus present or drainage, but as a precaution we started him on Keflex. His potassium of 3.4 was corrected, medically he was stable. His exam was completely normal for HEENT, neck, heart, lungs, abdomen, and lower extremities except for scabs mentioned. The patient was very difficult to work with and was cursing with attitude towards nursing staff and in general was belligerent and somewhat dangerous. The patient was finally discharged to [state operated mental health facility] which is extremely appropriate given his psychiatric condition.” The HRA inquired as to whether or not a chest X-ray was completed during his stay at the county hospital. The hospital responded that there were no records indicating a chest X-ray had been done.

C. State Operated Mental Health Facility records: The HRA reviewed the recipient’s chart at the state operated mental health facility where he was admitted immediately following his stay at the county hospital. The Initial Psychiatric Nursing Assessment completed on 7/27/15 was reviewed. His vital signs were good upon admission, medication allergies were listed but the recipient was uncooperative with extensive questioning. He stated he had venom in his veins and that his entire body hurt. A scabbed, draining, yellow wound approximately 5 x 2 cm area to buttocks was noted as well as scratches to bilateral armpits, multiple small wounds to buttock and an open area to his left foot. A Wound Assessment Form was completed by a physician at the facility. This form described his wounds as “traumatic” and noted them to be a 1 cm scabbed open area on his right foot, lower leg anterior; a right foot lower leg posterior scabbed area measuring 0.5 cm x 3 cm; a left buttock 2 cm x 2 cm open area that “appears to be a pressure ulcer stage 2; right buttock 2 cm x 5 cm open area appears to be pressure ulcer stage 2 to 3.” An Injury Report noted the sores to buttock and left foot and the recipient had stated it was due to a snake bite. Antibiotics were administered on order from the physician after evaluation as well as PRN [as needed] analgesics. On 8/1/15 a physician was called in to evaluate the recipient who appeared to be having tachycardia. The recipient was transferred to the county hospital and from there to the regional medical center to be treated for pulmonary emboli. The recipient returned to the facility 4 days later and was noted to have “healing pressure sores.” He was described as angry and having no complaints of shortness of breath. He was also on anticoagulant therapy. The physician examined him and wrote orders to continue current medications. The case notes on the days following confirmed that he was on 1:1 Special observation for safety, took medications and had a very good appetite. An antibiotic ointment was used to treat the pressure sores. It was noted that he would be medically monitored for 3 months.

D. Regional Medical Center Records: The medical center’s records documented that the recipient was admitted August 1st and discharged August 5th. His final diagnoses were pneumonia, fever, pulmonary embolism, leukocytosis secondary to “some infectious process”; sinus tachycardia and was noted to have some skin breakdowns. The admitting physician’s note stated that the recipient was transferred from county hospital with tachycardia that had been ongoing for a couple of days that was unresolved with beta blockers. The county hospital’s emergency room “workup” showed the patient to have bilateral lower lobe pulmonary embolus. The recipient reported a family history of his mother having a blood clot at a young age. The

patient was admitted and treated for bilateral pulmonary emboli. An ultrasound was done of his lower extremities which indicated deep vein thrombosis of the mid to distal right femoral vein. It was noted that he was discharged in stable condition to the state operated mental health facility.

WebMD states that a pulmonary embolism “usually happens when a blood clot called a deep vein thrombosis (DVT), often in your leg, travels to your lungs and blocks a blood vessel. That leads to low oxygen levels in your blood. It can damage the lung and other organs and cause heart failure, too. A PE can be life-threatening...” Some of the causes of DVT/pulmonary embolism are listed as “Clots in the leg can form when blood flow is restricted and slows down. This can happen when you don't move around for long periods of time, such as: •After some types of surgeries •During a long trip in a car or on an airplane •If you must stay in bed for an extended time...”

III. Jail Policies and Training

A. High Security Chair Policy: The policy states that the chair “*is to be utilized in the event a detainee becomes disruptive or needs to be restrained to prevent harm to themselves.*” The Use of the Chair section outlines instructions for proper chair use. “*When a detainee is placed in the Segregation Unit all restraints are to be utilized that are attached to the chair and the restraints are to be secure. The detainee is to be left in the chair until the Correctional Officer deems the detainee has corrected their behavior and no longer needs restraint...The detainee shall not be left in the High Security Chair longer than two (2) hours unless the detainee has posed a threat to him/her self.*” The HRA found no policy on properly applying restraints or monitoring of individuals once in restraints.

B. Self-Protection Room Policy: The self-protection room is to be utilized in the event a detainee has attempted suicide or threatened suicide or the staff has reason to believe the detainee might harm himself. Use of the self-protection room is outlined as follows: “*Prior to securing a detainee in the self-protection room the detainee is to be stripped and issued a self-protection smock and a self-protection blanket...Once the detainee has been placed in the self-protection room, they are not to be released back into general population unless approved by the Sheriff, Jail Administrator or the Jail medical psychologist. Staffs are to follow the 30 minute security check unless otherwise directed. Any disruptive behavior by the detainee, staff has the approval to remove the inmate from the self-protection room and place the detainee in the high security chair. Upon removal from the high security chair the detainee is to be placed back into the self-protection room.*”

C. Training: The jail currently has 8 full time employees and 3 part time employees that were just added in 2016. There is annual training that all employees, both full and part time, are required to attend. The training records reviewed by the HRA for 2015 showed 3 ½ hours training on mental health, blood borne pathogens, alcohol awareness and administering of drugs; 1 hour on corrections policy training; ½ hour staff meeting; 1 hour taser recertification and 2 hours death in cell training. The signature pages showed 10 employees in attendance. The HRA inquired as to what topics are covered in the mental health training. The Jail Administrator informed the HRA that training was provided through a contracted medical company. He

directed the HRA to the contact person for this agency to get the details of training topics. The contact person informed the HRA that their agency is only responsible for “suicide risk reduction” training.

IV. 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.”

Section 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...Mental Health Training: annually, jail officers and other personnel primarily assigned to correctional duties shall be trained on suicide prevention and mental health issues. The training shall be approved or provided by a mental health professional...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.”

Section 701.130 outlines the requirements for supervision of detainees housed in the county jails. *“There must be a sufficient number of officers present in the jail, awake and alert at all times, to provide supervision directly or indirectly while detainees are in custody.*

A) Direct supervision means direct and continuous supervision of detainees by a jail officer on a 24-hour basis. The jail officer shall be in direct visual and oral contact with the detainees, without separation by security walls or other barriers.

B) Indirect supervision means non-continuous direct visual and oral contact with detainees and may include separation by security walls or other barriers.

*2) A jail officer shall provide personal observation, **not including observation by a monitoring device, at least once every 30 minutes.** A record of the observation shall be documented in the shift record....*

b) Shift Record

A written record book or log with entries in ink or a time clock type record with electronic recorder shall be maintained by each jail officer assigned to cell block duty on each shift. Entries shall show the time of each visit by the jail officer, his or her written or digital signature, and any relevant remarks such as incidents and activities occurring on the shift...”

Section 701.140 requires that *“jail officers and other personnel assigned to jail duty must be trained in security measures and handling special incidents in accordance with Section 701.10...jail sections housing persons who are escape risks, suicidal or mentally disturbed or impaired, or who present special security concerns, shall be given appropriate care and supervision and checked more frequently than the standard 30 minute check...persons who may be authorized to use a control device such as...restraint chairs...in accordance with the jail’s written policy, shall be trained in the proper employment of the device. Training shall be documented. 1) Control devices shall be used only as a last resort to bring detainees under the necessary degree of control and only after thorough consideration of alternative means and of the hazards involved, including the physical characteristics of the area where it is to be used. A record of the occurrence shall be documented 2) detainees affected by the control device used shall be given a thorough medical examination and appropriate treatment immediately after security control has been gained...8) requires that “jail sections housing persons who are escape risks, suicidal or mentally disturbed or impaired, or who present special security concerns, shall be given appropriate care and supervision and **checked more frequently than the standard 30-minute check...**) Control Devices: Persons who may be authorized to use a control device, such as chemical agents, oleoresin capsicum (OC), electro-muscular disruption devices, restraint chairs, batons, etc., in accordance with the jail’s written policy, shall be trained in the proper employment of the device. Training shall be documented. 1) Control devices shall be used only as a last resort to bring detainees under the necessary degree of control and only after thorough*

consideration of alternative means and of the hazards involved, including the physical characteristics of the area where it is to be used. A record of the occurrence shall be documented. 2) Detainees affected by the control device used shall be given a thorough medical examination and appropriate treatment immediately after security control has been gained.”

Section 701.210 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 one was that an inmate with mental health needs was held in a restraint chair for an excessive amount of time resulting in injuries and health concerns. The county hospital, where the recipient was placed directly from jail, had no records of blood clots and even stated that his lungs were clear upon examination. However, the hospital records did indicate discovery of pressure sores on his buttocks and scabbed areas on his ankles. The state operated facility where the recipient was placed next, first discovered a medical problem 5 days after admission when tachycardia was discovered which resulted in his transfer to a regional medical center. This hospital stay is where the pulmonary emboli were first discovered along with DVT (deep vein thrombosis) in his leg. The jail records had some documentation of when the recipient was in and out of the chair. The longest documented period, without a release for a few hours, was 11 hours. There were other instances documenting that he went in the chair with no documentation of when he was released so the HRA could not determine if 11 hours was the maximum time in the chair or not. Jail Standards requires that “*Control devices shall be used only as a last resort to bring detainees under the necessary degree of control and only after thorough consideration of alternative means and of the hazards involved, including the physical characteristics of the area where it is to be used. A record of the occurrence shall be documented.*” The county jail policies stated that “*the detainee shall not be left in the High Security Chair longer than two (2) hours unless the detainee has posed a threat to him/her self.*” The recipient continued to have SIB which, according to policy, warranted the continued use of the restraint chair even beyond the 2 hour limit set in the policies. However, there was no video recording to review and there was a lack of documentation of the restraint occurrences as required by the county jail standards. Also, the hospital documented moderate to severe bed sores indicating that the recipient had not been mobile for some extended period of time. Therefore the allegation is **substantiated** and the following **recommendations** are made:

- 1. Ensure that proper documentation is being kept of restraint chair episodes as required by County Jail Standards. The HRA is aware that a new system was being put into place during the course of this investigation which should have made it easier to document restraint episodes. To meet this recommendation, the HRA requests information on the new system, the status of installation, and staff training on proper documentation.**
- 2. Ensure compliance with County Jail Standards that require proper training on restraint chairs, 30 minute or more frequent checks of persons at risk, and**

proper medical exams of those affected by control devices. Develop a policy regarding proper restraint procedures including checking limbs for proper application of restraints and conducting physical examinations upon release either by a medical professional, nurse or, if none available, security staff should check for injuries and document whether or not any injuries were noted. Staff should be properly trained on said policy as required by Jail Standards (20 IL ADC 701.140) To meet this recommendation, the HRA requests a copy of the policy.

Allegation two was that staff were inadequately trained and failed to properly monitor an inmate with mental health needs. The Jail Administrator provided computer printouts and hand written documentation of the times that the padded cell was checked by jail staff and stated that the recipient was the only one in that cell during the timeframe of the printed reports. The computer printouts are a result of the door scans when the detainees are checked. The times detailed in the printout and listed above in this report ranged from 1-5 hours with the exception of 2-3 instances when there were 30 minutes in between checks. According to County Jail Standards (20 IL ADC 701.130) *“a written record book or log with entries in ink or a time clock type record with electronic recorder shall be maintained by each jail officer assigned to cell block duty on each shift. Entries shall show the time of each visit by the jail officer, his or her written or digital signature, and any relevant remarks such as incidents and activities occurring on the shift...”* Jail standards (20 IL ADC 701.140) also require that *“Jail sections housing persons who are escape risks, suicidal or mentally disturbed or impaired, or who present special security concerns, shall be given appropriate care and supervision and checked more frequently than the standard 30- minute check.”*

County Jail standards (20 IL ADC 701.90) require that *“annually, jail officers and other personnel primarily assigned to correctional duties shall be trained on suicide prevention and mental health issues The training shall be approved or provided by a mental health professional...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.”*

Since the documentation showed that the padded cell, housing this recipient, was not checked at least every 30 minutes and the training did not include any mental health training other than suicide risk reduction, the allegation is **substantiated**. The following **recommendations** are made:

- 1. The jail policy stated that when in the self-protection room *“Staffs are to follow the 30 minute security check unless otherwise directed.”* The jail policy should be updated to reflect the requirements of the County Jail Standards which states *“jail sections housing persons who are escape risks, suicidal or mentally disturbed or impaired, or who present special security concerns, shall be given appropriate care and supervision and checked more frequently than the standard 30- minute***

check. Jail staff should be retrained on the revised policy and a copy of the revised policy is to be provided to the HRA.

- 2. Staff should be retrained on the County Jail Standards and facility policy requirement of 30 minute checks. To meet this recommendation, provide proof of the training to the HRA.**
- 3. The annual training should be revised to include all elements of mental illness that are required in County Jail Standards (20 IL ADC 701.90). Provide the HRA with a revised training agenda.**

The HRA also makes the following **suggestions**:

1. The recipient was in the restraint chair for several days due to SIB which did not improve when released briefly from the restraint chair. In the future, when there is a significant decline in a recipient's mental health resulting in this type of emergency situation where interventions do not appear to be resolving the situation promptly, a mental health professional should be contacted immediately. Develop a linkage with a mental health agency for emergency and other needs at the jail.
2. The HRA was also concerned by the documentation of the jail physician during a follow up visit for his Paxil medication which documented that the recipient "*thinks he's on Ativan*". The HRA strongly suggests that in the future, the physician and/or psychiatrist ensure that detainees are educated on the medication they are taking and address any concerns or questions they might have regarding that medication.

The HRA commends the facility for its cooperation and assistance throughout the course of its investigation.