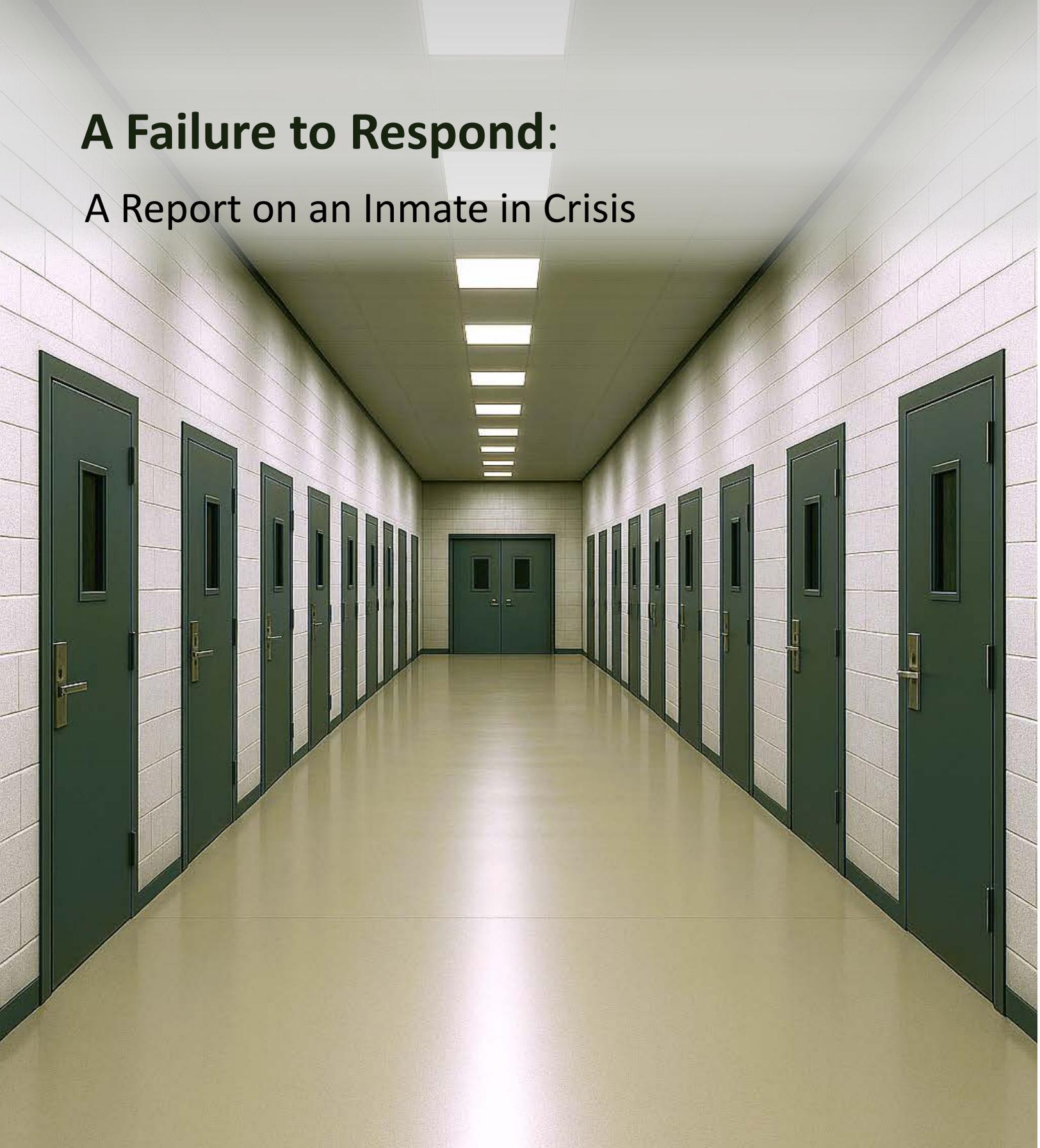


A Failure to Respond:

A Report on an Inmate in Crisis



IOWA OFFICE OF OMBUDSMAN

BERNARDO GRANWEHR, OMBUDSMAN

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Message from the Ombudsman

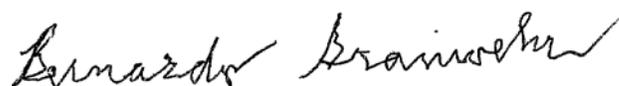
Our office exists to ensure that government agencies act lawfully, reasonably, and humanely. When a person enters a jail with minor redness to her face and leaves less than a day later with severe bruising, swelling, and head injuries—all self-inflicted while in the government’s care—it is our responsibility to examine what went wrong and to determine how to prevent it from happening again. My office undertook such an investigation when one woman’s Christmas Eve stay at the Scott County Jail prompted profound questions about safety, oversight, and the treatment of individuals experiencing a mental health crisis. We found failures in medical care, mental health responsiveness, policy compliance, inmate observation, and staff judgment.

Surprisingly, we also found that the Scott County Jail misinterpreted our 2024 public report on restraint-chair practices to mean that restraint chairs should not be used at all. That was never our message. The restraint chair is intended to be used sparingly and responsibly—but it is, and always has been, a necessary tool when an inmate is actively and repeatedly harming themselves. By treating our cautionary report as a prohibition, Scott County unintentionally removed one of the few effective options available to protect a person in crisis like our complainant, Sarah.

Compounding these mistakes, the jail had no mental-health provider to call on during weekends or holidays, leaving staff without the ability provide these services to Sarah. And unlike many Iowa jails, Scott County did not have a padded cell, one of the safest environments available for people who pose an immediate risk of self-harm. In combination, these three factors meant that when Sarah began spiraling, the jail was left with neither clinical resources nor safe physical alternatives. It truly tied its own hands.

Although I am troubled by the Scott County Jail’s oversights, its staff was responsive to our concerns. The jail cooperated fully with our investigation, provided extensive documentation and video, initiated its own internal review, corrected the problems we identified, and took steps to strengthen its wellness-check procedures and policy language. It is paradoxical to criticize an agency for serious lapses while also recognizing the underlying strengths that make it capable of genuine improvement, but both are true. The bones of a good agency are present in Scott County’s willingness to confront its shortcomings rather than deny or minimize them.

Scott County’s response demonstrates that accountability and collaboration toward improvement can coexist. I appreciate the county’s engagement, and I hope this report supports its continued efforts to strengthen its practices, enhance staff readiness, and ensure that what happened to Sarah does not happen again.



Bernardo Granwehr
Ombudsman

Executive Summary

In December 2024, Sarah, a woman experiencing a mental health crisis, was arrested following a domestic disturbance and transported to the Scott County Jail after a brief hospital evaluation. When she entered the jail, she had only minor facial redness. Nineteen hours later, she left with extensive bruising, swelling, cuts, and head injuries—injuries that video showed were inflicted entirely through repeated, severe self-harm. Jail staff did not intervene.

The Ombudsman initiated this investigation after Sarah reported that jail staff had failed to protect her from self-harm, failed to provide medical or mental health care, and failed to follow required procedures. The investigation included a review of nearly 19 hours of video, body camera footage, supervision logs, incident reports, medical documentation, policies, emails, and interviews with jail leadership and health providers.

The evidence, in summary, revealed significant failures in medical care, mental health responsiveness, policy compliance, inmate observation, and staff judgment. These failures resulted in Sarah suffering substantial preventable injuries while in the custody and care of the Scott County Jail.

Key Findings

Excessive Delay in Completing Booking

Sarah was not fully booked until 19 hours after arrival, contrary to policy and accepted standards requiring immediate screening. The jail’s use of “short booking” was undocumented and inappropriate. This delay likely prevented the jail from identifying her mental health risks.

Unsafe and Improper Transport After Suicide Attempt

Following Sarah’s attempt to wrap a phone cord around her neck, staff forced her to stand and walk despite her repeated pleas of pain and inability to walk. Officers carried her by her limbs rather than using safer alternatives such as a wheelchair or restraint chair, increasing risks to both Sarah and staff.

Staff Dismissal and Minimization of Mental Health Crisis

Body camera footage captured staff making insensitive, dismissive remarks about Sarah’s pain, injuries, and suicide attempt—suggesting she was “faking it” or trying to “go to the hospital.” These comments reflect poor training and judgment and contributed to a failure to appropriately respond to her crisis.

Serious Failures in Wellness Checks

Although logs indicated that staff checked on her every 15 minutes, video showed that in-person or meaningful observations did not occur, and staff did not intervene despite hours of violent

self-harm visible on camera. Sarah should have been under continuous observation based on jail policy and state law.

Failure to Protect Sarah from Self-Harm

Sarah repeatedly struck her head on cell doors, walls, and the floor; pulled out her hair; vomited; and lost balance and consciousness—with little to no response from staff. The jail did not use its restraint chair or other protective measures despite acknowledging that this was an instance where the restraint chair should have been used.

Insufficient Medical Response

Medical staff did not evaluate Sarah after her self-harm or suicide attempt. Staff documented severe facial swelling and bruising but failed to ensure she received medical attention. The jail's only medical documentation was an unsigned note referencing earlier concerns that were unrelated to her later injuries.

Lack of Mental Health Services

Neither medical nor mental health providers evaluated Sarah during her crisis, and staffing arrangements did not provide for mental health availability during holidays. Staff did not appear to understand they could contact the Chief Medical Officer in emergencies.

Improper Incident Reporting

The jail failed to report Sarah's suicide attempt and self-harming incidents to the state jail inspector within the required 24-hour timeframe. Misclassification of the incident prevented reporting.

Lack of a Padded Cell

Despite being one of Iowa's largest jails, Scott County does not have a padded cell—an important alternative to the restraint chair and a safer setting for inmates demonstrating severe self-harm. Many smaller jails have built padded cells to reduce injuries.

Recommendations

Based on these findings, the Ombudsman makes the following recommendations to the Scott County Jail:

1. Revise the short-booking process to ensure compliance with Iowa law and capture essential health and suicide-risk information upon arrival.
2. Use wheelchairs for non-ambulatory inmates whenever feasible; consider the restraint chair when safety concerns exist.
3. Provide annual staff training on interpersonal communication, de-escalation, and professional conduct.

4. Retrain staff on wellness checks, including policies requiring continuous observation for suicidal inmates, and conduct random video audits.
5. Add electronic scan points in the booking area to ensure accurate and accountable wellness checks.
6. Reinforce proper restraint-chair use by sharing the Ombudsman's 2024 restraint chair report and retraining staff.
7. Add at least one padded cell to prevent serious inmate self-harm.
8. Ensure staff understand mental health emergency procedures, including when to contact the CMO or transfer an inmate to the hospital.
9. Adequately photograph and document injuries, especially when noted in incident reports.
10. Transition to electronic supervision logs to improve accuracy and accountability.
11. Ensure timely reporting of all suicide attempts and self-injury incidents to the state jail inspector.
12. Update jail policies to adopt the most current ACA detention standards and remove references to irrelevant ACA residential standards.

Role of the Ombudsman

The Office of Ombudsman (Ombudsman) is an independent and impartial agency in the legislative branch of Iowa state government. The Ombudsman investigates complaints against most Iowa state and local government agencies. The Ombudsman has jurisdiction to investigate any administrative action of any person providing child welfare or juvenile justice services under contract with an agency that is subject to investigation by the Ombudsman. The governor, legislators, judges, and their staffs fall outside the Ombudsman's jurisdiction. The Ombudsman's powers and duties are defined in Iowa Code chapter 2C.

In response to a complaint or on the Ombudsman's own motion, the Ombudsman determines whether an agency's actions were unlawful, contrary to policy, unreasonable, unfair, oppressive, or otherwise objectionable. The Ombudsman may make recommendations to the agency and other appropriate officials to correct a problem or to improve government policies, practices, or procedures. If the Ombudsman determines that a public official has acted in a manner warranting criminal or disciplinary proceedings, the Ombudsman may refer the matter to the appropriate authorities.

If the Ombudsman decides to publish a report of the investigative findings, conclusions, and recommendations, and the report is critical of an agency, official or employee, they are given an opportunity to reply to the report, and the unedited reply is attached to the report.

Introduction

The Christmas holiday season is stressful for many people. For Sarah¹, that time of year in 2024 posed a particular emotional challenge since she had recently changed her mental health medication and was suffering from suicidal depression. The holidays and her personal struggles culminated in a domestic fight between Sarah and her husband on Christmas Eve, resulting in minor injuries to both and a call to police.

When officers from the Davenport Police Department arrived, they noted that Sarah had “some minor redness and swelling to the right side of her face” from an alleged slap by her husband. Sarah’s husband had scratches on his ear and neck.²

The police decided to charge both Sarah and her husband with domestic abuse and transport them to the Scott County Jail. However, Sarah complained of numbness in her lower extremities and was unable to walk. Paramedics were called to the home and, once her vitals were taken, Sarah indicated her desire to be transported to the hospital for an evaluation, which the officer accommodated before taking her to jail.³

Nineteen hours after her admission to the jail, Sarah left with much worse injuries than the “minor redness and swelling” with which she had entered. She had suffered extensive bruising and cuts to her face and head as well as her arms.⁴ The difference can be seen in before-and-after photos, captured on the officer’s body camera at the time of her arrest, and a photo Sarah took herself after her release.⁵

To protect Sarah’s anonymity, we are not including photographs in this report. However, the image captured on the officer’s body camera at the time of her arrest showed only slight redness to Sarah’s right cheek, and no other injuries. The photograph that Sarah shared with us showed numerous facial injuries, including purple and dark brown swelling and bruising around both eyes, which extended up towards her eyebrows and down towards her cheeks; swelling and bruising on her forehead; and what appeared to be scratches around her head and face.

Sarah contacted our office two months after her incarceration, in February 2025, recounting what she had endured at the jail. She described how her injuries were not directly caused by jail staff. Rather, they resulted from a series of self-harming episodes throughout her stay at the jail and during which staff had failed to intervene. She described having suffered a moderate-to-severe closed head injury, neck injury, concussion, extensive facial swelling, and bruising. Despite these injuries, jail staff did not provide her with medical or mental health services. She reported

¹ To protect medical confidentiality, we used a pseudonym for the complainant in this report.

² Complaint and Affidavit filed on December 24, 2024. *See also* Davenport Police Case Report 2024-00091681 dated December 24, 2024: “(Sarah) had injuries to the right side of her face that appeared to be fresh scratches.”

³ Davenport Police Case Report 2024-00091681 dated December 24, 2024.

⁴ Scott County Jail’s Booking Observation Report dated December 25, 2024, at 9:10 a.m., in which jail staff responded to the question, “Do you have any injuries?” with “Refused to answer my questions. Cuts and (marks) that she did to herself in holding cell overnight – no marks when she was arrested on 12/24.”

⁵ According to the police report, Sarah refused to allow officers to take photos of her face.

that, at the time she contacted the Ombudsman, she was still receiving medical treatment for her injuries.

Troubled by the allegations and corroborating photo evidence, we agreed to look into Sarah's allegations.

Just days prior to Sarah's incarceration, the Ombudsman released a report, "Sitting in Place: A Re-Examination of Restraint Device Use and Regulations for Iowa's County Jails," that examined multiple complaints against two county jails concerning inmates' access to medical and mental health care in conjunction with the use of the restraint chair.⁶ During our review of Sarah's complaint, the allegation arose that the Scott County Jail had *failed* to use the restraint chair when she was self-harming and causing severe injuries to herself.

Methodology

We began communicating with the Scott County Jail in February 2025 after receiving Sarah's complaint. We requested documentation relating to her classification status, supervision logs, booking documentation and photograph, medical and mental health records, and video footage. Although we initially contacted the Scott County Jail Administrator, Major Joseph Caffery, responses were provided by Capt. Stefanie Bush. Throughout the course of the investigation, Capt. Bush was our main source of information and explanations from the jail. Capt. Bush responded promptly to our requests, providing several incident reports, supervision logs, booking information and questionnaire, a medical note, intercom audio, relevant jail policies, and emails between staff.

In response to our request for video footage, Capt. Bush initially indicated it was likely not available at that point, 50 days after Sarah's incarceration. However, Capt. Bush quickly confirmed that the videos – 18 ½ hours of footage – were available because a sergeant had decided to archive the records after reviewing the incident reports. In addition to stationary camera footage, Capt. Bush also provided body camera video from five jail employees.

We also corresponded with Scott County Jail Medical Director Leslie Ronnebeck concerning medical services, and Davenport Police Department Lt. Dennis Colclasure regarding Sarah's arrest and involvement with police. Further, we reviewed multiple sources of jail standards and best practices, including the Federal Performance Based Detention Standards⁷, the American Correctional Association (ACA) Performance-Based Standards and Expected Practices for Adult Local Detention Facilities (ALDF)⁸, and the National Commission on Correctional Health Care's (NCCHC) Standards for Health Services in Jails.⁹

⁶ <https://ombudsman.iowa.gov/browse/files/7c43c51eccc49ed89c992b29d875edb/download>.

⁷ U.S. Marshals Service, Prisoner Operations Division, Federal Performance Based Detention Standards, December 2024.

⁸ American Correctional Association, Performance-Based Standards and Expected Practices for Adult Local Detention Facilities, Fifth Edition. *See also*: American Correctional Association, Standards Supplement, 2016.

⁹ National Commission on Correctional Health Care, Standards for Health Services in Jails, 2018.

After we initiated our investigation, Capt. Bush reported to us that the jail had initiated its own internal review of Sarah’s incarceration. Capt. Bush shared the details of this review, including the findings and steps taken to address the issues. We commend jail officials for the steps they took to review this case independently. Nevertheless, due to the seriousness of the issues and the range of concerns, we determined our investigation should continue and our findings should be shared in writing.

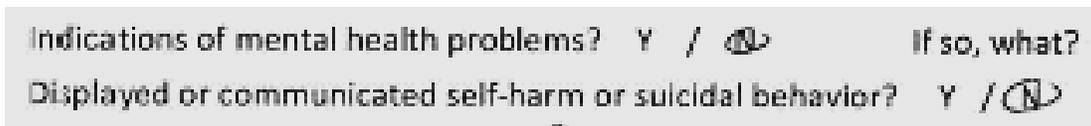
Background Facts

JAIL ADMISSION AND HOLDING CELL #9

Following her arrest but before her transport to the jail, police took Sarah to MercyOne Genesis Davenport Medical Center. During her time at the hospital, Sarah complained of numbness and struggled to support herself when moving from a gurney to a wheelchair. According to body camera and audio footage from a Davenport police officer, Sarah was seen twice by a hospital medical provider who determined that Sarah need not be admitted.

Hospital staff and Davenport police officer Brockton Trice assisted Sarah into a police vehicle and Officer Trice transported her to the jail. Once she arrived at the jail at 2:14 p.m., Sarah was able to walk without a wheelchair but needed help from jail staff who held her arms. Officer Trice told jail staff that Sarah’s condition appeared to have improved, as she no longer required the assistance of a wheelchair.

Officer Trice marked on a jail booking sheet that Sarah had injuries and had been “treated prior to being brought to the jail.”¹⁰ Officer Trice circled “N” on whether Sarah showed “indications of mental health problems” and whether she had “displayed or communicated self-harm or suicidal behavior”:



Jail staff took custody of Sarah, conducted a pat-down, and took her to Holding Cell 9. According to an incident report, Sarah was taken to the holding cell “based on her behavior and the fact that her ‘victim’ was also (at the jail).”¹¹ This jail report also described Sarah as being an “uncooperative female” upon arrival at the jail.¹² Another incident report described her behavior in more detail:

“(Sarah) has been uncooperative upon her arrival, refusing to stand on her own, and attempting self-harm. ... Due to her current behavior, I was unable to complete a fingerprint process.”¹³

¹⁰ Scott County Jail Booking Sheet dated December 24, 2024, by Davenport police officer Brockton Trice.

¹¹ Officer Susanne Brooks’ incident report dated December 25, 2024.

¹² *Id.*

¹³ Officer Bryse Sunderlin’s incident report dated December 24, 2024.

Upon entering Holding Cell 9, security video showed Sarah sitting on a bench and attempting to put her socks on. In her effort, she fell off the bench and landed on her hands. Sarah then sat on the ground, scooted around the cell floor, and appeared to talk to staff. Although there is no audio with the video, Sarah's actions appeared to show that she was speaking towards the cell door, where staff could be seen outside the door. Sarah then laid on her side on the cell floor. At this point, Sarah did not appear to be injured and staff did not enter the cell to check on her.

Holding Cell 9 includes concrete benches along the perimeter of the cell, a small metal stool, toilet, sink, and a mounted telephone with a long curly cord. The cell has two windows on the door and large panel windows on either side of the door.

A few minutes after she entered the cell, Sarah yelled to staff that she was in pain and needed help.¹⁴ Jail staff initially entered the cell at 2:28 p.m. and offered Sarah a water cup, which she did not accept. Sarah then sat on the bench, clasped her hand over her chest, and appeared to attempt to get staff's attention. At 2:35 p.m., medical staff entered the cell and checked her pulse and blood pressure. Sarah was offered pain medication, but she refused it.¹⁵ According to an undated and unsigned note provided by the jail, medical staff assessed Sarah's chest pain to be "unremarkable."¹⁶

After staff exited the cell, Sarah spent the next half-hour speaking to staff through the door, sitting, and even falling on the floor. At 3:00 p.m., Sarah began banging her head against the cell door, then took a brief break before repeatedly banging her head again. Staff arrived within a minute and spoke with her through the door for three minutes before leaving.

At that point, Sarah again began banging her head. During this period, Sarah spent three minutes hitting the back of her head against the door, approximately **50 times**. An officer came to the door at 3:07 p.m., but by then, Sarah was lying on the floor facedown, seemingly unresponsive to what the officer said. Sarah got up at 3:09 p.m. and began hitting the front of her head approximately **40 times**. At 3:20 p.m., Sarah stood up and slammed the front of her head rapidly against the door multiple times.

Sarah spent three minutes hitting the back of her head against the door, approximately **50 times**. ... (Sarah) began hitting the front of her head approximately **40 times**.

At 3:21 p.m., Sarah moved to the other side of the cell, toward a phone. While in a seated position, she grabbed the phone cord and wrapped it around her neck. Within seconds, six jail officers arrived in the cell and removed the cord from Sarah's neck.

A jail staffer then decided to move Sarah to Holding Cell 2. It is unclear from jail reports why Sarah was moved, but we were informed that Holding Cell 2 does not have a coiled phone cord

¹⁴ Officer Susanne Brooks' incident report dated December 24, 2024.

¹⁵ *Id.*

¹⁶ A copy of the unsigned medical note is attached as Appendix A.

such as the one in Holding Cell 9.¹⁷ Capt. Bush reported that the jail does not have a padded cell, so it was not an option to place Sarah in this type of seclusion area. In response to our inquiry about the lack of a padded cell, Capt. Bush shared:

We have not discussed doing this as this is the first person in our new facility which is not 15 plus years old, that has self-harmed to this magnitude. Clinton County had a padded room ... and someone destroyed it quickly after they opened the jail. It is very costly.

TRANSFER AND HOLDING CELL 2

We reviewed body camera footage from five jail employees: Alyssa Cousins, Bryse Sunderlin, Jesse Handley, Joeseeph Cool, and Susanne Brooks. According to the footage, which does contain audio, the officers urged Sarah to walk on her own through the jail minutes after her suicide attempt¹⁸ and despite her pleas of being in pain and needing help. The following exchanges occurred between Sarah and the jail officers around 3:22 p.m.:

Officer 1: “We are going to move her. ... Are you able to stand up?”

Officer 2: “She is going to stand up.”

Sarah: *(as officers start to grab Sarah’s arms in an effort to get her to stand up):* “Please, don’t do that right now.”

Officer 1: “Stand up. We’re going to help you.”

Sarah: “My leg hurts so bad ... please don’t do that leg that way, I’m begging you.”

Officer 3: “Sarah!”

Sarah: “I know, I know, I know, I will comply, it’s just, please watch my leg, please.”

Officer 1: “Watch your own leg.”

Sarah: “You’re hurting me.”

Officer 2: “You walked in here, you can walk out.”

Sarah: “I know, but I’m in pain, please.”

Officer 3: “Put your foot in front of the other.”

Officer 1: “Soon we’ll be walking out this door.”

¹⁷ Capt. Bush reported that Holding Cell 2 has a cordless, wall-mounted phone.

¹⁸ Our use of the phrase “suicide attempt” is in reliance on jail staff’s interpretation of the incident (*see* Officer Susanne Brooks’ incident report dated December 25, 2024).

Sarah: “I don’t feel good, please wait. Just give me a minute. My whole head hurts.”

Officer 4: “Well, you were hitting it.”

Officer 2: *(after 15 seconds):* “Go ahead and move, we’re not going to stand here all day. If you don’t move, I’m going to have them physically move you.”

Sarah: “Okay.”

Officer 2: “Start going, right now.”

Officer 3: “Quit leaning on me.”

Sarah: “I can’t okay, the leg hurts, I can’t.”

Officer 1: “Walk, let’s go.”

Officer 2: *(after Sarah was unable to walk on her own and slumped to the ground):* “We’re going to use more force. Physically pick her up and move her.”

At 3:24 p.m., five officers picked Sarah up and began carrying her. Officer Alyssa Cousins, along with another female officer, carried her legs and feet while two male officers, Jesse Handley and Bryse Sunderlin, carried her by her arms/shoulders. Officer Joseph Cool carried Sarah from her shoulders/back.

Officer Cousins’ body camera captured Sarah making snoring sounds while officers carried her. One of the officers pointed out the sound and asked if Sarah was snoring.¹⁹ It does not appear based on the body camera footage that any officer responded to this question. Officers carried Sarah the entire way to Holding Cell 2, which took about 30 seconds.

The jail’s security video shows Holding Cell 2 as a concrete and cinder block cell with a metal bench connected to the wall, a toilet, a sink, and an intercom button. The cell also has a wall-mounted cordless phone.

Once they entered Holding Cell 2, the female officers removed Sarah’s clothing, and she was given a suicide smock. Staff draped the smock over Sarah without helping to put on the garment.

The jail told us that magnetic curtains were placed over the cell window because Sarah remained naked for periods of time. The curtain appeared to obscure all view into and out of the cell from a standing height; however, the lower window (near the bottom of the door at foot level) was uncovered for the first eight and a half hours that Sarah was in Holding Cell 2.

While female staff were undressing Sarah, body camera footage from officers outside the cell captured staff discussing Sarah’s behavior, with the following exchange:

¹⁹ 2:36-minute mark of Officer Cousins’ body camera video.

Officer 1: “You want me to call medical or do it later?”

Officer 2: “You could call them now and let them know. She’s up now, so we’re good. She was faking it ... (inaudible) ... I guess we could have them check her because she tried to [hand quotes] ‘hurt’ herself.”

Officer 1 then leaves.

Officer 2 (to female staff in cell): “You can take her cuffs off now. She’ll probably just talk to her through the [slot] so....”

Before leaving the cell, staff informed Sarah that she would be assessed by medical staff shortly: “We’re going to have our medical staff come check you out and talk to you.”²⁰ Sarah’s handcuffs were then removed, and Sarah yelled out and asked for help. Staff left the cell at 3:26 p.m., two minutes after they had placed Sarah there. According to an incident report, medical staff conducted a verbal assessment of Sarah and placed her on a 15-minute watch²¹ until she could be assessed by mental health staff.²²

Jail documentation is unclear on whether medical staff conducted an assessment “through the [slot]” as the officer had suggested. Jail video from outside of Holding Cell 2 was no longer available at the time we requested it.

The jail’s medical director, Leslie Ronnebeck, could not say for sure whether medical staff had seen Sarah after her placement in Holding Cell 2. Ms. Ronnebeck shared her thoughts in an email to the Ombudsman:

I cannot confirm that the medical staff saw inmate (Sarah) again after she wrapped the telephone cord around her neck. It is noted a verbal assessment was done, so my indication is that medical staff instructed correctional staff to place the inmate in a smock and 15- minute watch for her own safety, it was also noted that Inmate (Sarah) had been hitting her head prior to the phone cord incident and correctional staff had told her to stop.

Ms. Ronnebeck also seemed to echo comments from a jail officer regarding whether Sarah was “faking” her suicide attempt:

I am not sure that this was indeed a suicide attempt, versus an attempt to go to the hospital and not to be in jail. Inmate (Sarah) was in a sitting position on the cell floor and reached up for the phone and wrapped the cord around her neck, all while remaining in the exact same position, not placing any pressure onto her

²⁰ 4:19-minute mark of Officer Cousins’ body camera video.

²¹ A 15-minute watch is identified in the jail’s policy as a “wellness check” in the context of suicide prevention/intervention in which a corrections officer “observes an inmate or staff by sight and sound, directly or by CCTV and intercom, and sees that the inmate and/or staff is safe and the surroundings are normal.” *See* Scott County Sheriff’s Office Policy 16002.13 (Suicide Prevention/Intervention).

²² Officer Susanne Brooks’ incident report dated December 24, 2024.

throat. She did all of this while correctional staff was outside her cell watching and they were in her cell and had removed the cord within seconds. The inmate was in no distress after the cord was removed. If medical staff was needed in this instance, they would have responded to booking to assess the inmate again.

On the other hand, an officer's incident report characterized Sarah's action as a suicide attempt:

After several unsuccessful attempts to return to the hospital she then wrapped the phone cord around her neck in an attempt to commit suicide.²³

We questioned the meaning of the officer's comment, and Capt. Bush shared:

Arrest[ee] (Sarah) did not go to the hospital from jail. I assume the writer meant she was trying to get to the hospital. She must have been asking to go, medical had been in there prior to her attempt of suicide and assessed her. I hold that as more opinion than fact and will coach the writer from making statements such as that in the future.

The jail supervision logs indicated that Sarah was checked every 15 minutes starting on December 24, 2024, at 2:54 p.m., until December 25, 2024, at 10:14 a.m. The first entry on the supervision log stated, "15 min incomplete," which Capt. Bush explained was a designation that Sarah's booking paperwork had not yet been completed.

Almost immediately after staff left the cell at 3:26 p.m., Sarah sat up and knocked on the cell wall. She then began tugging at her hair, pulling out large chunks. At one point, Sarah wrapped her hair around her neck in what appeared to be a self-harming strangulation attempt. She spent hours violently hitting her head on the cell door, walls, and floor with periods in between during which she laid on the ground and appeared to rest.

She spent hours violently hitting her head on the cell door, walls, and floor... (Sarah) appeared to have blood on her face and head.

The video footage showed that Sarah displayed signs of disorientation and injury, as she would lose her balance and fall to the floor. She also appeared to have blood on her face and head.

Although there is no audio available with the video, the footage appeared to show Sarah call out to staff on several occasions. Video indicated that no staff responded to either her calls for help or violent body strikes against the cell door. Video also showed Sarah appearing to vomit in the toilet on numerous occasions.

After about two hours in Holding Cell 2, staff gave Sarah toilet paper and a cup for water (for use in the cell's sink) through the food slot. Sarah continued to self-harm by hitting her head

²³ Officer Susanne Brooks' incident report dated December 25, 2024.

against the walls and door of the cell. At 7:21 p.m., Sarah hit her face so hard against the wall that she fell over from the force and appeared to pass out against the door.

At 7:50 p.m., Sarah crawled over to the toilet in the cell and appeared to get sick again. She then moved out of camera view for the next 37 minutes, with no staff entering the cell or looking through the curtain, despite the jail documentation stating 15-minute checks were done.

Sarah hit her face so hard against the wall that she fell over from the force and appeared to pass out against the door.

At 8:27 p.m., Sarah went to the door and appeared to say something. A jail staffer then moved the curtain aside and looked into the cell but did not enter. Shortly after, Sarah went to the other side of the cell and ran towards the door, slamming her body into it. Sarah then hit her head several more times against the door and fell onto her back. Still, Sarah continued to hit her face, head, and body against the cell walls and door for extended periods of time with very few breaks. Security video appeared to show further bloody injuries to Sarah's head and face.

The pattern of self-harm, falling to the ground and/or passing out continued for several more hours without staff intervention. Shortly before 11:00 p.m., more than seven hours after Sarah was placed in Holding Cell 2, she again moved to the toilet area and was off camera. She appeared briefly one time over the next hour, with staff glancing through the curtain only twice despite the 15-minute check directive. Sarah moved in and out of view for several more hours, with staff occasionally looking through the window at inconsistent intervals.

Video shows that on two occasions – 12:49 a.m. and 3:54 a.m. – Sarah stood up and appeared to press the intercom button in the cell. Although there is no audio available from the security video we reviewed, Sarah appeared on both occasions to be visibly upset and, at 3:54 a.m., she seemed to be yelling while holding her hands to her chest. No staff came into the cell or opened the peephole cover. According to the jail, there was only one recorded intercom use while Sarah was in Holding Cell 2, “at approximately 0032hrs”. However, the recording of the intercom was only a second long and did not contain any audio.

Sarah's movements continued to appear unstable, and she eventually laid back down by the toilet at 3:55 a.m. Following this, a staff person opened the peephole cover at 4:15 a.m., 4:27 a.m., and 4:56 a.m. This was the first instance in which video showed staff conducting somewhat regular 15-minute wellness checks from outside the cell. Sarah sat up around 5:00 a.m. and appeared to lean over the toilet, possibly getting sick.

MEAL TIME

At 6:08 a.m., security video appeared to show Sarah sitting up and screaming next to the toilet. About 20 minutes later, at 6:30 a.m., Officer Susanne Brooks, who had been involved in Sarah's cell transfer, opened the curtain and placed a food container on the food slot to Sarah's cell. After speaking to and observing Sarah, Officer Brooks wrote an incident report detailing her observations:

At 0630, while I was assisting in handing out breakfast trays I noticed that New Arrest[ee] (Sarah) (24-30579) had a severely swollen face and bruises on her arms.

When (Sarah) was arrested yesterday she was assessed at the Hospital prior to arrest and came in as “uncooperative” female.

After the pat search, based on her behavior and the fact that her “victim” was also here she was placed in Holding 9. At that time (Sarah) did not have any bruises on her face or arms.²⁴

Officer Brooks noted in her report that following Sarah’s suicide attempt with the phone cord, “she still had no marks on her.” Despite the fact that Sarah had put up some resistance when being dressed in the suicide prevention outfit, Officer Brooks stated that the incident was “nothing that would cause bruising of this magnitude.”

Officer Brooks speculated in her report what caused Sarah’s extensive injuries:

(Sarah) stayed in Holding 2 where she was the sole occupant the entire night.

When I saw her this morning she had a severely swollen face and bruises up and down on her arms. I can only assume, and I am sure CCTV will confirm that the bruises on her arms and face are self-inflicted.²⁵

Indeed, the security video shows these injuries were self-inflicted. The video from Holding Cell 2 also showed that Officer Brooks was the only member of the jail staff to have entered the cell since 3:27 p.m. on December 24 – **15 hours prior**.

At 6:32 a.m., a few minutes after the food tray was dropped off, two jail staffers entered Sarah’s cell to hand her a new suicide smock and her medication.²⁶ Sarah did not eat the food on the tray and instead went back to the toilet and appeared to be sick.

At 6:51 a.m., an officer entered the cell and retrieved the food tray. At this time, Sarah was sitting by the toilet, rocking back and forth. Sarah moved to the bench at 7:45 a.m. and appeared to yell. A staff person looked through the peephole about 20 minutes later, but video showed that staff did not respond until 9:01 a.m. At that time, a male officer stood outside the cell, removed the curtain, and appeared to speak to Sarah.

²⁴ *Id.*

²⁵ *Id.*

²⁶ According to Sarah, she “was left with only a urine-soaked smock to wear for hours” until she was provided a new smock (at 6:32 a.m.) before seeing the judge. Sarah reported to us that she had notified staff numerous times before that she needed a new smock because the one she was provided after moving to Holding Cell 2 was covered in urine and vomit.

Despite the severity of the injuries and multiple officers entering the cell on Christmas morning, no photographs were taken of Sarah, with the exception of a booking photograph taken over two hours after staff first entered her cell that morning.

BOOKING PROCESS

The security video from Holding Cell 2 footage ended at 9:03 a.m. Jail records indicated that Sarah was taken to booking shortly after. Sarah's booking documentation is dated December 25, 2024, at 9:10 a.m., nearly 19 hours after Sarah arrived at the jail the day before at 2:14 p.m.

Jail documentation indicated that staff were aware that Sarah's booking had not yet been completed during her stay. An email from Officer Brooks to "SD Jail Booking and ID" dated December 24, 2024, at 5:18 p.m. stated that Sarah's booking was incomplete.

Another email dated December 25, 2024, at 5:45 a.m. from jail staffer Cory Elam to "Sheriff Jail Booking and ID" stated that Sarah's booking was still incomplete and that she was on 15-minute checks and wearing a suicide smock. The email stated that Sarah "has been screaming and hitting the door for most of the night."

The jail reported to us that Sarah was "short booked" prior to her official booking because she was initially uncooperative. Short booking requires the same paperwork as a regular booking process, but only involves attempting to obtain an inmate's physical descriptors and social information. A report is normally written on the reason for this alternative process, but Capt. Bush said it was not clearly documented in this case.

Capt. Bush further shared the following:

The "short booking" is done because we are sure they are leaving very quickly, and we don't need to know medical or suicide assessment answers. ... It would happen when the person arrives with their bond money, or a bonding company has already dropped off the bond at the time of arrival or the time of booking. It could also happen when another agency / department is there to pick up the subject instantly.

Capt. Bush explained that short booking may also occur if the person is being uncooperative and is expected to be released early: "We aren't going to argue with someone to complete a medical assessment just to release them out the door 5 minutes later."

Sarah's full booking was eventually completed shortly after the video from Holding Cell 2 ended on December 25. Part of the booking process included completion of the Suicide Screening Questionnaire, which was time stamped at 9:10 a.m. When asked whether there was "any indication of a prev(ious) suicide attempt to include scars, marks & bruises," a staff member who filled out the form answered "No":

DOES THE INMATE APPEAR OVERLY ANXIOUS, AFRAID, OR ANGRY	Yes	
DOES THE INMATE TALK IN A STRANGE MANNER	No	
ANY INDICATION OF A PREV. SUICIDE ATTEMPT TO INCLUDE SCARS, MARKS & BRUISES	No	
HAVE YOU EVER TRIED TO HURT YOURSELF	Yes	
HAVE YOU EVER TRIED TO KILL YOURSELF	Yes	
HAVE YOU TRIED TO KILL YOURSELF WITHIN THE LAST TWO YEARS	Yes	dressed in to safety smock on 12/24 by A team
ARE YOU CURRENTLY THINKING ABOUT HURTING YOURSELF	Yes	smocked by A team on 12/24

However, Sarah’s booking photograph, taken at 9:03 a.m., minutes before the Suicide Screening Questionnaire was completed, clearly showed numerous significant injuries to her face and head. The photograph showed Sarah’s right eye completely swollen shut, with purple and pink bruising above and below the eye. Sarah’s left eye was partially covered by her hair, but the image showed dark purple and black bruising above and below her eye. Sarah’s cheeks appeared swollen and red, and her forehead had significant purple and pink bruising and swelling from her eyebrows to her hairline. Sarah’s face and head showed scratches similar to those shown on the image Sarah shared with our office shortly after her release from jail.

The jail reported that this was the only photograph taken of Sarah’s injuries, though Officer Brooks noted in her report from her encounter with Sarah earlier that day that there were also “bruises up and down her arms.”²⁷

Sarah’s records indicated that she attended her court hearing after the booking documentation was completed. According to a jail report, “[t]he courts were made (aware) of this unique situation in case there were questions as to what happened to (Sarah).”²⁸ Sarah was ultimately released from the jail on bond at 10:21 a.m.

Analysis

We explored several areas where we felt jail staff should have taken alternative actions to ensure Sarah remained safe while in their custody. We found bad practices, improper behavior, policy failures, and poor decision-making by staff in the booking process, cell transfers, inmate monitoring, and medical and mental health reviews. We will address each of these findings in this section.

In analyzing the steps staff took throughout Sarah’s stay, we not only looked to Scott County Jail’s policies and Iowa law, but also applied the standards from the National Commission on Correctional Health Care (NCCHC) and the American Correctional Association (ACA), which we cite throughout this report. We note that the Scott County Jail incorporates some, though not all, of the standards from these organizations in its policies. We chose to reference additional standards that we have identified as best practices.

²⁷ Officer Susanne Brooks’ incident report dated December 25, 2024.

²⁸ *Id.*

DELAY IN BOOKING

The jail's booking policy references the 2003 version of the NCCHC standards, stating:

J-E-2 Receiving Screening (essential)

Receiving screening is performed on all inmates immediately upon arrival at the intake facility.²⁹

An updated version of the NCCHC standard explains that the screenings should be completed as soon as possible and without unnecessary delay “to ensure that emergent and urgent health needs are met.”³⁰

Despite the policy, jail staff did not immediately or “upon arrival” complete the booking process. In fact, the process was not initiated until 19 hours after Sarah had arrived at the jail.

As explained earlier in this report, Sarah was “short booked” into the jail. No clear reason was documented for why Sarah was short booked.

An “incomplete booking” report is created if an individual is at the jail for more than 1½ hours without completing the booking process. Jail staff are to document in this report that one or more attempts were made to “gain compliance” from the inmate and provide a brief description of the inmate’s “defiance in completing the process.” However, Sarah’s behavior was not clearly noted in the “incomplete booking” report.

The delay in fully booking Sarah was significant because this hindered the jail from obtaining important mental health information from questionnaires and paperwork that are completed during booking. The Iowa Administrative Code, which does not provide for “short booking,” requires that certain information be obtained from the inmate upon arrival:

c. As a part of the admission procedure, a medical history intake form shall be completed for each person admitted to the jail. The intake procedure shall include screening for potential self-injury or potential suicide. Jail staff with actual knowledge that there is a substantial risk that a prisoner intends to commit suicide shall take reasonable measures to abate that risk. The jail shall have a written suicide prevention plan. Essential elements of the plan shall include annual training to recognize the potential for suicide, communication between staff, appropriate housing and intervention procedures.³¹

Jail policy also requires that questions be posed to inmates during the booking process:

²⁹ Scott County Sheriff's Office Policy 15005.1 (Booking), referencing NCCHC J-E-02 (2003).

³⁰ NCCHC Standards for Health Services in Jails, J-E-02 (2018).

³¹ IOWA ADMIN. CODE r. 201—50.15(6).

The Booking Officer asks the new arrestee medical and mental health screening questions during the booking process along with suicide risk assessment questions and documents the answers in [Offender Management System].³²

Although not adopted by the jail's policy, the ACA's "best practices" standards detail the information that should be obtained during the initial mental health screening at the time of admission:

The mental-health screening includes, but is not limited to:

- Inquiry into whether the inmate:
 - Has a present suicide ideation.
 - Has a history of suicidal behavior.
 - Is presently prescribed psychotropic medication.
 - Has a current mental health complaint.
 - Is being treated for mental health problems...
- Observation of:
 - General appearance and behavior.
 - Evidence of abuse and/or trauma.
 - Current symptoms of psychosis, depression, anxiety, and/or aggression.
- Disposition of inmate:
 - ... Referral to appropriate health care service for emergency treatment."³³

In our 2024 report on restraint device use, we advocated for the Brief Jail Mental Health Screen.³⁴ This form can be used even by staff who have no formal mental health training. The form helps to identify individuals who may need the attention of a mental health professional for further evaluation and treatment. The form, or a similar one, may have been useful to assess Sarah's mental health needs. If the screening had suggested that Sarah needed further evaluation, the jail may have been able to pursue alternative placement through an involuntary mental-health commitment, also known as a "229 order."³⁵

Short booking may have caused jail staff to miss follow-up discussions about Sarah's mental state upon her admission. Had jail staff followed up with full booking immediately upon Sarah's arrival, more detailed information could have been obtained regarding her mental health history along with her state of mind at the time of booking.

³² See Scott County Sheriff's Office Policy 16002.5 (Health Appraisals). See also Sarah's Suicide Screening Questionnaire, completed on December 25, 2024.

³³ 5-ALDF-4C-28.

³⁴ An eight-question form endorsed by the National GAINS Center, a federal agency that develops mental health services in the justice system.

³⁵ A 229 order refers to a court order to involuntarily commit, treat, or hospitalize a person who suffers a serious mental impairment and/or who has a substance use disorder. a person who is experiencing serious mental impairment or has a mental illness and because of that illness, The "respondent," or subject of concern, "lacks sufficient judgment to make responsible decisions with respect to the person's hospitalization or treatment..." The respondent must meet one of the following criteria: likely to physically injure the person's self or others, likely to inflict serious emotional injury, lacks the ability to meet needs, has a history of treatment noncompliance. See *Iowa Code section 229*.

TRANSFER TO HOLDING CELL 2

Staff initially placed Sarah in Holding Cell 9, but soon transferred her when she wrapped a phone cord around her neck. In doing so, staff made her stand up immediately and allowed her only a few moments to rest after she said she was unable to walk. Staff then carried her through the jail by her limbs and shoulders when she could not walk unassisted. Video from the incident captured apparent snoring sounds, possibly caused by her partially obstructed airway due to her body position.

According to Capt. Bush, the jail's protocol is to request a wheelchair from medical for transporting inmates who are physically incapable of walking themselves. However, this was not done in Sarah's situation because, according to Capt. Bush, jail staff believed Sarah's decision not to walk was "behavioral." Capt. Bush explained:

We direct officers to support the shoulders of the subject when forced to carry a subject. Officers/ Sergeants are directed to encourage the subject to walk, to use escort holds or pressure points to encourage walking on their own, and avoid carrying subjects to avoid injury to staff or the subject. Refusing to walk or "dead weight" tactic is a form of passive resistance.

Capt. Bush further explained her staff's decision to carry Sarah instead of using a wheelchair or restraint chair:

Due to her attempt of suicide, the Sergeants deemed it important to get her to the holding cell to place her into the suicide safety smock. They had felt she was uncooperative. Waiting for a wheelchair, they believed could cause potential issues in a use of force. They could have waited and taken that chance; however, we ensure they are not carrying someone when we review video to avoid injury. It could have injured staff as well in carrying her. My preference would be to use a wheelchair when feasible. In this situation, I am unsure she would have sat in one or not.

Capt. Bush also acknowledged our concern about Sarah's apparent snoring sounds:

Had I been there to hear that noise, I would suggest laying her down on the ground and assessing her again or having medical (check) if she had labored breathing for a possible issue from the hanging attempt or another medical issue.

We agree with Capt. Bush that, when feasible, it is preferable to use a wheelchair to transport an inmate who is unable to walk on his or her own. With that in mind, the manner in which Sarah was transported from Holding Cell 9 to Holding Cell 2 was unnecessary and unsafe.³⁶ Officers could also have allowed Sarah to rest for a longer period of time to gain her strength back to walk herself. While monitoring her during this rest period, staff could have requested the

³⁶ See National Library of Medicine case report, "Sudden deaths from positional asphyxia" dated June 15, 2018 (<https://pmc.ncbi.nlm.nih.gov/articles/PMC6023692/#:~:text=The%20mechanism%20of%20asphyxia%20can,thus%2C%20must%20be%20excluded%20first.>).

wheelchair from medical and, if Sarah had refused to sit in the wheelchair, staff could have considered alternative options, including a restraint chair.

STAFF DISREGARD AND MINIMIZATION OF SARAH'S STRUGGLES

Body camera video captured staff's unprofessional and insensitive comments toward Sarah during the transfer between holding cells. First, staff showed little tolerance when Sarah expressed the need to wait to walk because she was experiencing pain in her leg and head. She was met with comments from officers such as:

"You walked in here, you can walk out."

"Well, you were hitting it." (*Referring to Sarah's head hurting.*)

"We're not going to wait here all day."

Additionally, when describing Sarah's actions in Holding Cell 9, an officer used air quotes when stating she tried to "hurt" herself. Other jail staff appeared to question the authenticity of Sarah's suicide attempt, including Medical Director Leslie Ronnebeck, who said that she was "not sure that this was indeed a suicide attempt, versus an attempt to go to the hospital." The comments appeared to be speculative and based on staffs' personal opinions. These unsupported judgments on Sarah's behavior appeared to be another example of staff disregarding and minimizing her struggles.

These dismissive comments are juxtaposed against other staff taking the matter more seriously by moving her to another cell, stripping her of her clothes, and forcing her to wear a suicide smock.

Capt. Bush later commented on the officers' behavior: "When I see someone acting in appropriately [sic] or laughing, cussing etc, they are coached/counseled as necessary such as this video as an example." Capt. Bush reported that the jail has some newer officers who "always need to learn when faced with an uncomfortable situation, how to react appropriately."

WELLNESS CHECKS

How often inmate checks occur is contemplated in the jail's policies, as well as in the ACA and NCCHC standards. Jail policy describes a wellness check in the context of suicide prevention/intervention in which a corrections officer "observes an inmate or staff by sight and sound, directly or by CCTV and intercom, and sees that the inmate and/or staff is safe and the surroundings are normal."³⁷ Wellness checks for suicidal inmates occur "at least every 15 minutes on an irregular schedule," according to the jail's policy.³⁸

³⁷ Scott County Sheriff's Office Policy 16002.13 (Suicide Prevention/Intervention).

³⁸ *Id.*

The jail's policy also references the ACA's best practices concerning observing suicidal inmates as well as inmates classified as "special management":

All **special management inmates** are personally observed by a correctional officer at least every 30 minutes on an irregular schedule. Inmates who are violent or mentally disordered or who demonstrate unusual or bizarre behavior receive more frequent observation; **suicidal inmates are under continuous observation** until seen by a mental health professional.³⁹ (Emphases added.)

The jail's policy defines "special management" inmates as those individuals demonstrating one of the following problems: "acute chemical dependency withdrawal, handicapped, mental health problems, physical injuries, serious health problems, potential suicide, or protective custody status."⁴⁰ According to Capt. Bush, inmates classified as "special management" who are not suicidal are personally observed every hour, pursuant to Iowa's administrative rules.⁴¹

In reference to "continuous observation," the jail's policy provides the following definition:

The Corrections Staff watches an inmate directly, or by CCTV, without interruption, to immediately identify emergency conditions when they arise.⁴²

The jail's suicide prevention/intervention policy specifies that booking staff must conduct continuous observation of an inmate who "appears to be an acute suicide risk" until the inmate can be seen by mental health staff.⁴³ Further, the policy states that, if any inmate exhibits suicidal behaviors, the inmate is placed on 15-minute checks and "[i]f applicable, the Shift Supervisor notifies the Central Control Officer by phone, to conduct continuous observation until the inmate is seen by a mental health professional and directs otherwise."⁴⁴

We found other relevant ACA and NCCHC standards regarding wellness checks, particularly those for inmates who are considered suicidal and/or "special management." These standards, which are not referenced in the jail's policy, include:

Supervisory staff conducts a daily patrol, including holidays and weekends, of all areas occupied by inmates.⁴⁵

Written policy, procedure, and practice require all special management inmates are personally observed by a correctional officer twice per hour, but no more than 40 minutes apart, on an irregular schedule. Inmates who are violent or mentally

³⁹ *Id.*, referencing 5-ALDF-2A-52.

⁴⁰ Scott County Sheriff's Office Policy 16002.10 (Special Needs Inmates).

⁴¹ IOWA ADMIN. CODE r. 201—50.13(2)(a)(3): "At least hourly, personal observation of individual prisoners shall be made and documented."

⁴² Scott County Sheriff's Office Policy 16002.13 (Suicide Prevention/Intervention).

⁴³ *Id.*

⁴⁴ *Id.*

⁴⁵ 5-ALDF-2A-11.

disordered or who demonstrate unusual or bizarre behavior receive more frequent observation; suicidal inmates are under continuing or continuous observation.⁴⁶

Suicides are prevented when possible by implementing prevention efforts and intervention.⁴⁷

In regard to Sarah's checks, the supervision logs indicated that wellness checks occurred every 15 minutes for the entire duration of Sarah's 17½ -hour stay in Holding Cell 2. However, video showed that the curtain/peephole moved on only a handful of occasions and staff opened the door and/or physically entered the cell only four times. Three of the four occasions that staff entered Holding Cell 2 were after Sarah had been in the cell for 15 hours.

The jail's policy at that time allowed for wellness checks to be completed in person or through CCTV. Sarah's self-harming behavior occurred in clear view of the camera, and no staff responded or intervened, indicating that continuous observation was likely not done. Further, there were numerous occasions where Sarah was out of the camera view for prolonged periods and thus unable to be observed through CCTV. During these occasions, in-person checks were not occurring, as the curtain/peephole was not moved, nor was the cell door ever opened.

Since our inquiry, the jail updated its policy to remove the option to conduct wellness checks by CCTV, and the checks now must be completed in person.

We commend the jail for taking this step. However, we urge the jail to consider additional changes that could ensure wellness checks are completed appropriately. First, the jail could consider implementing an electronic scan system in the area of the jail Sarah was housed, which would be utilized by staff before conducting each round of wellness checks.⁴⁸ Officers would be required to personally scan electronic points throughout the unit during wellness checks. The electronic scan points bring accountability, as officers are notified when each wellness check is due. Additionally, jail administrators are notified if a wellness check is not completed within the designated time frame.

Although the booking area where Sarah was housed lacks an electronic scanning system, Capt. Bush told us that the jail has "reviewed companies that include this feature in software updates in the past year." However, she said the jail had "no current plans to upgrade" to the system due to budgetary constraints.

The jail should also consider transitioning from paper recording (supervision logs) to an electronic handheld device for purposes of conducting checks and tracking inmate activity. In

⁴⁶ 5-ALDF-2E-10.

⁴⁷ NCCHC J-B-05. See Discussion: An active approach to the management of suicidal inmates is recommended. In facilities where 24-hour mental health staff coverage is not present, designated health and/or custody staff should be able to initiate suicide precautions until the qualified mental health professional on call can be contacted for further orders.

⁴⁸ Capt. Bush explained that, in all other areas of the jail except booking, a product from Guard1 called the PIPE is used for the jail's security guard monitoring system (<https://www.guard1.com/solutions/security-guard-monitoring-system/>). She shared with us, "[i]t starts at 10PM and ends at 5AM. We hit the buttons which are in certain areas of each housing unit every hour."

our office’s review of another county jail’s restraint chair use, we found that one of the positive steps taken by the jail during our investigation was switching from paper logs to electronic handheld devices. These devices allow staff to record the date, time, and location of a check, as well as what is observed. It also alerts staff when it is time to check on an inmate. This would provide another avenue of accountability and accuracy for staff to ensure that the in-person wellness checks occur appropriately and pursuant to policy. According to Capt. Bush, the jail is “looking into services which enhance (the) managing (of) security rounds.”

SELF-HARMING AND LACK OF RESTRAINT CHAIR USE

Iowa Administrative Code 201 – 50.15(6) states, “Jail staff with actual knowledge that there is a substantial risk that a prisoner intends to commit suicide shall take reasonable measures to abate that risk.” Several jail policies provide further direction and certain requirements for handling inmates who self-harm and/or are suicidal:

If any staff at any time sees that an inmate needs restrained to prevent serious self-harm, the staff notifies the Shift Supervisor by the most direct means. (See 15001.20 Restraints and 15001.21 Restraint Chair).⁴⁹

If the arrestee remains uncooperative, combative, or becomes a risk of injury to himself or others, the Shift Supervisor may decide to place the arrestee in the restraint chair, recording the process on videotape.⁵⁰

Signs of Suicidal or Bizarre/Deranged Behavior ... 2. The Corrections Staff takes immediate steps necessary to provide for the inmate’s safety, which includes, but is not limited to, the removal of the inmate’s property from the immediate area, the use of a safety suicide smock and/or the use of appropriate restraints and follows 15001.20 Restraints and 16002.13 Suicide Prevention/Intervention as needed.⁵¹

ACA jail standards cover the topic of jail staff responding to emergency situations, including inmates’ display of violent behavior:

Correctional and health care personnel are trained to respond to health-related situations within a four-minute response time. The training program is conducted on an annual basis and is established by the responsible health authority in cooperation with the facility or program administrator and includes instruction on the following:

- Recognition of signs and symptoms, and knowledge of action that is required in potential emergency situations. ...
- Signs and symptoms of mental illness, violent behavior, and acute chemical intoxication and withdrawal.

⁴⁹ Scott County Sheriff’s Office Policy 16002.13 (Suicide Prevention/Intervention).

⁵⁰ Scott County Sheriff’s Office Policy 15005.1 (Booking).

⁵¹ Scott County Sheriff’s Office Policy 16002.9 (Mental Health Services).

- Procedures for patient transfers to appropriate medical facilities or health care providers. ...⁵²

Accordingly, correctional staff have a vital responsibility to respond to situations quickly and appropriately to ensure inmates are safe from the dangers they pose to themselves and others. The video of Sarah during her time at the Scott County Jail clearly demonstrates that staff failed to protect her from harm. The aforementioned descriptions of events in Holding Cell 2 speak for themselves – Sarah brutally harmed herself for hours with no interventions by staff.

Our investigators have watched hundreds of hours of video in jail settings, but observing the footage from Sarah’s incarceration was unlike any other. Sarah’s self-harming actions were so upsetting and troubling that our assistant had to stop watching at one point and walk away.

Sarah has reported extensive injuries as the result of her self-harming behavior, including a moderate-to-severe closed head injury, neck injury, concussion, extensive facial swelling, and bruising. Upon watching the video footage, we have no reason to doubt the extent of the injuries she reported.

Capt. Bush admitted there were shortcomings in her staff’s oversight, but with a caveat:

I do ask it is taken into consideration how loud, busy and staff who grow numb to hearing people pound on doors throughout their twelve-hour shifts when those around them are drunk or under the influence of substances. They hear screaming, yelling, banging etc for the duration of their shifts. We also have grown to tolerate banging on doors rather than placing them into restraint chairs unless they are a danger to themselves as in this situation where she was.

Capt. Bush later offered a clarification:

Staff clearly failed to see that she was banging her head on the wall/door repeatedly for hours. When I said to you “numb” please redact my statement. I cannot speak for others at all. I can only tell you that there are people down in booking screaming, yelling and banging at times from numerous holding cells. Staff should have checked on her for the banging. I don’t know how loud the sound of her head hitting the wall would have been. I don’t think that makes a loud sound. Hitting her head on the door would be much louder. When someone starts to kick a cell door, it is extremely loud. I did not observe her kick a cell door.

Additionally, Capt. Bush informed us that she had directed jail staff to personally check on inmates who make such noises:

An email was sent to the booking and ID staff when they hear any type of banging, they need to physically go check on it and ensure it is not someone self-harming.

⁵² 5-ALDF-4D-08.

It appears that at least some staff *did hear* Sarah yelling and banging, as an email from a jail staffer stated that Sarah had been “screaming and hitting the door for most of the night.” The noise level of a unit should not deter staff from completing the checks necessary to ensure inmates are safe and unharmed. As previously mentioned, Sarah’s self-harming behavior could clearly be seen on CCTV or through in-person checks (if they had occurred regularly).

Further, we considered whether the jail had failed to use the restraint chair in accordance with law and policy. Iowa law requires that use of restraint devices be restricted to those circumstances when an inmate is an imminent risk of harm to themselves or others or is jeopardizing jail security.⁵³ The jail’s policy concerning restraint chair use states:

The Jail may control a violent inmate by restraining them in the restraint chair to keep them from harming themselves, others, attempting to escape or jeopardizing Jail security.⁵⁴

This jail policy also references the NCCHC Standards for Health Services in Jails, including:

... Background: If an inmate is actively self-destructive and/or displaying active resistance or once an inmate has been identified as being very resistant, combative or refuses to physically move to a specified location, the PRO-STRAINT restraint chair is a means of accomplishing this move while limiting this individual’s movement and in limiting the ability to harm staff or themselves.⁵⁵

The ACA’s jail standards provide information regarding the circumstances in which a restraint chair should be used:

Restraint devices are never applied as punishment. There are defined circumstances under which supervisory approval is needed prior to application.

Comment: Restraint devices should be used only to prevent self-injury, injury to others, or property damage. Restraints are not applied for more time than is necessary.⁵⁶

Four-/five-point restraints are used only in extreme instances and only when other types of restraints have proven ineffective or the safety of the inmate is in jeopardy. ... Subsequently, the health authority or designee must be notified to assess the inmate’s medical and mental health condition, and to advise whether, on the basis of serious danger to self or others, the inmate should be in a medical/mental health unit for emergency involuntary treatment with sedation and/or other medical management, as appropriate.⁵⁷

⁵³ IOWA ADMIN. CODE r. 201—50.13(2)(f).

⁵⁴ Scott County Sheriff’s Office Policy 15001.21 (Restraint Chair).

⁵⁵ *Id.*, referencing NCCHC J-I-01 (2003).

⁵⁶ 5-ALDF-2B-02.

⁵⁷ 5-ALDF-2B-07.

Capt. Bush believed Sarah should have been placed in the restraint chair to prevent herself from further self-harm and should have been evaluated by medical staff after causing injuries to her head. However, she explained that staff are “cautious” about using the device because of our recent public report that found other county jails in Iowa overused the restraint chair.

(Capt. Bush) explained that staff are “cautious” about using the device because of our recent public report that found other county jails in Iowa overused the restraint chair.

Still, Capt. Bush prudently notified staff that “[Sarah’s situation] is an instance where someone is a danger to themselves, and it is the exact reason we have [the restraint chair].”

Capt. Bush gave further direction to jail supervisors: “When someone is repeatedly hitting their head and harming themselves, the restraint chair should be used.”

LACK OF MEDICAL ASSISTANCE

The jail’s policy states the following concerning health appraisals:

All inmates admitted to the Jail are health screened within 48 hours to provide the inmate with prompt and appropriate health care, and to help prevent the spread of illness and disease.⁵⁸

The jail’s booking policy references the ACA’s best practice standard:

Prior to accepting custody of an inmate, staff determines that the inmate is legally committed to the facility, and that the inmate is not in need of immediate medical attention.⁵⁹

Policy also references the following from NCCHC standards:

The initial health screening begins during the booking process and is completed by the Health Staff.⁶⁰

Sarah’s “initial health screening” appeared to be completed during her booking process, which occurred 19 hours after she arrived at the jail. We found that this screening appeared to have inaccurate and inconsistent information, as Sarah’s injuries were noted in an incident report⁶¹, but the health screening answered “No” to whether there was “any indication of a prev. suicide attempt to include scars, marks & bruises.”⁶²

⁵⁸ Scott County Sheriff’s Office Policy 16002.5 (Health Appraisals).

⁵⁹ Scott County Sheriff’s Office Policy 15005.1 (Booking), referencing 4-ALDF-2A-19.

⁶⁰ Scott County Sheriff’s Office Policy 16002.5 (Health Appraisals), referencing NCCHC J-E-04 (2003).

⁶¹ Officer Susanne Brooks’ incident report dated December 25, 2024.

⁶² See Suicide Screening Questionnaire, completed on December 25, 2024.

Although Sarah was released from the jail within the 48-hour window for a health screen pursuant to jail policy, we inquired about what medical assistance Sarah received following her suicide attempt and her self-injuries. We saw that staff were aware of Sarah's injuries, as an incident report noted at 6:30 a.m. that Sarah had "a severely swollen face and bruises up and down her arms."⁶³ However, the only written documentation from jail medical staff concerning an assessment of Sarah was an undated, unsigned note that described Sarah's preexisting health concerns, an assessment that was conducted while she was in the first holding cell, and her suicide attempt with the telephone cord.⁶⁴

Ms. Ronnebeck confirmed that staff should have evaluated Sarah's injuries; however, she explained that, because the self-harming behavior was not reported to medical, staff were unaware of the injuries and could not conduct an evaluation. Nevertheless, Ms. Ronnebeck shared her regrets on what happened:

This is an unfortunate outcome, and things could have been handled better to prevent inmate (Sarah) from obtaining these self-inflicted injuries.

Through the course of the 20 hours that Sarah was at the jail, she self-harmed to the extent that she suffered serious external injuries. There is no indication that Sarah was evaluated after her self-harming incidents in Holding Cell 2, and it is unclear whether Sarah was in fact evaluated after her suicide attempt. However, as staff informed Sarah following the cell transfer that she *would be* evaluated following her suicide attempt, it appears staff believed an evaluation was warranted.

Additionally, the only photograph the jail took of Sarah's injuries was the booking photograph, which was taken over two hours after Officer Suzanne Brooks wrote an incident report describing the injuries as severe. That photograph did not capture all of the injuries noted in the report.

LACK OF MENTAL HEALTH SERVICES

Iowa's administrative rules provide guidance on how jails must handle inmates experiencing mental health issues. Iowa Administrative Code 201 – 50.15(6) states that an individual demonstrating self-harming behaviors due to his/her mental illness "shall be admitted to the jail only after the arresting officer/agency has demonstrated a reasonable effort to comply with the emergency hospitalization procedure, as provided in Iowa Code section 229.22."⁶⁵

Further, the administrative rule goes on to state:

The jail shall have a written plan to provide prisoners access to services for the detection, diagnosis and treatment of mental illness."⁶⁶

⁶³ Officer Susanne Brooks' incident report dated December 25, 2024.

⁶⁴ A copy of the unsigned medical note is attached as Appendix A.

⁶⁵ IOWA ADMIN. CODE r. 201—50.15(6).

⁶⁶ *Id.*

At the time of our initial inquiry with the jail⁶⁷, its policy concerning mental health services stated:

The Jail provides mental health screenings, evaluations, medications and recommendations for the transfer of mentally ill inmates to psychiatric facilities, and referrals to community mental health service providers for treatment after release.⁶⁸

In response to a later inquiry, the jail provided its current policy concerning mental health services, which eliminated the above statement and replaced it with the following:

The Jail provides mental health screenings, medications, and recommendations for the transfer of mentally ill inmates to psychiatric facilities.⁶⁹

Both versions of the policy reference 24-hour emergency mental health services available to inmates:

The Jail provides 24-hour emergency medical, mental health and dental services as directed by the Chief Medical Officer.⁷⁰

The jail's policy also references the ACA's Adult Community Residential Services best standards, including:

Emergency Health Care

4C-03 Twenty-four hour emergency medical, dental, and mental health care is provided for offenders, which includes arrangements for the following:

- On site emergency first aid and crisis intervention
- Emergency evacuation of the offender from the facility
- Use of an emergency medical vehicle
- Use of one or more designated hospital emergency rooms or other appropriate health facilities.
- Emergency on-call physician, dentist, and mental health professional services when the emergency health facility is not located in a nearby community.⁷¹

We noticed that the jail's policy above references the ACA's Performance-Based Standards for *community residential services* in addition to the ACA's Performance-Based Standards and Expected Practices for Adult Local Detention Facilities (ALDF), which are applicable for jail facilities. Additionally, we found that the jail's policy references ACA's fourth edition ALDF

⁶⁷ Our initial inquiry was on February 24, 2025. This report's references to Scott County Sheriff's Office policies are based on the language identified in policies effective at the time of the request unless otherwise specified.

⁶⁸ Scott County Sheriff's Office Policy 16002.9 (Mental Health Services), *effective date December 19, 2018*.

⁶⁹ Scott County Sheriff's Office Policy 16002.9 (Mental Health Services), *effective date June 5, 2025*.

⁷⁰ *Id.*

⁷¹ *Id.*, referencing ADRS-4C-03.

standards, released in 2022; however, the ACA released the fifth edition ALDF standards in 2023. The fifth edition includes an update to what mental health services should be offered:

Mental health services include at a minimum:

1. Mental health services and activities are approved by the appropriate mental health authority.
2. Crisis intervention and the management of acute psychiatric episodes.
3. Stabilization of the mentally ill and the prevention of psychiatric deterioration in the correctional setting.
4. Referral to outpatient services for the detection, diagnosis, and treatment of mental illness.
5. Referral and admission to licensed mental health facilities for inmates whose psychiatric needs exceed the treatment capability of the facility.

...⁷²

The jail's policy also references portions of the NCCHC Standards for Health Services in Jails, including, "Mental health services are available for all inmates who require them."⁷³

The policy, however, does not include all relevant standards identified by the NCCHC concerning access to mental health services. Other relevant standards include:

Inmates have *access to care* for their serious medical, dental, and mental health needs.⁷⁴

Planning for *emergency health care* ensures that all staff are prepared to effectively respond during emergencies.⁷⁵

The jail's responsibility to identify and address inmates' mental health concerns is articulated in Iowa law, jail policy, and best practices. However, it is apparent that Sarah experienced a mental health crisis while at the jail over the Christmas holiday and her struggles went undetected by

⁷² 5-ALDF-4C-27.

- See also 5-ALDF-4C-08: "There are 24-hour emergency medical, dental, and mental health services. Services include the following: On-site emergency first aid and crisis intervention. ... Use of one or more designated hospital emergency rooms or other appropriate health facilities. ... *Comment*: In the event primary health services are not available, and particularly in emergency situations, back-up facilities or providers should be predetermined. The plan may include the use of an alternative hospital emergency service or a physician on-call service."
- See also 5-ALDF-4C-09: "If infirmary care is provided onsite, it includes, at a minimum, the following: ... A physician on call or available 24 hours per day. Health care personnel have access to a physician or a registered nurse and are on duty 24 hours per day when patients are present. ..."

⁷³ Scott County Sheriff's Office Policy 16002.9 (Mental Health Services), referencing NCCHC J-G-04 (2003).

⁷⁴ NCCHC J-A-01. See Discussion: "Inmates must have access to care to meet their serious health needs. This is the fundamental principle on which all [NCCHC] standards are based and is the basic principle established by the U.S. Supreme Court in the 1976 landmark case *Estelle v. Gamble*. Unreasonable barriers to inmates' access to health services are to be avoided. Examples of unreasonable barriers include the following: ... Having an understaffed, underfunded, or poorly organized system with the result that it is not able to provide appropriate and timely access to care."

⁷⁵ NCCHC J-D-07. See Compliance Indicators: The facility provides 24-hour emergency medical, dental, and mental health services."

staff. Capt. Bush stated that “there would not be any psych staff working the holidays,” despite policy setting the expectation of 24-hour emergency mental health services. Capt. Bush clarified that, at the time of our initial inquiry, the jail contracted with Genesis Psych Associates, and the contract dictated “when they work and to what degree.” Capt. Bush explained that the jail’s contract with Genesis Psych Associates did not require staff availability on holidays, such as when Sarah was at the jail.

We sought information from other county jails in an effort to compare the mental health services available to inmates under similar circumstances. We toured two other county jails (one smaller than Scott County Jail and one larger) and had the opportunity to speak to jail staffs regarding what mental health services were available outside of regular business hours and on holidays.

- The larger jail reported that, when there are no mental health staff present at the jail, staff will contact an on-call supervisor, and options would be discussed. It was shared that, depending on the circumstances, they could pursue a 229 action (hospitalization for persons with mental illness).
- The smaller jail reported that, during the hours when the nurse is not available, the jail has an on-call physician’s assistant who can make referrals and evaluations. The jail utilizes mental health services from a nearby hospital, 24 hours a day, seven days a week, including holidays.

During the course of our investigation, we learned that the jail’s contract with its mental health care provider would not be renewed. According to a news article on the development, Sheriff Tim Lane emphasized the need for a provider who could identify and address the inmates’ mental health needs:

In the jail environment, these services are essential to us in our day-to-day operations ... We have a good percentage of inmates that do have mental health issues, and some of them are very severe. The services they provide help alleviate the issues for people that suffer from these conditions.⁷⁶

A NEW HEALTH PROVIDER MOVING FORWARD

Capt. Bush shared with us that the jail now contracts with Community Health Care, Inc.⁷⁷ for inmates’ mental health needs. Capt. Bush explained there have been positive changes with the new contract, including that providers have visited the jail more than the previous provider and inmates are not waiting as long to be seen for medications. Additionally, Capt. Bush reported:

... [A] long-time inmate who had not been getting a medication he wanted under Psych Associates is now getting that medication and seems much more stable.

⁷⁶ Sarah Watson, Scott County Jail contract for mental health care rejected, Quad-City Times, August 1, 2025, (https://qctimes.com/news/local/government-politics/article_2f898e24-967d-4aba-a723-e17415563dc9.html).

⁷⁷ Community Health Care offers medical, dental, and behavioral health care services at several clinics throughout the Quad Cities area. Community Health Care is registered with the Iowa Secretary of State as a not-for-profit organization. See <https://www.chcqca.org/>.

Capt. Bush indicated that, although she advocated for Community Health Care to also provide mental health counseling services for inmates, it was not included in the contract due to the expense. Additionally, the contract does not include provider availability on the weekends or holidays. She explained:

In working on the contract, they did not and could not agree to hours on the weekends. Should someone become too mentally unstable, we will send them to the hospital and have done so.

We received conflicting information on how the jail would provide 24-hour emergency mental health services in light of the new health provider's limited availability. Capt. Bush cited the jail's policy that the medical staff can recommend to the Chief Medical Officer (CMO) that an inmate in extreme mental health crisis be transported to the hospital for assessment.⁷⁸ However, Scott County Jail's Medical Director, Leslie Ronnebeck, initially informed us that "we do not call the CMO for mental health issues." After we sought clarification for these discrepancies, Ms. Ronnebeck responded that the jail "would only call the CMO in an extreme case [as] mental health is typically referred to the mental health providers."

As there appeared to be a misunderstanding concerning whether the CMO could be called concerning mental health concerns, we questioned whether jail staff know and understand policy and protocol for these situations. Ms. Ronnebeck reported:

If an inmate was experiencing an extreme mental health crisis that could not be handled in the jail the CMO could be reached for orders to send the individual in crisis to the hospital. This would typically be done by medical staff.

In the absence of medical staff, corrections have the ability to contact the CMO for orders, correctional staff is aware of this, and they have called for needed medical issues. I do not recall an extreme situation regarding mental health that the jail staff called the CMO.

INCIDENT REPORTING REQUIRED BY LAW

The Iowa Administrative Code requires that jails report specific incidents to the state's jail inspector at the Iowa Department of Corrections:

- 201--50.22(14) Incident reports.** Records shall be made to document the following:
- a. Use of force;
 - b. Suicide/suicide attempts;
 - c. Threats to staff, staff assaults, escapes, fires, prisoner abnormal behavior, any verbal or nonverbal references to suicide and self-mutilation.
 - d. The state jail inspection unit of the department of corrections shall be notified within 24 hours of any death, attempted suicide, fire, escape, injury to staff or

⁷⁸ See Scott County Sheriff's Office Policy 16002.9 (Mental Health Services), *effective date June 5, 2025*: "The jail provides 24-hour emergency medical, mental health and dental services as directed by the Chief Medical Officer."

prisoners from assaults, or use of force and prisoner self-injuries. A copy of the investigative reports and other records shall be given to the state jail inspector upon request.⁷⁹

According to the jail’s policy, “Daily, the Classification Specialist reads all current Disciplinary Reports, Incident Reports, Use of Air Taser, and Use of Restraint Chair reports, scans and emails the required reports to the State Jail Inspector.”⁸⁰

However, a review of the state jail inspector’s online database showed no reference to a report filed by the jail concerning Sarah’s suicide attempt or self-injuries. Capt. Bush found that Sarah’s incident report was inexplicably marked as “Other: Smock” instead of “Suicide” or “Other: Suicide Attempt,” and as a result, the report was not sent to the state jail inspector.

TYPE OF INCIDENT (Check One or More)	
<input type="checkbox"/> Accident(s)	<input type="checkbox"/> Escape(s)
<input type="checkbox"/> Assault(s)	<input type="checkbox"/> Hostage(s)
<input type="checkbox"/> Behavior Control	<input type="checkbox"/> Medical
<input type="checkbox"/> Criminal Act(s)	<input type="checkbox"/> Property Damage
<input type="checkbox"/> Death(s)	<input type="checkbox"/> Suicide
<input type="checkbox"/> Disturbance(s)	<input type="checkbox"/> Use of Force
<input checked="" type="checkbox"/> Other: (specify) <u>Smock</u>	

Upon discovery of this error, Capt. Bush stated that the incident report was corrected and re-sent to the state jail inspector as a suicide attempt. A subsequent review of the state jail inspector’s online database confirmed that the incident report concerning Sarah’s suicide attempt was created on April 30, 2025.

Although the jail submitted the incident report concerning Sarah’s suicide attempt to the state jail inspector, Iowa’s administrative rules also require that the jail inspector be notified of “prisoner self-injuries” incidents.⁸¹ As such, it appears that the jail also had a responsibility to submit the reports about Sarah’s self-harm that occurred before and after her suicide attempt.

LACK OF A PADDED CELL

Scott County is the third-largest county in Iowa and the jail is the main detention center in the county, housing up to 394 inmates. The jail, however, does not have a padded cell. It has cited the prohibitive cost of incorporating this tool, commonly used in other Iowa county jails to control violent inmate behavior.

⁷⁹ IOWA ADMIN. CODE r. 201—50.22(14).

⁸⁰ Scott County Sheriff’s Office Policy 15006.1 (Jail Operations / Classification).

⁸¹ IOWA ADMIN. CODE r. 201—50.22(14).

Iowa law requires jails to consider alternative options to the use of a restraint chair.⁸² The Ombudsman has advocated the use of padded cells as an appropriate alternative option. Padded cells are a particularly attractive option when the alternative is continuing self-harm in a concrete cell. We highlighted the benefits of padded cells in our recent restraint chair investigation, where some county jails reported no restraint chair use because they utilized the padded cell instead.

We learned of the benefits of padded cells, anecdotally, to safely control inmate behavior without the use of restraint devices in our prior investigation and during our tours of both large and small jails:

- A large jail recently added six padded cells, after it identified a greater need for a safe place to house inmates who were experiencing a mental health crisis or threatening suicide or self-harm.
- A small jail that went without a padded cell for 15 years recently submitted a proposal for a new county jail that includes *at least four* padded cells. Officials with that jail – which has the capacity to house less than 100 inmates, one-fourth the size of the Scott County Jail – said they have a great need for padded cells and are making them a priority in their proposed new facility.

It is also worth mentioning that the Boone County Jail, one of the county jails featured in our recent restraint chair report, added a padded cell as a result of our findings. The jail, which holds approximately one-seventh the number of inmates as the Scott County Jail, determined that the padded cell was necessary to ensure inmates who demonstrated self-harming behavior could be housed in a safe environment. The sheriff shared his rationale for incorporating the padded cell:

That gives us a lot more opportunity to humanely keep somebody from hurting themselves ... It puts them in an environment where it becomes pretty difficult for them to figure out how to hurt themselves. That's going to be our ultimate solution.⁸³

Findings and Conclusions

DELAY IN BOOKING

The Ombudsman concludes that the 19-hour delay in booking Sarah was unreasonable in addition to being contrary to jail policy, and that the jail inappropriately determined she could be “short booked.” Sarah’s booking paperwork – particularly the Suicide Screening Questionnaire – should have included important and pertinent information about her medical and mental health needs. The jail did not follow its own policy when booking Sarah, and the Ombudsman concludes this likely had a detrimental impact on Sarah’s safety and well-being at the jail.

⁸² IOWA ADMIN. CODE r. 201—50.13(2)(a)(3): “Four/five-point restraints shall be used only when other types of restraints have proven ineffective.”

⁸³ Broker, Celia. “Iowa Ombudsman report alleges restraint chair misuse in Boone, Webster county jails.” *Ames Tribune*, December 20, 2024, <https://www.amestrib.com/story/news/local/2024/12/20/why-were-boone-county-webster-county-jails-investigated-for-restraint-chair-use-ombudsman/77092036007/>.

TRANSFER TO HOLDING CELL 2

The Ombudsman concludes that jail staff prematurely concluded that Sarah needed to be physically carried to Holding Cell 2 following her suicide attempt. Staff did not allow Sarah an opportunity to rest after her suicide attempt and made her stand and walk immediately after. Staff ultimately determined Sarah could not walk unassisted and did not consider transport options beyond carrying her. The Ombudsman agrees with Capt. Bush's determination that, when feasible, a wheelchair should be used in a non-emergent situation like Sarah's to avoid secondary injuries to the inmate and to staff.

STAFF'S DISREGARD AND MINIMIZATION OF SARAH'S STRUGGLES

Video documentation shows that several staff members did not treat Sarah with respect or compassion, particularly following her suicide attempt. The Ombudsman appreciates the jail's response that staff "always need to learn when faced with an uncomfortable situation, how to react appropriately." ACA standards suggest that jails provide officers with at least 40 hours of annual training that include interpersonal communication skills and standards of conduct.⁸⁴ The Ombudsman believes that jail staff should receive such training that will assist with learning and understanding what reactions are appropriate.

WELLNESS CHECKS

Although Sarah's wellness checks were documented, the Ombudsman concludes that these checks did not in fact occur, based on the video footage. Sarah's violent behavior took place within CCTV/camera view, yet no staff intervened. Either staff were not watching the footage, or staff ignored Sarah's severe and violent behavior. The jail's new policy requires in-person checks to occur every 15 minutes; however, the Ombudsman concludes that Sarah should have been on *continuous* observation based on her suicidal behavior, as required by jail policy. Continuous observation would have clearly caught Sarah's violent self-harming behavior, which would have given officers the opportunity to stop it early on.

SELF-HARMING AND LACK OF RESTRAINT CHAIR USE

The Ombudsman concludes that jail officers failed to notice or intervene in Sarah's self-harming behavior. Jail staff opted not to use the restraint chair to control Sarah, reportedly because of criticisms we made in our previous report of some jails' misuse or overuse of restraint chairs. However, we did not say that restraint chairs should never be used. Per our previous report, the jail could have ultimately determined that it was necessary to use a restraint chair

⁸⁴ See 5-ALDF-7B-11: "Written policy, procedure, and practice provide all correctional officers receive at least 40 hours of annual training. This training shall include at a minimum the following areas:

- Standards of conduct/ethics.
- Security/safety/fire/medical/emergency procedures.
- ... De-escalation strategies.
- Interpersonal communication skills.
- Crisis intervention teams.

while also considering other alternatives, including pursuing a 229 action. This incident also illustrates the importance of having a safe housing option such as a padded cell for inmates who engage in self-harming behavior. Ideally, a jail should have more options to prevent self-harming, not less.

LACK OF MEDICAL ASSISTANCE

The Ombudsman concludes that, based on the information provided by the jail, staff failed to provide sufficient medical assistance to Sarah during the periods of her self-harming and following her suicide attempt. The jail failed to provide any substantive health assessment of, or treatment for, Sarah's injuries, which were clearly visible to staff and were described as "severe." The Ombudsman concludes that, in addition to failing to treat Sarah's injuries, jail officials also did not adequately photograph her injuries.

LACK OF MENTAL HEALTH SERVICES

The Ombudsman concludes that the jail failed to provide adequate mental health services to Sarah during her incarceration. Although Sarah was at the jail for only 20 hours, her extreme self-harming behavior should have been a sign to staff that a review for mental health services was warranted. The Ombudsman understands that the jail's contract for mental health services did not include 24/7 care or care during holidays. Capt. Bush indicated, however, that if an inmate experiences an "extreme mental health crisis" when mental health staff are not available, the Chief Medical Officer can recommend that the inmate be transported to the hospital. Although Sarah appeared to experience a mental health crisis that resulted in significant injuries, it is unclear whether staff were aware of the option to contact the Chief Medical Officer, especially considering the jail's Medical Director initially reported that this is not an option.

INCIDENT REPORTING REQUIRED BY LAW

The Ombudsman finds that, following Sarah's suicide attempt, the jail did not submit the required reporting paperwork to the state jail inspector within the required 24-hour timeframe. Further, Iowa's administrative rules require the jail to submit reports concerning inmates' self-harming incidents, which would have included reports concerning Sarah's behavior in Holding Cells 2 and 9. The jail did not do so.

LACK OF A PADDED CELL

The Ombudsman understands the jail's position that padded cells are costly to install and maintain. However, the benefits of adding a padded cell have justified the costs for other jails, big and small. For that reason, we believe the jail should reconsider its decision not to install at least one padded cell.

Recommendations

Because it appears that Scott County Jail staff misinterpreted the message of our 2024 restraint chair report and consequently disregarded its restraint chair as an option in this situation, we recommend that jail administrators re-read the report and retrain its staff on the correct and appropriate use of its restraint chair, as outlined in the report. Further, based on the findings of our investigation, the Ombudsman makes 12 other recommendations to jail administrators:

1. The jail should amend its “short booking” process to ensure that enough information is captured to comply with Iowa’s administrative rules, which do not recognize such a process and require certain information to be captured upon arrival.
2. When feasible, the jail should use a wheelchair to transport incapacitated inmates in non-emergent situations. If jail staff have a concern that the inmate is or may become combative, the jail should consider using the restraint chair as an option to transport the inmate.
3. The jail should ensure that staff are trained at least annually on interpersonal communication skills and standards of conduct.
4. To ensure the safety of inmates, the jail should train staff on its policies governing 15-minute wellness checks and continuous observation. The jail should also conduct random video audits to periodically verify such checks are done.
5. Electronic scan points have been implemented in many areas of the jail, but not in the booking area. The jail should consider the installation of scan point(s) in the booking area to ensure accountability and accuracy for staff conducting in-person wellness checks.
6. Jail administration should share our 2024 restraint chair report (Sitting in Place: A Re-Examination of Restraint Device Use and Regulations for Iowa’s County Jails) with jail staff for a full understanding of our office’s findings and recommendations as it relates to jails’ use of restraint chairs. The jail should consider responsible and safe use of a restraint chair as a viable means or tactic to prevent inmates from committing self-harm.
7. The jail should consider adding at least one padded cell as another viable alternative to allowing an inmate to self-harm.
8. The jail should ensure that staff are trained on mental health procedures for referring an inmate who is experiencing an extreme mental health crisis to the hospital.
9. The jail should adequately document and photograph injuries that are articulated in incident reports.
10. The jail should consider transitioning from paper supervision logs to an electronic handheld device to ensure accountability and accuracy for staff conducting in-person wellness checks.

11. The jail should ensure that incidents involving inmate suicide attempts and self-injury are reported to the state jail inspector.

12. The jail should update its policies to reflect the most recent version of the ACA's Performance-Based Standards and Expected Practices for Adult Local Detention Facilities (ALDF). The jail should replace its policy references to ACA's Performance-Based Standards for Adult Community Residential Services with the applicable ACA ALDF standards.

Appendix A: Unsigned Medical Note

From Medical

[REDACTED]
[REDACTED]
[REDACTED] Seen for chest pain, assessment unremarkable. Then tried to hang herself with telephone cord. Placed in smock and on a 15-minute watch. Did state she has breast cancer and goes to Genesis, can her sign a release if she stays after court. *Release*

[REDACTED]
[REDACTED]
Shift report 12/24/24
7a - 7p