COOK COUNTY SHERIFF'S MERIT BOARD

Sheriff of Cook County	)	
vs.	)	**Docket # 1755**
Richard Labreck	)	
Cook County Correctional Officer	)	

DECISION

THIS MATTER COMING ON to be heard pursuant to notice, the Cook County Sheriff's Merit Board finds as follows:

Jurisdiction:
The Respondent's, Richard Labreck, (hereinafter "Respondent") position as a Cook County Correctional Officer involves duties and responsibilities to the public; and
Each member of the Cook County Sheriff's Merit Board, hereinafter "Board," has been duly appointed to serve as a member of the Board pursuant to confirmation by the Cook County Board of Commissioners, State of Illinois, to sit for a stated term; and
The Board has jurisdiction of the subject matter and of the parties in accordance with Chapter 55 of the Illinois Compiled Statutes; and
The Respondent was personally served with a copy of the Complaint and Amended Complaint and Notice of Hearing and appeared before the Board to contest the charges contained in the amended complaint; and
The Board has heard the evidence presented by the Sheriff and the Respondent, and evaluated the credibility of the witnesses and supporting evidence. After considering the evidence, the Board finds as follows:

Background:
By complaint dated March 27, 2014, the Cook County Sheriff Thomas J. Dart sought the separation from employment of Respondent. The complaint alleges Respondent was assigned to Division II and on September 14, 2013 he was assigned to the 1400 – 2200 hour shift to guard a detainee, [redacted] at Mount Sinai Hospital Room 320. On that date the detainee asked that the privacy curtain be closed around her bed to use a bedpan to urinate. The complaint alleged that the detainee utilized deodorant to slip her wrists out of the handcuffs and exit the room without Respondent's knowledge at approximately 1413 hrs. The complaint alleges that the Respondent failed to position himself to prevent the detainee from escaping from the room and that a surveillance video shows the detainee exited the doorway and entered the emergency room. At approximately 14:14: 45 the video shows the Respondent exited a stairwell doorway and with the assistance of hospital security placed the detainee back in custody. The complaint further alleges on October 21, 2013 the Respondent was interviewed and provide a signed

statement to OPR stating that he had checked the handcuffs, shackles and stun cuffs, all appeared to be secure and operational. The Complaint alleged this violated several rules and regulations of the Cook County Sheriff's Department, and the Cook County Sheriff's Merit Board, specifically: General Order 4.1 III A1 and the Rules and Regulations of the Cook County Sheriff's Merit Board, Article X paragraph B 3.

Issues Presented: Whether the actions of the Respondent violated any of the General or Sheriff's orders or Merit Board Rule set forth above and what if any discipline is appropriate if a violation occurred.

Resolution of Issues Presented: The Merit Board finds that a violation of General Order 4.1 III A1 and the Rules and Regulations of the Cook County Sheriff's Merit Board, Article X paragraph B 3.occurred.

Findings of Fact: An evidentiary hearing in this matter was held on July 16, 2014 at the Cook County Administration Building, 69 West Washington Street, Room 1100, Chicago, Illinois before James P. Nally. Present were Petitioner by counsel and Respondent by counsel. Four witnesses testified for the Sheriff: [redacted], [redacted], [redacted] and [redacted]. The Respondent testified on his own behalf.

Sheriff's Exhibits 1-9 and Respondents Exhibit 1 were admitted into evidence.

Evidence:

[redacted] testified that he is the Director of security and transportation for Sinai health system. His job is to oversee all security functions and systems and personnel. He has about 15 years experience in the security industry at various locations. He testifies that the department he heads manages and maintains the security camera system for the hospital. He explained cameras feed to a digital video recorder and images are stored there on discs. He testified that the video system was in place on September 14, 2013 and made a recording of the events that occurred at Mount Sinai Hospital on that date. It was a recording made of an incident with the patient leaving their room and attempting to escape the hospital. The witness identified Sheriff's Exhibit 1 as the video disc of the incident. It included a recording in the hospital gift shop and of the patient making an attempted escape in the emergency room area. The video was viewed by the witness and counsel. A date stamp was identified showing the date and time. The witness testified there was no ability to modify or alter the camera images on the hard drive.

Witness [redacted] testified he is a senior investigator at the Office of Professional Review and previously worked for the City of Chicago Police Department for 30 years, retiring as a lieutenant. He was assigned to investigate allegations against the Respondent in relation to a prisoner escape at Mount Sinai Hospital. He testified he interviewed people who responded to the scene and also the detainee who tried to escape, as well as the Respondent and Officer [redacted] and reviewed videos from Mount Sinai Hospital of the incident. He testified that he interviewed the Respondent and took a statement from him on October 21, 2013. He testified the Respondent reviewed the statement and signed it. The witness testified that the Respondent told him that he reported to the hospital in relief of the day crew. He was supposed to have a partner

but that person was not there at the moment he arrived. He told the witness that the detainee indicated she needed to use the bedpan and he pulled the curtain around her. He tried to make notification that he did not have a partner on his radio but the battery was dead. Shortly thereafter Officer [redacted] came into the room and asked where the detainee is and they determined that the detainee was not there. The witness said that the Respondent told him Officer [redacted] said he thought he saw her walking down the hall, and told the Respondent to go downstairs while [redacted] notified hospital security. The detainee was recaptured on the first floor. The witness said the Respondent said normally he should have a female with him to guard a female detainee. The witness identified the videotape of the gift shop area and also the stairway and elevator near the emergency room. The video showed the detainee coming out of the stairwell and the Respondent coming out of stairwell shortly thereafter when the Respondent and hospital security converged. The witness testified that the video showed an officer in the gift shop at Mount Sinai whom he later determined had gotten reassigned from Stroger hospital. The witness identified the General Order 4.1 regarding "Negligence leading to an escape". He also identified the Merit Board Rules subject of the complaint in this action. He testified Officer [redacted] was not found to have violated any rules because he had been reassigned from another hospital and had not taken charge of the detainee. The witness testified after review through proper channels the recommendation was for separation for the Respondent. The witness testified he made no recommendation as to what discipline the Respondent should receive. He also testified that he spoke to nurse [redacted] regarding the incident. He testified that based on his years in law enforcement the detainee would be hand cuffed to a bed and at least one officer would be guarding them at all times until relieved. It was not a practice to leave the only route out of the room vacated. The witness testified the Respondent never denied that the detainee left the room on September 14, 2013. He testified that the inmate in this case was shackled on the ankle and on the wrist and also had a stun cuff on the ankle not secured to the bed.

Witness [redacted] testified he was a correctional officer in external operations. The duties of an officer assigned to guard a detainee at the hospital is to make sure it's the right inmate and that their security devices that are secured, also checking for equipment, your radio your charger, and whether or not a stun cuff is on, also check the paperwork and check the area to make sure it's safe. He has worked in hospitals numerous times and typically it's always two officers guarding an inmate in an outlying hospital, such as Mount Sinai. The witness testified he was assigned to the 2 PM to 10 PM shift. He has instances where he showed up for his shift and his partner had not arrived. He would ask the previous officers to stay but could not give them a direct order. He is insistent that you have to officer stay at all times. The witnesses worked at Mount Sinai 30 to 40 times. A detainee in a hospital is a security risk since you are not within the confines of the jail. The witness explained a stun cuff is a device that's attached to the arm of the detainee and can provide an initial burst of electricity to stun the detainee from attempting to escape. Handcuffs and shackles are also used to attach the inmate to the bed. On this date he was told to go to Stroger hospital and on arrival was told that he was assigned to Mount Sinai Hospital so he left and went there. He arrived at Stroger before 2 PM and drove to Mount Sinai. His partner that day was the Respondent, whom he had not worked with before. It took him a few minutes to get there because traffic was heavy. He parked his car in the garage and went to the lobby and stopped in the gift shop to get a soda and some chips before heading up to the

room. He took the elevator up to the third floor and saw there was a lot of movement on the floor, patients walking back and forth. He stopped at the nurse's desk and inquired about the status of the inmate in the room. He went to the room and saw the Respondent, and asked him where the inmate was, and was told the inmate was behind the curtain. He testified the room has a small and narrow hallway that goes to where the beds are, to the right there is a sink in the bathroom and it's confined. It's very small quarters to get into the main room. The detainee was in the first bed closest to the door. He testified the Respondent was sitting on the corner of the first bed by the window at most 10 feet away. The witness testified he called out to the inmate and there was no response, and he told the Respondent he was going to move the curtain when he got no response, and when he did the detainee was not in the bed. He testified they attempted to transmit on the radio and use a stun cuff remote control but neither worked. He testified they both went into the hallway and he remembered seeing a female walking across the hall when he first entered the floor and told the Respondent thought he saw the detainee going down the stairs. He testified the Respondent ended up going down the stairs and that the witness checked the floor to see if he could find her and proceeded to the elevator to take it to the first floor. When the witness arrived on the first floor near the ER, he eventually saw the Respondent with hospital security officers and the inmate handcuffed to a gurney in the ER. They requested that the medical staff evaluate the inmate to make sure she was clear to go back to the room. They then transported her back up to the room and secured her to the bed. As soon as the inmate was secured the witness made contact to Stroger hospital, and informed them that he had an attempted escape, and the inmate was back in custody. Sgt. [redacted] then came to Mount Sinai. The witness spoke to Sgt. [redacted] and gave him an explanation of what had happened. He and the Respondent were relieved by two other officers and returned to external operations to file a report. The witness then read from the report that he prepared on that date. He testified that the sentence in the report saying that he observed the detainee exiting the room was incorrect, that he had seen a female patient in the hallway. He did not change the report to correct this, he did not know he was allowed to revise it. The witness verified that he did not hear the stun cuff fire. He testified that a female officer guarding a detainee can remain in the room when the detainee needs privacy, which male officers cannot do. He testified that officers are not given backup batteries for the radio but are sometimes given a charger, which does not always work. The witness testified he did not believe the detainee ever got outside the hospital building. He believed this was the first time that he'd been assigned a male partner while guarding a female detainee. At Stroger hospital if you're inside the room with a female detainee, they usually have a nurse or another female officer present. The witness testified the Respondent could not have watched the female detainee use the bedpan.

[redacted] testified he is a Department of Corrections sergeant assigned to external operations. His job duties are to supervise officers assigned to external posts, inspecting equipment to determine it is working, inspect assignments, report unusual circumstances and verify paperwork, and respond to any emergencies. An officer assigned to guard a detainee at a hospital provides supervision as well as security for the hospital staff and civilians, fills in hospital log sheets, relieves other officers, and briefs them of any unusual circumstances, and stays in constant contact with the Stroger office. When they arrive in an assignment they're supposed to call into the Stroger office to let them know they are there and verify the equipment that they have. At that point they are in charge of the detainee. Typically two officers are assigned to outlying hospitals. If two officers do not arrived to relieve a shift then the officer on

early shift should stay until the second officer arrives. There is nothing stated regarding officer leaving a path to the door. The witness testified on September 14, 2013 he was notified of an attempted escape at Mount Sinai. He immediately went to Mount Sinai and spoke to the Respondent and Officer [redacted] who had the detainee in the room secured with handcuffs and shackles. He asked what happened. Officer [redacted] told him he was at the nurses station checking in while the Respondent was in the room. The witness testified he spoke to the nurse, [redacted], who verified she had talked to [redacted] and also had done a security check to ensure the handcuffs and shackles were not too tight on the detainee. The witness identified the incident report from the date of the attempted escape. The witness testified he was told that the stun cuff did not fire. He tested the stun cuff and it was not working, and did not fire. They also told him that the radio did not work. The witness testified that both officers had their cell phones or could use a landline inside the room or at the nurse's station. They are not instructed to do this but it is common sense. The witness interviewed the detainee who told her that she had used deodorant to first slip out of the shackles on her ankle. The witness testified he did not know if there was a landline in Room 320, and in his experience there was never a time when two male officers were assigned to watch a female detainee on his shift. After this incident the practice was changed to ensure there would be a female on every female detainee. The witness had no reason to believe that the detainee was not shackled because Ms. [redacted] had told them she had done a security check to verify the cuffs and shackles were not too tight. The witness testified he was never told that the officers had given him a different version of events then they gave OPR. To his knowledge Officer [redacted] was never subjected to discipline for an untruthful report. As to this incident the witness contacted Lieut. [redacted] who said the officers could write just one report. The witness testified that there is a window that does not open in the room. The witness testified that the detainee was in the bed closest to the door.

The Respondent testified on his own behalf that he had been with the Department of Corrections for 11 years. He'd been working on September 14, 2013 assigned to Mount Sinai Hospital Room 320. He'd previously been assigned to watch detainees in other hospitals. He had worked at Mount Sinai Hospital once or twice before. He received his assignment by calling in to the external operations prior to a shift starting. He went straight to the room where he was assigned and spoke to the officers that were there and asked about the inmate. He was informed that it is a female and that nothing unusual had happened. He then proceeded to check the restraints on her. He did not recall the names of the officers who were there that he relieved. There was one male and one female. He knew he was going to have a partner at an outlying hospital but did not know who it was. When he got there he found out his partner was not there. The officers whom he relieved stayed until he completed checking the equipment. He was not able to call into Stroger because there was no phone in the room and the radio was malfunctioning. He did not know that until the other officers had left. His cell phone was not working, the battery was dead. He could not go to the nurse's station to use a phone because he would leave the detainee in the room by herself. He did not ask any of the off going shift officers to stay while he waited for his partner. He assumed one of them would stay but as soon as he went to key up the radio they both left. In his experience officers from the off going shift wait until both officers have arrived at the post at an outlying hospital. The Respondent testified he did not have any authority to require the other officers to stay. He testified that the detainee's right leg was shackled to the bed and she also had a stun cuff. It was affixed to her left leg and the green light was on. Nurse [redacted] came in 5 min. later and checked the restraints to make sure they were not too tight. After that he plugged in his

cell phone so he could try to powered on. The only plug he could use was on the other side of the room, closest to the window where the radio was being charged. He did not have a spare radio battery. The detainee then said she needed to use the restroom. If it was a male detainee he would have let him use the bedpan. It was the first time he was in that situation with the female so he pulled the bed curtain for her to give her privacy. He testified he could hear her urinating into the bedpan as he was looking at paperwork, standing on the other side of the bed curtain. In a few minutes he told her to hurry up. At this point he was only 3 feet away from her, separated by the curtain. There was overhead lighting in the room but it was not turned on. He could not see any shadows through the curtain. He had no reason to believe the detainee had any contraband. He did not hear any sign of struggle or the chains being moved around. Respondent testified that his partner came into the room and asked where the inmate was. He called out to her and proceeded to pull the curtain. He then pushed the stun cuff button. The Respondent ran to the window and tried to use the radio, it still would not transmit. Officer [redacted] said he would go to the nurse's station, he thought he saw someone going down the stairwell. [redacted] activated the stun cuff but they did not hear anything. Respondent ran down the stairwell as fast as he could, and he went out the door. He saw that door closing and went to the door and saw the detainee in front of him. The detainee struggled with him once he caught up to her. He grabbed her with the assistance of Mouth Sinai security and they put her gently on a gurney. Respondent pulled out his own handcuffs on his belt and placed them on her wrist, handcuffed her to the gurney. The detainee still had the stun cuff on when he recovered her in the ER. To Respondent's knowledge she never got outside the building. Officer [redacted] arrived and they transported the inmate back up to the room. Officer [redacted] notified Sgt. [redacted] of what happened who came to the hospital. Sgt. [redacted] asked a series of question and also talked to the detainee. After relief arrived Respondent and Officer [redacted] went back and did reports. The Respondent offered to handwrite a written report, but was told those were no longer done. He could not do a computer report as his login was not fixed for about three days. At some point he returned to the hospital and there were two male and one female officer watching the detainee. The Respondent testified that Sgt. [redacted] tested the stun cuff in his presence the light was blinking green when tested which meant that it was not working. The Respondent testified that it was not blinking green when he arrived initially at the room. The Respondent testified that all prior times he was involved with inmate using stun cuffs they worked properly. The Respondent testified that he was surprised that there was not a female officer assigned to work with him. The Respondent believes the detainee was released after getting out of the hospital. The Respondent testified that on five times when a partner arrived late at least one of the officers on the previous shift stayed until his partner arrived. In this case both officers just walked out of the room. The Respondent testified he was busy with the radio when they left. He called out to them and they just kept going. While looking at paperwork the Respondent tried to keep a visual on the detainee but he could not, due to the curtain. He did see people walking past the room and in the hallway. He was not focusing on the paperwork to the extent that everything else was blocked out. The Respondent testified that after he closed the curtain the detainee got out of the handcuff on her arm and leg and also got out of the room. The Respondent testified that after closing the curtain he was still within 2 feet of the bed. Where he was standing at the time he was not between the detainee and the door. After Sgt. [redacted] arrived it stood out to him that Officer [redacted] said that he had helped restrain the detainee, which was not correct. After his login was fixed he asked the Lieut. [redacted] if he should file a report, and was told he did not need to, that they would go off Officer [redacted] report. He testified that when he spoke to OPR he gave them what happened

to the best of his recollection. The Respondent testified that he believed the detainee was being held on a warrant from Colorado and was never extradited, and that she was never charged with anything in Cook County.

Findings:

The Board finds that the evidence shows that Respondent did violate General Order 4.1 III A1 and the Rules and Regulations of the Cook County Sheriff's Merit Board, Article X paragraph B 3. as charged. Once the Respondent took charge of the detainee at the hospital, it was his responsibility to ensure she did not escape. The detainee in fact was able to leave the room for a short period of time, although she never left the hospital building and was recaptured within a matter of minutes by the Respondent and hospital security. In mitigation, the Respondent has an otherwise good work history. The fact that both the stun cuff and the radio were not working contributed to the incident, and his inability to communicate with Stroger to let them know his partner had not arrived. Officer [redacted] had erroneously been told to report to Stroger and was therefore late getting to Mount Sinai. There was no telephone in the room to use, and the Respondent could not leave the room with the detainee alone. However, the Respondent could have immediately requested that at least one of the officers from the prior shift stay on the scene until his partner arrived. He did not do this. Further, when Nurse [redacted] came in to check the restraints, he could have asked her to call Stroger to notify them he was without a partner, or could have asked her to provide a telephone or cell phone. The fact that his own cell phone was not properly charged contributed to his inability to contact his superiors. Further, with a female detainee involved, a female officer should have been assigned along with Respondent. Knowing that he was alone at the time, the Respondent could have more diligent in ensuring that he was between the only exit in the room and the location of the detainee. Nonetheless, with malfunctioning equipment and no ability to communicate to his superiors to find out where his partner was, the Respondent was placed in a very difficult situation.

Conclusions of Law: Based on the evidence presented, and after assessing the credibility of witnesses and the weight given to the evidence in the record, the Merit Board finds that the Respondent did violate General Order 4.1 III A1 and the Rules and Regulations of the Cook County Sheriff's Merit Board, Article X paragraph B 3.

Order: Wherefore, based on the foregoing, it is hereby ordered that the Respondent Richard Labreck be suspended from employment for 180 days effective March 27, 2014.

RICHARD LABRECK #1755

[redacted]

James P. Nally, Chairman

[redacted]

Kim R. Widup, Board Member

[redacted]

Byron Brazier, Vice Chair

[redacted]

Vincent T. Winters, Board Member

[redacted]

John Dalicandro, Secretary

[redacted]

Jennifer E. Bae, Board Member

[redacted]

Brian J. Riordan, Board Member

[redacted]

Patrick Brady, Board Member

Dated October 19, 2015