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HUMAN RIGHTS AUTHORITY- CHICAGO REGION

REPORT 12-030-9018
Cermak Health Services of Cook County

Case Summary: The HRA substantiated one of the six complaints filed: The recipient was denied his clothing and eyewear when he was discharged. The facility's response is attached below.

INTRODUCTION

The Human Rights Authority of the Illinois Guardianship and Advocacy Commission opened an investigation after receiving a complaint of possible rights violations at Cermak Health Services of Cook County (Cermak). It was alleged that the facility did not follow Code procedures when:

1. A recipient was told he would be held overnight and then transferred to a state mental health center. Instead he was incarcerated for 25 days;
2. A recipient was denied phone calls for no reason;
3. A recipient was denied contact with a clergy and advocacy;
4. A recipient was exposed to other inmates' injuries and open wounds and denied health care;
5. A recipient was made to share soap, a comb, and deodorant with 15 other inmates and his cell was filthy;
6. A recipient was denied his clothing and eyewear when he was discharged.

If substantiated, these actions would violate the Mental Health and Developmental Disabilities Code (405 ILCS 5/100 et seq.) and the Administrative Code for County Jail Standards (20 Ill. Admin. Code 701 et seq.).

Cermak Health Services of Cook County is an affiliate of the Cook County Bureau of Health Services and the health care delivery system of the Cook County jail. It provides an array of on-site ambulatory and infirmary clinical services to approximately 105 mental health detainees housed daily in the jail. Cermak's Department of Mental Health Services provides screening and assessment services in the intake department of the Cook County Department of Corrections, infirmary level of acute psychiatric care in the Cermak building, intermediate care

in the Residential Treatment Unit for males in Division II and X and for females in Division IV, mental health clinics for the general population, and twenty-four hour crisis assessment services located in the Cermak emergency department. All the clinical and support staff in Cermak are Cook County employees with oversight provided by the Cook County Board. The approximate ratio of mental health recipients to staff is 4:1.

Cermak Health Services of Cook County is voluntarily not accredited by the National Commission on Correctional Health Care, although documentation has been submitted to begin the accreditation process. Additionally, the facility must meet American Correctional Association standards as well as the Illinois Department of Corrections Jail Standards.

To review these complaints, the HRA conducted a site visit and interviewed the Interim COO (also the Deputy COO), the Risk Manager, the First Assistant General Counsel, a Unit Commander, the Associate Medical Director, and the Chief Psychologist. Relevant hospital policies were reviewed, and records were obtained with the written consent of the recipient.

COMPLAINT SUMMARY

The complaint indicates that the recipient violated his conditional release and had a court hearing on 4/06/12. At that time the judge remanded him to Elgin Mental Health Center. The recipient was told he would be in a holding cell overnight and transferred to Elgin the following day but was then processed into the Cook County jail and transferred to Division 10. He was there until 4/12/12. During this time the complaint indicates that the recipient was not allowed phone calls. The recipient was then moved to Protective Custody at 2 North, the Acute Division. The complaint indicates that the unit was filthy, and there was no soap. The recipient was then transferred to 2 South. He was allegedly still denied phone calls. He was allegedly placed in a room with three other men, one of whom had an open wound which bled and oozed fluids. Again, the recipient was allegedly denied phone calls. When the recipient asked to speak with a person of authority the staff allegedly told him, "Talk to [Cook County Sheriff]." He requested a meeting with a clergy or a rabbi or the OIG but was laughed at. At one point the complaint alleges that the recipient threatened not to eat until he was allowed to speak with an authority figure. He did not eat for 4 days. During this time the complaint alleges that the recipient and other inmates used the same comb and deodorant for 15 men. On 4/29/12 the recipient became unconscious and allegedly an officer, upon seeing him on the floor, came to the door and asked, "Do you want me to call a nurse?" The complaint alleges the recipient lost 18 pounds in 2 weeks. On Tuesday, May 1st he was told he would be transferring to Elgin and in the waiting room at Cook County Jail he asked for his clothing and his glasses, which he was denied, and told that he could get his things when he returned to the jail.

FINDINGS

The recipient's record shows that he had served 16 years at Elgin Mental Health Center for 1st degree murder, committed in 1997 for which he was determined to be Not Guilty by Reason of Insanity. He was then released and recently violated his parole and was sent back to court where it was determined he violated his Conditional Release and was ordered by the court to be remanded back to Elgin. He was held in the Cook County Department of Corrections

(CCDOC) facility until a bed was available for his return. The following complaints involve the period of incarceration from 4/06/12 until 5/01/12.

1. A recipient was told he would be held overnight and then transferred to a state mental health center. Instead he was incarcerated for 25 days.

The recipient's clinical record contains the Court Order from the Circuit Court of Cook County, entered on 4/06/12, which indicates that the recipient's conditional release has been revoked and he is remanded to the Department of Human Services (DHS). The Order states that "DHS is to evaluate [the recipient] and provide a treatment plan to the court within 30 days." The record contains documentation that that this information was faxed from the Cook County Department of Corrections (CCDOC) to Elgin Mental Health Center on 4/10/12. On April 30, 2012 the Director of Forensic Services at the Office of Mental Health at Elgin Mental Health Center sent correspondence to CCDOC stating that they had received the information and were authorizing the transport of the recipient on Tuesday, May 1, 2012. While incarcerated at CCDOC, the recipient was housed in Division 10, was then moved to Protective Custody because he was threatened with sexual assault by a cellmate, then moved again to 2South while awaiting transfer to the mental health center.

Nursing Progress Notes entered on 4/13/12 state, "[Recipient] observed to be sitting out in the milieu with minimal to no contact with peers or staff noted. Alert, responsive with the chief complaint that he has been waiting a week for his court ordered transfer to Elgin MHC. Mood and affect serious, labile. Pt observed to become calm, until pt asked why he is here, or discussing his going to Elgin. Pt then noted to become easily agitated, and hostile, stating how would you feel if you were waiting to be transferred.. and it wasn't happening. 1:1 interaction given and pt allowed to verbalize his thoughts and feelings. Hostile, aggressive behavior redirected, and pt explained that Elgin transfers are based on bed availability. And has nothing to do with staff holding him here."

Facility Representatives' Response

Staff were interviewed about the complaint. They indicated with regard to the recipient's 25 day detention, this decision is completely dependent on the availability of beds at the Elgin Mental Health Center. They noted that very often the wait for a bed can extend for 4-6 weeks and that the CCDOC would much rather it was a shorter wait. Staff indicated that the recipient was told by staff that the decision was not one that could be influenced by the CCDOC staff.

2. A recipient was denied phone calls for no reason.

The record shows that the recipient complained about not being able to make phone calls. On 4/13/12 the Mental Health Progress Notes state, "Pt. continued to ask about making a collect call, and if the MHS [Mental Health Specialist] could call for him." This note indicates that the recipient is "disruptive" and "inappropriate" at this time. A later note that day states, "…He is disappointed about being back here for no reason and he is not given chance to call the legal counselor. He demands to see the CRW [Correctional Rehabilitation Worker]…." Again on 4/28/12 the Progress Notes state, "…I want to speak with my lawyer'." Phone calls logs were

included in the clinical record. They indicate that on 4/11/12 "CRW left message on voicemail for attorney." On 4/18/12 another entry states, "CRW spoke to attorney. He said try him on Monday. He is out of town right now and he will try to speak with you at Elgin [Mental Health Center]." On 4/19/12 an entry in the log states, "No listing for Hasidic Prison/Jail Outreach Program thru 411." On 4/27/12 an entry states, "CRW left message on voicemail for attorney to visit." The last entry states, "CRW phoned attorney…. He said he is available on his cell. He can't come until several days. You can let CRW or someone know what the emergency is, he needs more [illegible]."

Facility Representatives' Response

Staff were asked about the recipient's request for phone calls. Staff were adamant that restrictions are very seldom placed on phone calls. Phones are available on the wall of the open area of each unit (as observed by the HRA who visited each unit) and these phones are used for collect calls, which can be made at any time. Calls made to an attorney or to clergy are made with the recipient's social worker and these calls are free. Recipients are asked to complete a request form to meet with the social worker who is available 5 days per week. Recipients have access to medical social workers as well as correctional social workers.

3. A recipient was denied contact with a clergy and advocacy.

The record shows that on 4/27/12 the recipient requested a religious diet and contact with a rabbi: "Mr. … refused to come out of his room by saying, 'My questions are not answered and everybody is lying to me.' He talks about his rights and how no body is helping him to get a phone call. He is also getting frustrated about not knowing about his transfer to DMH. Pt. is requesting to be on low fat diet and wants to see rabbi for kosher diet. He denies feeling depressed or psychotic. No manic symptoms noted. He is refusing to eat the food today. He is keeping up with his hygiene and demanding to see the s.w. [social worker] about his rights." On 4/29/12 the Progress Notes state, "Provided an intervention as pt was knocking on door to get this writer attention. Pt wanted to know why social worker hadn't gotten back to him about his request. Explained the many reasons why he may not have gotten a reply, to which pt started talking about his rights and asking me to make calls for him. Further explained why I could not do this while lunch was being passed. At this time, pt refused his lunch and indicated to this writer that he has been refusing his meals because, 'you are violating my rights.' Neither this writer, security or the nurse is aware of how many meals he has missed. Will closely monitor this behavior while on 2S." A Nursing Progress Note made on 4/27/12 indicates that "Patient spoke with Dr…. about a diet change. Dr. … informed patient that she will inquire about a diet change."

Mental Health Progress Notes from 4/27/12 state, "Pt reports being hungry however states that he will not eat until he sees an inspector from the OIG [Office of Inspector General]." "Pt refused his breakfast this morning. Pt Stated 'I am not eating until I see an inspector from OIG. I am waiting to go to Elgin and currently my rights are being violated. There is an impostor posing as [Cook County Sheriff]. Do you think this is proper treatment of someone who can keep their room clean?' This writer encouraged pt to eat his breakfast however patient continues to refuse his meal. This writer also encouraged pt to remain hydrated…."

Facility Respresentatives' Response

Staff were asked about the recipient's access to clergy. They stated that although there are religious services in the general population of the jail, there is no religious denomination whose representatives make regular visits to Cermak. The record shows that an attempt was made to locate a Hasidic outreach program, however this was not available. The recipient may request free phone calls to clergy through the unit correctional and clinical social workers.

Staff were asked about the ability of recipients to make reports to OIG. They stated that this call could be made free with the assistance of the CRW. Also, the recipient would be able to write a complaint if necessary.

Staff were asked about the relationship between the correctional staff and the mental health recipients. Staff indicated that all the correctional staff who work at Cermak are trained to work with mental health recipients. It is the goal of the staff to maintain the safety of detainees and staff and correctional officers will strive to work with the recipients so that they can get the greatest benefit from their time at Cermak. Also, Corrections Officers are part of the multidisciplinary team.

4. A recipient was exposed to other inmates' injuries and open wounds and denied health care.

The record does not indicate that the recipient ever mentioned or complained about the open wounds or health conditions of other detainees.

The recipient's complaint indicates that on 4/29/12 he fainted due to not having eaten in 4 days. The Progress Notes show that on the 29th he had indicated he would not eat until his rights were honored, particularly his phone rights. On this date the record shows that the recipient refused his breakfast and lunch with no documentation of the evening meal. It is documented in the Progress Notes that he ate all of his breakfast on the morning of the 30th and ate well for dinner. For the meals on 4/26, 4/27, 4/28, and 4/29, the record shows that the recipient ate an average meal at least once per day. There is no indication from the record that he reported, or that staff observed, the recipient having fainted or reported fainting. The clinical record indicates throughout that the range of weight loss for the recipient during his detention was approximately 5 pounds.

Facility Respresentatives' Response

Facility staff were interviewed about the complaint. Staff indicated that in order to be detained in Cermak, a recipient must be examined by a physician and all marks, abrasions, bruising, etc. would be identified and treated. Cermak residents have access to an infirmary as well as a nurse 24 hours per day, 7 days per week, and detainees are able to request nursing care at any time. Staff stressed that Cermak is a medical facility and for the prevention of the spread of infection or disease, it would behoove staff to report and treat any ailments or injuries.

Staff were asked about the facility response to a report of a detainee's refusal to eat. They indicated that there is a protocol for this response and that all members of the treatment team would be made aware of the threat and monitor the detainee, checking his vital signs, monitoring his eating habits, and sharing this information with all team members. In the extant case there was never a determination made that the recipient was on a hunger strike, and the notations in the Progress Notes indicate that the recipient was eating a meal at least once daily. Staff were asked if the detainees are provided with special diets such as a kosher diet and they indicated that the CRW would facilitate a request for special diet as was done in this case. Staff acknowledged that this is a slow process and that the recipient's physician makes the final determination for a religious diet, however a kosher diet is not unheard of and can be accommodated.

5. A recipient was made to share soap, a comb, and deodorant with 15 other inmates and his cell was filthy.

The clinical record does not indicate that the recipient ever requested additional hygiene products or that he reported that his cell was dirty. The record does show that the recipient refused to take a shower [reason not given] on 4/15, 4/16, 4/27, and 4/28.

Facility Representatives' Response

Cermak staff were interviewed about the availability of soap, combs and deodorant. They indicated that for safety reasons and purposes of cleanliness, bar soap is not used on the units. A large pump container is available on a table on the unit and recipients are able to pump soap into a paper cup for use during showering. Staff indicated that there would never be a reason to use another detainee's hygiene materials and that they would only have to request these products, which are stored behind the staff desk and replenished by the commander. The HRA noted that the staff area is separated from the common area of the detainees by a low desk area only. There is no enclosure for staff except the desk, not even a glass partition, and this gives the staff and detainees complete access to each other except for a low desk-level door which is locked. A separate room is provided for counseling. All areas were clean and in order.

6. A recipient was denied his clothing and eyewear when he was discharged.

The recipient reported that when he was checked into the CCDOC his clothing was removed along with his prescription glasses. When he was informed that he would be transferred, he states that he was given older, used clothing to wear and was told that his belongings and his glasses were gone. The clinical record does not contain an inventory of his belongings when he was admitted, and there is no indication that he received his belongings when he was discharged. The recipient's Intake Health Screening indicates in the Assistive Devices section that the recipient was wearing eyeglasses when he was interviewed.

Facility Representatives' Response

Staff were interviewed about the recipient's personal belongings. They stated that when a detainee is admitted, he is issued CCDOC clothing and his personal belongings are sent to Property and Intake. When the recipient is discharged, the belongings are brought back and the

detainee packs these belongings before leaving. Staff indicated that eyeglasses may be stored on the unit (this is a determination that is made by staff and included in the Treatment Plan for each detainee depending on his level of dangerousness). Detainees whose glasses are stored on the unit must request them for use. Staff did not know why the recipient would not have been given his belongings, along with his glasses, when he left. They indicated there is no inventory of belongings and it is not documented anywhere in the record that the detainees' belongings are returned when they are discharged.

STATUTES

The Mental Health Code states that "No recipient of services shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution, or the State of Illinois, or the Constitution of the United States solely on account of the receipt of such services" (405 ILCS 5/2-100 a). Also, "A person with a known or suspected mental illness or developmental disability shall not be denied mental health or developmental services because of age, race, religious belief, ethnic origin, marital status, physical or mental disability or criminal record unrelated to present dangerousness" (2-100 b).

The Mental Health Code states that "A recipient of services shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan." (2-102 a).

The Mental Health Code states that "a recipient who resides in a mental health or developmental disabilities facility shall be permitted unimpeded, private, and uncensored communication with persons of his choice by mail, telephone and visitation. This communication may be restricted by the facility director "only in order to protect the recipient or others from harm, harassment or intimidation, provided that notice of such restriction shall be given to all recipients upon admission. When communications are restricted, the facility shall advise the recipient that he has the right to require the facility to notify the affected parties of the restriction, and to notify such affected party when the restrictions are no longer in effect. However, all letters addressed by a recipient to the Governor, members of the General Assembly, Attorney General, judges, state's attorneys, Guardianship and Advocacy Commission, or the Agency designated pursuant to 'An Act in relation to the protection and advocacy of the rights of persons with developmental disabilities, and amending Acts therein named', officers of the Department, or licensed attorneys at law must be forwarded at once to the persons to whom they are addressed without examination by the facility. Letters in reply from the officials and attorneys mentioned above must be delivered to the recipient without examination by the facility authorities." Additionally, "No facility shall prevent any attorney who represents a recipient or who has been requested to do so by any relative or family member of the recipient, from visiting a recipient during normal business hours, unless that recipient refuses to meet with an attorney" (405 ILCS 5/2-103).

The Administrative Code for County Jail Standards mandates that floors, toilets, shower stalls, and sinks must be cleaned and sanitized daily with detergent and a germicidal agent and that trash and garbage must be removed at least once daily and disposed of in a sanitary manner.

Additionally, an adequate supply of clean clothing, bedding, towels, soap, and cleaning supplies will be maintained (20 Ill. Admin. Code Title 20 Section 701.120 Sanitation).

The Administrative Code for County Jail Standards mandates that jails provide a competent medical authority to ensure that the following documented medical and mental health services are available: Collection and diagnosis of complaints, treatment of ailments, prescription of medications and special diets, environmental health inspections, etc. Also, a medical doctor must be available to attend to the medical and mental health needs of detainees. Additionally, there is a daily sick call to address emergency complaints. (20 Ill. Admin. Code Title 20 Section 701.90 Medical and Mental Health Care).

The Mental Health Code states that "When a recipient is discharged from the mental health or developmental disabilities facility, all of his lawful personal property which is in the custody of the facility shall be returned to him" 405 ILCS 5/2-104 c).

The Mental Health Code mandates that whenever the rights of a recipient are restricted, the person responsible for overseeing the recipient's service plan must give prompt notice to the recipient, their guardian if applicable, a person designated by the recipient, if any, the facility director, the Guardianship and Advocacy Commission, and the recipient's substitute decision maker. The same person is responsible for recording the restriction in the recipient's record (405 ILCS 5/2-201).

CERMAK HEALTH SERVICES POLICY

Cermak Health Services provided the HRA with their policy on telephone use (#24.14.110), which is equipped with a personal identification number system as well as voice recognition. The policy indicates that inmates will be given access to phone use for maintaining contact with legal counsel, family, and the community within the guidelines prescribed by the CCDOC. It states that upon Intake inmates are given a reasonable number of phone calls to their attorney and family members or a friend. For general phone use, inmates may place at least one phone call per week and phones are located on all living units. Additional calls may be permitted by the Executive Director or his designee. A minimum of 5 minutes and a maximum of 15 minutes is allotted for each call and all calls are collect, however pre-paid calls via inmate accounts may be established. Inmates are not permitted to receive incoming calls and all calls may be monitored. Inmates housed in Protective Custody, Special Management, or Disciplinary Segregation have access to the telephone daily during their one hour exercise period. Emergency calls are permitted for verifiable emergencies and these calls are first forwarded to the Watch Commander prior to contacting the inmate. Telephone calls may be monitored unless prior special arrangements have been made to make court ordered confidential calls to or from the inmate's attorney.

Cermak Health Services provided the HRA with their policy and procedure for Management of Clinical Space, Equipment and Supplies. It states, "All clinical areas shall be maintained, cleaned, and supplied regularly so that the clinical staff have necessary equipment and supplies to provide appropriate patient care. All clinical areas shall have and follow a cleaning schedule, a par stock level for supplies, and a list of all equipment and assigned

locations for furnishings and equipment. …Area supervisors shall be responsible for inspecting their areas on a regular basis and shall address non-conformances in accordance with Policy D-03b. …Assigned supervisory staff shall make rounds once per shift through their assigned areas and ensure that areas of work are maintained in correct order by line staff."

Cermak Health Services provided policy regarding Food Refusal and Hunger Strikes (#1-07). It states, "Cermak Health Services will evaluate and monitor inmates who undertake hunger strikes. In providing care to inmates on hunger strikes, clinicians will maintain clinical independence and will balance the ethical imperatives of beneficence and patient autonomy. Cermak will not engage in force feeding. Artificial feeding may be ethically acceptable and clinically appropriate under specific circumstances, as delineated in the procedure [provided]."

The Cermak policy indicates that there are different definitions of hunger strikes. Fasting is defined as the intake of no food or drink except for water during a period of over 24 hours. Dry fasting is defined as the intake of no food or drink whatsoever during a period of over 24 hours. A hunger strike is defined as voluntary fasting by a mentally competent person for the express purpose of protest or demand (other than to request different food). Inmates who refuse food as protest for over 72 hours are then placed on medical monitoring and the chief medical officer is notified. The inmate is interviewed to determine the inmate's perceptions of the risks and benefits of food refusal, as well as the inmate's decisional capacity, and an extensive and detailed protocol for monitoring the inmate is initiated. If the inmate's health status deteriorates and nutritional support is medically advisable, then the clinician will consider transfer of the inmate to a hospital.

CONCLUSION

The record demonstrates that the CCDOC detained the recipient only as long as it took to secure a bed for him at the receiving facility and this determination is made by DHS and not the CCDOC so this complaint is not substantiated. Additionally, the record shows that the recipient was not denied phone calls and was able to make free calls to clergy and advocates. These complaints are likewise not substantiated. The issue of the recipient being exposed to the injuries and wounds of other detainees cannot be determined, however a nurse is always on duty and the area where recipients are housed is open to staff who could observe any anomalies. Additionally, the recipient made a complaint to staff about his safety and he was immediately seen in the emergency department for an evaluation and transfer to another unit, so it appears that staff was responsive to his needs. The HRA does not substantiate this complaint. With regard to the availability of hygiene products, the HRA visited the units where the recipient was housed and in addition to being clean and in order, the hygiene articles are easily obtained from staff who are able to hand the items to the recipients from behind the desk. Additionally, soap is available in liquid form and distributed to recipients in paper cups so this too cannot be shared. The HRA does not substantiate the complaint that the recipient had to share hygiene materials and that the unit was filthy.

The complaint alleges that the recipient did not receive his clothing and eyeglasses when he was discharged from the CCDOC to another facility. The recipient's Intake documentation indicates that he was wearing eyeglasses at the time of his assessment so we know that he had

them. In interviewing staff about this matter they indicated that the detainees' belongings are not inventoried when they are admitted and there is no documentation that they are returned when the detainees are released. This is a violation of the Mental Health Code and seems disrespectful of what may be the meager but meaningful property of those who are incarcerated. It is especially devastating for the homeless, who may be carrying most of what they own when they are court ordered to Cook County Jail. The HRA substantiates that the recipient was denied his clothing and eyeglasses when he was discharged.

RECOMMENDATIONS

1. The HRA realizes the unique challenges of administering a mental health facility within a system as big and as complicated as the CCDOC, however we also feel that a plan should be developed for the proper storage of detainees' personal belongings and documentation of their return to the detainee upon discharge.

RESPONSE

Notice: The following page(s) contain the provider response. Due to technical requirements, some provider responses appear verbatim in retyped format.

Memorandum

Cook County Sheriff's Office
Legal and Labor Affairs
3026 South California Avenue, 2d Floor
Chicago, IL 60608
Phone: 773-674-4311 Fax: 773-674-4307

To: Ms. Patricia Betzen, Coordinator, Guardianship and Advocacy Commission

From: Matthew Burke, 1st Assistant General Counsel

Subject: **Report 12-030-9018**

Date: July 15, 2013

Thank you for your time and energy in putting Report 12-030-9018 together and working with Cermak and the CCDOC. The CCDOC's only item of concern is Finding #6.

The CCDOC strongly disputes the conclusion drawn on p. 9 of your report that the Mental Health Code was violated based on the assertion that either CCDOC or Cermak staff (it was not made clear where the staff member worked) indicated that "detainees' (plural) belongings are not inventoried when they are admitted and there is no documentation when the detainees are released." We apologize if staff were misunderstood, but, as we have attempted to point out subsequent to the site visit, it simply and absolutely is **not** true that inmate property is not inventoried or that records are not kept of this. Indeed, the CCDOC has practices and policies in place and spend a great amount of resources 1) to inventory and return the personal property that accompanies the 86,000+ inmates booked into the CCDOC annually and 2) to document this process. As evidence of this, please see Exhibits 1 and 2 for our current policies, as well as Exhibit 3, which is a random sampling of the "Received Clothing Receipts," with inmate signatures, of inmates who were released the same day as LF in May of 2012. (Exhibits were emailed on July 16th, 2013).

It should be kept in mind that nearly all inmates are initially in the custody of a local law enforcement agency (usually the Chicago Police Department) prior to being booked into the CCDOC. These arresting agencies generally inventory personal belongings, such as keys, cell phones, money, and wallets, and then send the arrestee and their property in a bag to the CCDOC. The CCDOC then is responsible for inventorying clothes, shoes, belts, and any item missed or not inventoried by the arresting agency.

Regarding eye glasses, the arresting agencies occasionally do not allow the arrestee to wear eye glasses and, instead, inventory the glasses with their other personal property. If an inmate informs the CCDOC of this fact during the intake process, the CCDOC will invariably open the arresting agency's property bag in front of the inmate, remove the glasses to give to the inmate, and re-seal the bag. Walking around any of the mental health units throughout the jail reveals that mental health caseload inmates routinely wear eyeglasses. Importantly, the CCDOC does not inventory or make note upon intake that an inmate has glasses. Because so many inmates wear eyeglasses and they are not considered contraband, the CCDOC feels it unnecessary. Further, the fact that a Cermak employee noted that LF was wearing glasses clearly indicates that the CCDOC permitted him to wear glasses, as the Cermak health screen occurs after CCDOC's booking process. It is impossible therefore to prove, and likely not true, that the CCDOC failed to allow LF to wear glasses or to return his glasses

upon discharge from the CCDOC or from the acute mental health living unit where he was housed, just as it is impossible for LF to prove that he didn't lose or misplace them during or right after his stay at the CCDOC.

The bottom line is that it is the official policy of the CCDOC to allow inmates who need eyeglasses to wear them during their incarceration, unless contraindicated by mental health or medical staff. It is also the official policy (as seen by Exhibit 1 and Exhibit 2) to inventory and return all inmate property and to keep record of this (as seen in Exhibit 3). If there was a hiccup in this policy and procedure in LF's case, then it can likely be attributed to the uniqueness of the way he came into and left the jail, i.e., coming directly from and returning to the custody of Department of Human Services, and/or a mistake that cannot in any way be characterized as anything other than an isolated incident. Although not conceding that a mistake or unjustified departure from its policies occurred in this situation, the CCDOC is committed to ensuring that mistakes are minimized.

The Sheriff of Cook County has been a leading voice in trying to draw attention and resources to those on the front lines of the troubling interaction between the criminal justice system and those with mental health issues. That is why the CCDOC is very disturbed that the GAC has concluded that the Mental Health Code was violated or that it was "disrespectful" despite the fact that an attempt to clarify the misunderstanding that led to this erroneous conclusion was made prior to the July 16th meeting. We therefore respectfully request that the conclusions drawn in the Report be modified to reflect that what happened to LF, if his version of what happened is taken as true, was nothing more than an isolated incident and that the CCDOC does not have policies or procedures, or a lack thereof, that are disrespectful to inmates with mental health issues or their property.

If you have any questions or concerns, or would like more information about the CCDOC's processes and procedures for inventorying and returning property, please contact me at the number or email below.

Sincerely,

Matt Burke
First Assistant General Counsel
Cook County Sheriff's Office
Matthew.burke@cookcountyil.gov
Ph. 773-674-7921