HB2397

LRB104 08043 RLC 18089 b

104TH GENERAL ASSEMBLY

State of Illinois

2025 and 2026

HB2397

Introduced 2/4/2025, by Rep. Nicolle Grasse

SYNOPSIS AS INTRODUCED:

730 ILCS 5/3-2-15 new

Provides that the Act may be referred to as the Eddie Thomas Act. Amends the Unified Code of Corrections. Provides that no later than December 1 of each year, the Department of Corrections shall prepare a report to be published on its website that contains, at a minimum, the following information about hospice and palliative care in its institutions and facilities during the prior fiscal year: (1) demographic data of committed persons who received hospice and palliative care; (2) data on the number of committed persons in the Department's hospice and palliative care programs; (3) data on the timing of hospice and palliative care programming; (4) the number of committed persons in the custody of the Department who died; (5) policies and administrative directives of each Department institution and facility regarding the institution of hospice and palliative care; (6) the staff available for hospice and palliative care; and (7) the cost of the Department's hospice and palliative care programs. Provides that all such data shall be anonymized to protect the privacy of the committed persons involved in the hospice and palliative care programs.

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A BILL FOR

AN ACT concerning criminal law.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 1. This Act may be referred to as the Eddie Thomas Act.

Section 5. The Unified Code of Corrections is amended by adding Section 3-2-15 as follows:

(730 ILCS 5/3-2-15 new)

Sec. 3-2-15. Department of Corrections; report of hospice and palliative care for committed persons.

(a) Purposes. The General Assembly finds that:

(1) The United States prison population is aging rapidly.

(2) Illinois' prison population is similarly aging rapidly, with over 1,000 prisoners aged 65 or older.

(3) As a result of the aging prison population more committed persons are in need of end-of-life care and support services.

(4) The Department of Corrections has a policy on end-of-life care, which provides, in part, that the goals are: "safe, dignified and comfortable dying, self-determined life closure and effective grieving".

(5) The Department of Corrections does not have a formal hospice program; rather, end-of-life care is provided on a prison-by-prison basis which results in inconsistent care for committed persons who have been diagnosed with terminal illnesses or who are expected to reach the end of their life.

(6) At some prisons, end-of-life care is at times provided, in part, by other committed persons assigned as aides.

(7) The Department of Corrections does not have centralized or consistent data on the number of committed persons receiving end-of-life care.

(8) The Department of Corrections does not have centralized or consistent data on the number of prisoner aides who are assigned to assist in providing end-of-life care.

(9) The Department of Corrections does not currently have a system for tracking patient outcomes or grievances related to the quality of end-of-life care provided.

(10) Data on the end-of-life care provided in the Department of Corrections is needed to give the General Assembly and the public an understanding of the Department's approach to end-of-life care for terminally ill committed persons in its custody.

(11) Eddie Thomas was a committed person of the Department of Corrections who died alone in the back of a

prison infirmary without any end-of-life care just 5 months after being diagnosed with late stage lung cancer.

(b) Definitions. In this Section:

"Advance directive for health care" means written instructions of the patient's wishes as to how future care should be delivered or declined, including decisions that must be made when the patient is not capable of expressing those wishes. Advance directives may also appoint an agent with power of attorney for health care.

"Department" means the Department of Corrections.

"Hospice and palliative care" means physical, social, emotional, and spiritual support care for committed persons who have been diagnosed with a known terminal condition with a life expectancy of 6 months or less. This includes, but is not limited to, assistance with activities of daily living and comfort care.

"Peer support" refers to assistance and companionship provided by committed persons who have been trained to offer emotional, social, and practical support to fellow committed persons receiving hospice and palliative care.

"Terminal condition" means an incurable or irreversible condition that, without the administration of life-sustaining procedures, will, according to reasonable medical judgment, result in death within a relatively short period of time; or a state of permanent unconsciousness from which, to a reasonable degree of medical certainty, there can be no recovery.

(c) Reporting requirement. No later than December 1 of each year, the Department shall prepare a report to be published on its website that contains, at a minimum, the following information about hospice and palliative care in its institutions and facilities during the prior fiscal year:

(1) demographic data of committed persons who received hospice and palliative care, separated by the following categories:

(A) race or ethnicity;

(B) gender;

(C) age;

(D) primary cause of terminal illness or condition; and

(E) length of incarceration prior to receiving end-of-life care;

(2) data on the number of committed persons in the Department's hospice and palliative care programs, including the following:

(A) the total number of committed persons enrolled in the Department's hospice and palliative care programs;

(B) the total number of admissions into and discharges from the Department's hospice and palliative care programs, including the number of committed persons who died while in the program and the number of committed persons who were removed from

the program for other reasons; and

(C) the number of committed persons denied entry into the Department's hospice and palliative care programs, including any reasons that they were denied;

(3) data on the timing of hospice and palliative care programming, including the following:

(A) the average length of time that committed persons receive hospice and palliative care; and

(B) the average length of time between the diagnosis of a terminal condition and admission into a hospice and palliative care program;

(4) the number of committed persons in the custody of the Department who died, separated by the following categories:

(A) committed persons who died while receiving hospice and palliative care; and

(B) committed persons who died without receiving hospice and palliative care, and the number of such committed persons who died as a result of natural, accidental, suicidal, or homicidal causes;

(5) policies and administrative directives of each Department institution and facility regarding the institution of hospice and palliative care. This data shall include the following information:

(A) the name of each institution and facility that offers hospice and palliative care services;

(B) criteria to be eligible for hospice and palliative care services, both Department-wide and at each institution and facility;

(C) a list of the types of hospice and palliative care services that are offered in each institution and facility. This list shall include, but is not be limited to, pain management, psychological counseling, peer support, and chaplain services. If available, this list shall also include supportive services offered to family members of committed persons;

(D) the accreditation status of the Department's hospice and palliative care programs, if available;

(E) the procedures for committed persons in the Department's custody to request an advance directive for health care in each institution and facility;

(F) the procedures for health care or legal staff to assist committed persons in completing advance directive instruments; and

(G) the procedures for health care providers to implement advance directives for health care in each institution and facility;

(6) the staff available for hospice and palliative care. This data shall include the following:

(A) the number of specialized staff at each institution and facility, including palliative care physicians, nurses, and social workers;

(B) the number of volunteers dedicated to hospice and palliative care, separated by the following categories:

(i) volunteers who are committed persons of the Department;

(ii) volunteers who are not committed persons of the Department; and

(iii) the ratio between the number of staff and the number of patients in the Department's hospice and palliative care programs; and

(7) the cost of the Department's hospice and palliative care programs, including the following:

(A) the annual costs associated with hospice and palliative care across the Department;

(B) the sources of funding for hospice and palliative care services; and

(C) the annual costs associated with hospice and palliative care at each Department institution and facility.

All such data shall be anonymized to protect the privacy of the committed persons involved in the hospice and palliative care programs.