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from: Illinois Law and Practice, Mentally and Dev. Disabled Persons, S.11, p. 574-76

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Appendix A: District Court's First Dismissal of plaintiff's complaint

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QUESTION(S) PRESENTED

1.) To what degree are standard psychiatry protocols to be followed in the event of an emergency involuntary commitment, transfer, discharge, and after-care planning?

2.) Do the benefits outweigh the risks of discharging a certifiably delusional, manic, agitated plaintiff, who was expected to harm himself or others - without involuntary commitment?

3.) Is a unilateral decision by a non-psychiatrist to override involuntary commitment order by a psychiatrist a medically justifiable decision?

4.) Have the lower courts failed to consider the significance, or standard utilization of an Inpatient Certificate (Exhibit A) itself - issued by the State - documenting the serious medical need for involuntary hospitalization?

5.) To what extent does the Emergency Medical Treatment and Labor Act [42 USCS § 1395 dd] apply to plaintiff's complaint, since he had not been stabilized prior to discharge?

6.) Did the plaintiff receive the same standard of mental health care as a "free-world" patient who was delusional, manic, agitated, threatening, unable to care for his own needs, and reasonably expected to hurt someone else or himself?

7.) Documented to be dangerously psychotic and delusional (see Exhibit A), did the plaintiff receive equal treatment as other "sane and sober-minded" detainees who are placed on house arrest?

8.) Have the lower courts overgeneralized and misinterpreted the scope, application of, and utility of the IL Mental Health Code [405 ILCS 5/100 et. seg.]?

9.) With a high risk for prejudice, may the lower courts assume to have its own subjective "expert" knowledge regarding standard psychiatry protocols in the event of an emergency involuntary transfer?

LIST OF PARTIES

[ ] All parties appear in the caption of the case on the cover page.

[✓] All parties **do not** appear in the caption of the case on the cover page. A list of all parties to the proceeding in the court whose judgment is the subject of this petition is as follows:

1.) Aahleah Balawender, Physician's Assistant at Cermak
2.) Helen Kanel, R.N. at Cermak.
3.) Dr. John Doe #1, psychiatrist at Cermak
4.) Dr. John Doe #2, emergency room physician at Mt. Sinai
5.) Jane Doe #1, R.N. at Mt. Sinai

To be added upon ammending complaint:

6.) Cook County Sheriff Watch Commander, John Doe #3, on duty Jan. 24, 2018 at 8:22 P.M.
7.) Cook County, IL

RELATED CASES

Questions Presented

10.) Is an expert witness necessary to interpret the plaintiff's objective standards of care claims?

11.) without a Discovery process being opened, how may the plaintiff prove his standards of care claims?

12.) Are IL statutes, plaintiff's psychiatric standards claims, the IL Mental Health Code [405 ILCS 5/100 et. seq.], Federal decisions, and a State-issued Inpatient Certificate enough to prove that the state compelled a private hospital (Mt. Sinai) to Involuntarily commit a detainee?

13.) According to the PAMI Act [42 USCS § 10801] the State is compelled to investigate any incidents of neglect, lack of treatment, and inadequate discharge planning of the mentally ill - if there is probable cause to believe that the incidents happened. Should the Appeals courts decision be reversed, and remanded back to the District court - with a court appointed lawyer - so that an adequate complaint is written, and Discovery process opened?

List of Parties

Defendants

1.) Aahleah Balawender, Physician's Assistant, employed by Cermak Health Services
2.) Helen Kanel, Registered Nurse, employed by Cermak Health Services
3.) Dr. John Doe #1, psychiatrist, employed by Cermak Health Services
4.) Dr. John Doe #2, emergency room physician, employed by Mt. Sinai Hospital
5.) Jane Doe #1, Registered Nurse, employed by Mt. Sinai Hospital

** other Defendants to be added on amended complaint:

6.) John Doe #3, Cook Co. Jail Watch Commander - on duty January 24, 2018 at 8:22 PM, employed by Cook County Jail
7.) Cook County IL, municipality, Indemnity claim under [745 ILCS 10/9-102]

Plaintiff

8.) Jeffrey Dean Ferguson, former psychiatric Registered Nurse, current detainee at Cook County Jail

Table of Authorities

Cases cited

Constitutional provisions, statutes, and books cited:

Opinions

It is unknown at this time if any of the opinions expressed by the lower courts have been published.

Supreme Court of the United States
Petition For Writ of Certiori

Jurisdictional Grounds

The United States Supreme Court has jurisdictional grounds to review decisions made by the federal court of appeals, according to [28 USC § 1254(1)]. This court has jurisdiction over the case because the U.S. 7th Circuit of Appeals chose to affirm the prior District court's decision to dismiss plaintiff's case.

The plaintiff requested a rehearing on December 7, 2020. This motion was granted on December 8, 2020, with the prior mandate being recalled. On January 4, 2021, the Appeals court chose to deny a rehearing - without a Discovery process ever being opened within the Federal justice system. The plaintiff's complaint itself was never given merit by the courts due to not stating a sufficient claim.

Statement of the Case

This is a civil rights action under [42 U.S.C. §1983] brought by a detainee of Cook County Correctional Facility in Chicago, IL. The plaintiff alleges that the State and its actors provided substandard emergency mental healthcare in the event of a State-ordered involuntary commitment to a private facility.

The plaintiff, who is mentally ill, claims that standard procedures and protocols within psychiatry were not followed during his transfer from one locked state psychiatric facility (Cermak) to another locked, private psychiatric facility (Mt. Sinai), while he was in custody of the State. Plaintiff claims that this amounted to reckless

disregard of the foreseeable consequences.

The District court - while assuming to have expert knowledge of psychiatric standards of care - dismissed plaintiff's complaint, stating that he did not state a sufficient claim. This decision made by the court was largely due its claim that plaintiff had not proven that he was in custody of the State while admitted to Mt. Sinai Hospital, a private actor.

The Appeals court, however, ruled that the plaintiff had been in custody of the State while he was admitted at Mt. Sinai, which rendered the District court's "custody argument" moot. The Appeals court then followed the District courts assumptions of expert knowledge of psychiatric standards of care. This decision upheld the District court's decision, while giving no merit to plaintiff's claims, despite plaintiff's own seven years of experience as a psychiatric R.N., while he conducted these very involuntary transfers. The lower courts also failed to consider plaintiff's claim that two separate Cook County Forensic psychiatrists diagnosed plaintiff to be "legally insane" at the time, and thus should have been involuntarily committed.

Psychiatric standards of care may appear to be subjective in nature to a non-psychiatrist. However, courts have found that these standard protocols are actually objective facts that must be confirmed by an expert witness. The National Commission on Correctional Healthcare (NCCHC) has deemed these standards essential to ensure continuity of care in the event of an emergency transfer, and that without them, there "may be dire consequences for the patient." (see Exhibit B)

Due to the nature of mental healthcare, Congress acknowledged that mentally ill individuals are subject to neglect, lack of treatment, healthcare,

and inadequate discharge planning [see PAMI Act, 42 USC § 10801, et. seq; Exhibit O] — all of which the plaintiff is alleging to have occurred. Other courts have found that there is a strong potential for bias against a plaintiff in a standards of care claim.

For this reason, the plaintiff requests that this court overturn the lower court's decision to dismiss, allowing him to prove his claims in the Discovery process. The plaintiff requests this court to remand this case back to the lower courts with a court-appointed attorney due to: the complicated nature of this case, plaintiff being mentally ill, and his own limited knowledge of the law (or how to write a sufficient complaint). Finally, plaintiff respectfully asks for a court-appointed psychiatry expert opinion regarding plaintiff's claims, and the use of Inpatient Certificates in the event of an involuntary psychiatric transfer.

Statement of Facts

The plaintiff was initially arrested on January 20, 2018, and was acknowledged to be delusional, manic, and grandiose. Taken to Cook County Jail in Chicago, IL, plaintiff was deemed dangerously psychotic, and taken to the Jail's locked psychiatric facility within Cermak Health Services - known as "2-North". The plaintiff was taken from this locked facility to court on January 24, 2018, where the judge placed him on house arrest with a $100.00 "I-Bond."

Plaintiff was then taken back to the county jail, where the psychiatry experts at Cermak deemed that plaintiff was still dangerously psychotic, and was a danger of hurting himself and others (see Exhibit A). The psychiatrist at Cermak

then approved of a transfer to Mt. Sinai Hospital for further treatment, while issuing an Inpatient Certificate that stated plaintiff was not to be released to house arrest without involuntary commitment.

At 8:22 PM on January 24, 2018, while in custody of the State, plaintiff was taken to Mt. Sinai Hospital, where an emergency room physician summarily discharged plaintiff to house arrest within hours of leaving Cermak - without involuntary commitment. Plaintiff was then taken to his home while still in a psychotic state, and recklessly placed on house arrest.

On the morning of January 25, 2018, Cermak Health Services then called plaintiff's Father, while informing him that plaintiff had not been involuntarily hospitalized as they had ordered, that he was still mentally unstable, and that he was alone in his studio apartment. No further follow-up with the plaintiff was provided by Cermak or Mt. Sinai Hospital. Within 11 days, the plaintiff - who is a 43 y.o working professional with no prior felonies - committed three additional felony charges. Plaintiff has been incarcerated without a bond since February 4, 2018.

Summary of Arguments

while in custody of the State, plaintiff contends that his 14th Amendment, Due Process, and Equal Rights protections were violated. Plaintiff also contends that his 8th Amendment, Deliberat Indifference protections were violated.

Plaintiff alleges that his rights under the Emergency Medical Treatment and Labor Act [EMTALA; 42 USC § 1395dd] were violated, since he was discharged

without stabilization, or placed in appropriate facility. As a mentally handicapped individual deemed "legally insane" at the time, under the Americans With Disabilities Act [42 USC § 12101, et. seq.], plaintiff claims that his rights were also violated. Finally, plaintiff invokes the PAMI Act [42 USC § 10801, et. seq., Exhibit D], pointing to the State's duty to protect his rights as a mentally ill individual, and act as his advocate. For this reason, the plaintiff respectfully asks for a court appointed attorney, and to investigate his substandard mental healthcare claims.

Reasons For Granting the Writ

Point #1

The District court overlooked several key points of the plaintiff's complaint.

A.) The plaintiff's civil action should be remanded back to the lower courts, due to the Appeals court's decision that he had been in custody of the State while admitted to Mt. Sinai Hospital.

1) The District court stated that "the fundamental problem with plaintiff's claim against the Mt. Sinai defendants..." is that they were not working under the color of the law. The District court reasoned that because the plaintiff had not proven that he was in custody of the State while admitted to Mt. Sinai, their employees were not liable for any constitutional violations that occurred while he was under

their care.

The District court reasoned that "with respect to the Mt. Sinai defendants, once they saw plaintiff, he was out on bond, i.e. no longer a detainee of the government, and thus their care decisions do not give rise to a claim for violation of plaintiff's constitutional rights. The District Court failed to acknowledge the fact the plaintiff was still in the custody of the Cook Co. Sheriff's Dept., and did not have the liberty of leaving Mt. Sinai. However, the District court's argument in this case is rendered moot, after the Appeals court decided that "the events at Mt. Sinai happened before Ferguson was taken home... so Ferguson was in custody (of the State) until he was released at his apartment."

2.) The lower courts insist that Cermak had no "ongoing duty" to the plaintiff after leaving the jail since it was only the Sheriff's Dept. that held him in custody while admitted to Mt. Sinai. Refuting this, [215 ILCS 134/40] states that "the enrollee's primary care physician (i.e. Cermak) shall remain responsible for coordinating the care of an enrollee (i.e. plaintiff) who has received a standing referral to a specialist physician or other healthcare provider" (i.e. Mt. Sinai).

3.) Courts have unanimously agreed that if a detainee is in custody of the State, it is responsible for that detainee's protection, and for providing standard healthcare services. The court in [Estate of Bailey v. County of York, 768 F.2d 503] found that there are "two circumstances in which the State and its agencies are chargeable with allegedly unconstitutional conduct resulting from omissions: if injuries occur while the injured party is in legal custody of the State or if the person whose affirmative conduct causes the harm is under direct control or supervision of the State. Not only was the plaintiff in legal custody of the State, but he was also under the direct

control and supervision of the State while admitted to Mt. Sinai.

4.) In [Mitchell v. Aluisi, 872 F.2d 577, 580 (4th Cir. 1989)] the court found that prisoners have a right of protection against private providers if their "conduct is fairly attributable to the State." According to this logic, since plaintiff was in custody of the State, and Mt. Sinai had orders from the State's primary care physician to involuntarily commit, this shows that their care was attributable to the State, and both hospitals may be held under the color of the law.

B.) Other errors were made in the District court's decision to dismiss the plaintiff's complaint.

1.) One major error that the District court overlooked (and the Appeals court chose not to comment on) was the court stating that the plaintiff "could not plead mental-state element (of a healthcare claim) because he could not show that commission of future crimes was a reasonably Foreseeable consequence the lack of mental health treatment in prison." As the 8th Amendment has been interpreted, if Cermak and Mt. Sinai knew of the Foreseeable consequences of plaintiff not being involuntarily committed, this would indicate Deliberate Indifference rather than Negligence.

2.) The plaintiff then pointed out to the District court in his Motion To Amend Judgement that the Inpatient Certificate (Exhibit A) stated that plaintiff was "reasonably expected" to hurt himself or someone else, and that his mental health would deteriorate if he was not involuntarily committed. This evidence summarily rendered the District court's

foreseeable consequences" argument moot, since the Certificate was apparently overlooked by the court.

3.) After plaintiff pointed this out, the District court then reverted back to its argument that he was not in custody, while justifying its decision to dismiss plaintiff's complaint. Logic then concludes that since plaintiff was in custody, and both hospitals were aware of the foreseeable consequences, their actions were "more than Negligence but less than subjective intent- something akin to reckless disregard" [see Miranda v. County of Lake, 900 F.3d 335, 353-54 (7th Cir. 2018)]. Thus, both hospitals disregarded the Certificate (Exhibit A) and have violated plaintiff's constitutional rights.

4.) The District court does appear to acknowledge that mistakes [illegible] made at Mt. Sinai, stating "plaintiff's allegations suggest, ... malpractice or Negligence." But the plaintiff argued that the hospitals knew of the foreseeable consequences of being released without involuntary commitment, and that 8th Amendment violations had taken place instead.

[Rogers v. Evans, 792 F.2d at 1058] stated that "whether an instance of medical misdiagnosis resulted from deliberate indifference or negligence is a factual question requiring expert witness" [see also: Smith v. Jenkins, 919 F.2d at 94; Miltier v. Beorn, 896 F.2d 848, 852 (4th Cir. 1990); Mandel v. Doe, 888 F.2d 783, 790 (11th Cir. 1989); Medcalf v. State of Kansas, 626 F. Supp. 1179, 1190 (D. Kan. 1986)]. Without Discovery process ever being opened on plaintiff's case, he has no way of proving his constitutional claims, or having an expert witness's opinion- thus showing prejudice.

Point # 2

The Appeals court overgeneralized and misinterpreted key elements of The IL Mental Health Code [405 ILCS 5/100 et. seq.], as well as standards of care in psychiatry - assuming its own Expert knowledge of these protocols - indicating possible prejudice.

A.) The plaintiff had been compelled by Cermak Health Services to be involuntarily committed at Mt. Sinai Hospital.

1.) In its attempt to prove that Mt. Sinai was not working under the color of the law, the Appeals court argued that an "inference" could not be made that Cermak had compelled them to involuntarily commit plaintiff. The Appeals court stated "private actors do not expose themselves to suit under § 1983 simply by being involved in the involuntary process, although a private actor may function as a state actor if compelled by the State to provide detainees with medical care."

2.) The issue now becomes the interpretation of the meaning behind being "compelled by the State." Logically, if Cermak had compelled Mt. Sinai to involuntarily commit plaintiff, then both hospitals may be seen as state actors. The plaintiff presented many different IL statutes showing that he had, in fact, been compelled - listed below:

a.) During an emergency involuntary committment, hospitals are to work in concert to share information, treatment, diagnoses, after-care planning, and discharge. [As noted in 405 ILCS 5/3-811; 405 ILCS

5/3-909; 215 ILCS 134/40(e); 215 ILCS 134/70(d); 215 ILCS 134/45.2]

b.) Other IL statutes point to protocols in psychiatry indicating that plaintiff should have been admitted directly to a mental hospital after an Inpatient Certificate was issued - not an emergency room, as plaintiff was at Mt. Sinai. As noted in [405 ILCS 5/3-605; 405 ILCS 5/3-606; 405 ILCS 5/3-607; 405 ILCS 5/3-702; 405 ILCS 5/3-754] + [405 ILCS 5/3-753]

c.) As noted in [405 ILCS 5/3-601; 405 ILCS 5/3-610; 405 ILCS 5/3-704], these statutes all state that "if the certificate states that the respondent is subject to involuntary admission but not in need of immediate hospitalization..." the respondent may be released. These same statutes go on to say that "if a psychiatrist... or qualified examiner does not issue a Certificate... the respondent shall be released forthwith."

P.A. Balawender was only a qualified examiner, and chose to issue a Certificate stating that the plaintiff was not "subject to" involuntary hospitalization - it stated that he was "in need of" involuntary hospitalization. Not only was a Certificate issued, but it stated that he was "in need of" involuntary commitment - thus, plaintiff should have been involuntarily hospitalized under the care of a psychiatrist.

3.) The plaintiff submitted an Inpatient Certificate (Exhibit A) to the lower courts as evidence that he had been compelled by Cermak to involuntarily commit him at Mt. Sinai.

a.) The Certificate states that plaintiff was manic, delusional,

agitated, aggressive, threatening, deteriorating, grandiose, and expected to harm himself or someone else if not committed. The Certificate had been signed by a Physician's Assistant (Balawender), and approved by the plaintiff's primary care psychiatrist at Cermak - who had ordered the committment to Mt. Sinai.

b.) As noted on his Appeal, plaintiff cited [405 ILCS 5/2-107.1 (A-G)] of the IL Mental Health Code, which indicates the "standards of care" - or standard symptoms in Illinois for involuntary committment. Plaintiff clearly met these conditions, as noted on the Certificate. [Exhibit E] displays these standard symptoms for committment, while plaintiff exhibited "serious mental illness," "worsening symptoms," and was displaying "threatening behavior."

4.) Federal case law, and Federal rules agree that with plaintiff's condition, he had been compelled by Cermak - and involuntary committment is the standard treatment for these symptoms.

a.) [Gibson v. County of Washoe, Nev., 290 F.3d 1175, 1191-92 (9th Cir. 2002)] found that someone who is "manic" has a serious need. Involuntary committment is the standard treatment for this condition within psychiatry. Especially for someone documented to be delusional, threatening, and dangerous.

b.) In [Eberhardt v. City of Los Angeles, 62 F.3d 1253, 1259 (9th Cir. 1995)] the court found that "as the text of the statute [42 USCS § 1395 dd(c)(1)] clearly states, the hospital's duty to stabilize the patient does not arise until the hospital first detects an emergency medical condition." The decision in [Eberhardt] was found that

"actual detection" of an emergency condition occurs once it has knowledge of of an emergency medical condition, and that during a transfer, diagnoses are continued From facility to facility.

C.) As stated on his Appeal, before plaintiff would have ever left Cook County Jail, Cermak would have given report to Mt. Sinai. Thus, Mt. Sinai would have been made aware of his diagnosis, his condition, accepted him for involuntary treatment, and even received clearance for insurance purposes. As the statute in [Eberhardt] was interpreted, Mt. Sinai's diagnosis would be the same as Cermak's - which was "dangerously psychotic", needing involuntary committment. Plaintiffs diagnosis at Mt. Sinai would also have been that he was "manic, delusional, threatening, and dangerously psychotic" based on Cermak's Certificate (Exhibit A). According to [42 USCS § 1395 dd (c)(1)] since Mt. Sinai had detected an emergency condition ahead of his arrival, the hospital had a duty to stabilize the plaintiff prior to his discharge.

B.) The Appeals court appears to have misinterpreted the scope, practice, and purpose of the Illinois Mental Health Code [405 ILCS - 5/100 et. seq.], and how it applies to the standards of care. [405 ILCS 5/3 - 610] (see Exhibit C) is the only statute that the Appeals court uses to support its opinion - which appears to have been mis-applied to plaintiffs emergency transfer.

1.) After citing the statutes mentioned above in part A (pg 9-10; pt 2a, 2b, 2c) in his Appeal, the court insists that "here the allegations do not support an inference that Mt. Sinai had to admit Ferguson. Illinois law does not force a receiving

institution to commit a patient; instead, medical professionals must conduct an independent examination and release a patient who in their judgment, does not require commitment." By the court making this statement, the paradox of plaintiff's situation becomes clear:

a.) As noted in Part A above (pg. 9, pt A, no. 1) the Appeals court stated that if a private Facility (Mt. Sinai) had been "compelled" by the State, then they are considered a State actor, and responsible under the color of the law for their actions - or lack thereof.

b.) yet the plaintiff, who was deemed to be in custody at the time was not "forced" by the State to be committed at Mt. Sinai (see pt (B)(1) above), (pg. 12) but it appears that he had been "compelled." (see Inpt. Certificate, Exhibit A) The court does not clarify or explain at all how it had decided that an "inference" could not be made that the State had not compelled involuntary commitment - despite all the evidence presented.

2.) As noted, the Appeals court bases its entire assertion here on its own interpretation of [405 ILCS 5/3-610; Exhibit C] - essentially assuming its own "expert" knowledge of psychiatric standards of care. In actuality, from a psychiatric healthcare perspective, the protocols of this statute appear to indicate that it does not apply to emergency involuntary psychiatric transfers at all.

The wording of [405 ILCS 5/3-610] frames the requirements necessary for an involuntary psych hospitalization, but not if those requirements had already been met (as Cermak was required to do) - such as the issuance of an Inpatient Certificate, medical clearance, involuntary commitment orders, Doctor to Doctor report, shared diagnoses, etc. Not once in this statute is

is the word "transfer" mentioned, which should be noted as well.

3.) This all points to an intention that [405 ILCS 5/3-610; Exhibit C] is intended to be utilized for a patient that has voluntarily admitted himself to the Emergency Room for a variety of ailments. Sometimes these voluntary patients may even need to be involuntarily hospitalized due to having concurring mental health concerns.

Other voluntary concerns that may bring a patient to an E.R. can range from having suicidal or homicidal thoughts, delusions, hearing voices, feeling agitated, drug abuse/withdrawal, anxiety, PTSD, sleep problems, and alcohol withdrawal. Some of these cases are more concerning than others, and not classified as "emergencies," and the E.R. physician then has the option of discharging the patient. In other situations, the E.R. physician may find someone to be a danger to self and others, and in these cases will then issue an Inpatient Certificate, and order is made for involuntary commitment. If the E.R. physician's hospital does not have a locked psychiatric ward, the patient will then be transferred to another hospital that does have a locked ward.

4.) Another issue is that plaintiff's Inpatient Certificate (Exhibit A) was not filled out by a psychiatrist, and was not examined by one at Mt. Sinai. [405 ILCS 5/3-610; Exhibit C] as well as [405 ILCS 5/3-753; Exhibit F] both state that "if a Certificate has already been completed by a psychiatrist following the respondents admission, the respondent (i.e. plaintiff) shall be examined by another psychiatrist (or qualified examiner). It goes on to state that "the psychiatrist ... may not be the person who executed the first certificate.

The text of the statute states that only "if" the Certificate had been filled out by a psychiatrist could an E.R. physician (or qualified examiner)

provide a second assessment. Since the Mt. Sinai physician was not a psychiatrist then considered only a "qualified examiner" according to this statute. Since the Inpatient Certificate (Exhibit A) was not issued by a psychiatrist (i.e. Physician's Assistent Balawender), the E.R. physician at Mt. Sinai — who was only a "qualified examiner" at the time - did not have the credentials to discharge the plaintiff.

5.) [405 ILCS 5/3-610] is also quite clear that a psychiatrist must personally examine a patient within 24 hours of his admission for a mental health emergency. Plaintiff was discharged from Mt. Sinai without seeing a psychiatrist.

The plaintiff had also informed the Appeals court on his Motion For Rehearing that he had only recently been allowed to (briefly) review his Cermak medical records with a physician. After reviewing these records, the Cermak physician found no records that plaintiff had even been assessed by a psychiatrist while admitted to Cermak's involuntary psych unit ("2-North") from January 22-24, 2018.

This indicates that plaintiff - who was dangerously delusional and psychotic — was never assessed by a psychiatrist at either facility before he was discharged to house arrest, while alone in his apartment. Cermak and Mt. Sinai both refused to allow plaintiff to have a physical copy of his medical records for further review.

6.) Federal courts agree that a psychiatrist is necessary for evaluation of mental health emergencies. Anything less may be considered a violation of plaintiff's constitutional rights:

a) [Smith v. Jenkins, 919 F.2d 90, 93 (8th Cir. 1990)] found that since a patient had not been seen by a psychiatrist within 24 hours, a

physician's assistant did not have the qualifications to discharge the plaintiff.

b.) A non-specialist (i.e. Mt. Sinai's E.R. physician) may be seen as an inferior opinion - as compared to a psychiatrist - especially since Cermak's psychiatrist had at least ordered the involuntary commitment [see Waldrop v. Evans, 871 F.2d 1030, 1036 (11th Cir.); Hamilton v. Endell, 981 F.2d 1063, 1066-67 (9th Cir. 1992)].

7.) Quite simply, IL statutes, federal tort decisions, psychiatric standards of care, and even Cermak's own orders agree that plaintiff was not to be discharged by an E.R. physician. He had been compelled by the State to be involuntarily commited at Mt. Sinai under the direct care of a psychiatrist.

C.) The Appeals court appears to give deference to plaintiff's first and second complaints which he had submitted - rather than his third (and final) amended complaint submitted to the District court.

1.) As the District court stated to plaintiff, "an amended complaint supersedes prior complaints and must stand complete on its own. If accepted, the amended complaint would control this case, and the court will only look to the amended complaint, and not to any prior complaints, when determining the claims and parties in this action."

2.) The Appeals court erroneously states that "Ferguson's complaint makes clear that Balawender had Ferguson sent to Mt. Sinai under civil-commitment laws because he was not a detainee anymore." In actuality, plaintiff stated in his final, third amended complaint that he had been "transferred" from Cermak (Balawender) and that he was still in custody, with both hospitals

working in concert together. Only on plaintiff's first and second submitted complaints had he stated that he had been "discharged." Furthermore, this argument by the Appeals court is rendered moot due to its own decision that plaintiff was still in custody while admitted to Mt. Sinai.

3.) Other evidence suggests that the Appeals court neglected plaintiff's final complaint altogether by responding to plaintiff's originally submitted (first) complaint - clearly, and admittedly inferior. On their response to his Appeal, the court spent a significant amount of time addressing the arresting Chicago Police Dept. officer, who was only mentioned in plaintiff's original complaint.

4.) By focusing on these two issues, which had already been left absent on plaintiff's final complaint, the Appeals court appears to have made a grievous error, since plaintiff's Failure to submit a claim, and the Complaint process itself is the primary issue so for in this case.

Point #3

In the event of a medical emergency, standards of care are the cornerstone of adequate healthcare treatment.

A.) As the Protection and Advocacy For Mentally Ill Individuals Act [PAMI; 42 USCS 10801; Exhibit D] states, "individuals with mental illness are subject to neglect, including lack of treatment... healthcare, and adequate discharge planning." The reasons for this vary, yet the subjective nature of mental health symptoms indicate the necessity for standard care in psychiatry.

1.) As previously stated, the Inpatient Certificate issued by the State stated that he was manic, delusional, labile, grandiose, unable to care for his own basic needs, aggressive, threatening, and reasonably expected to hurt someone unless involuntarily commited. As noted, [405 ILCS 5/2-107.1 (4)(A-G)] shows, the plaintiff clearly met the Illinois standard symptoms for involuntary hospitalization. (see Exhibit E)

2) As mentioned in his Appeal referencing the Americans With Disabilities Act, [42 U.S.C. § 12101 et. seq.] the plaintiff compared his emergency mental health condition with a more objective nature, such as a broken leg. The plaintiff reasoned that a broken leg (or a mental health condition) would not just simply heal itself by being transferred to another hospital. Therefore, he may have even been discriminated against due to his mental health condition.

3.) Regarding the plaintiff's 14th Amendment rights, the District court stated that the State's "affirmative duty to protect arises not from (its) knowledge of the individual's predicament or from its expression of intent to help him, but from the limitation which it has placed on his freedom to act on his own behalf." In plaintiff's case, it makes no difference that the State (Cermak) had expressed intent to involuntarily commit him. Yet since the State had placed limitations on plaintiff's freedom while at Mt. Sinai, it was the State's duty to provide standard, adequate healthcare. [see Spicer v. Williamson, 191 N.C. 487, 490, 132 S.E. 291, 293 (1926)]

4.) These standard protocols in healthcare may be considered evidence of the practitioner's knowledge of the risk posed by particular symptoms, according to [Mata v. Saiz, 427 F.3d 745, 757-58 (10th Cir. 2005); Phillips v. Roane County, Tenn., 534 F.3d 531, 541, 543-44 (6th Cir. 2008)].

5.) [E.L., 316 Ill. App. 3d 598, 249 Ill. Dec. 751, 736 N.E. 2d 1189 (1st Dist. 2000)] Found that "involuntary admission procedures... must be balanced against the need to provide care for those unable to care for themselves to protect society from the dangerously mentally ill."

6.) In another decision, the court found that "the procedures involved in involuntary psychiatric hospitalizations are not mere technicalities," but are "essential tools to protect the liberty interests of persons alleged to be mentally ill." [Matter of DeLong, 289 Ill. App. 3d 842, 225, Ill Dec. 112, 682 N.E. 2d 1189 (3d Dist. 1997)].

7.) In [Sanchez v. State of New York, 99 N.Y. 2d at 252], it was found that "officials have a duty of care..." to prevent harm that is "within the class of reasonably foreseeable hazards that the duty exists to prevent."

8.) As both of the lower courts have repeatedly pointed out, the "gold standard" precedent for determining healthcare lawsuits in Illinois is [Miranda v. Cty. of Lake, 900 F.3d 335]. In this case it was even determined that the State's "obligation to intervene covers self-destructive behaviors up to and including suicide."

9.) Finally, according to healthcare standards, a medical management decision is said to be justified when the benefits of that decision outweigh the risks, and that "the law encourages future decisions under similar circumstances." [see Fletcher GP. Fairness and utility in tort theory. Harvard Law Rev. 1972; 85: 537-573. doi: 10.2307/1339623] Clearly the benefits of involuntarily commiting the plaintiff outweighed the risks of the "reasonable expectation" of plaintiff harming himself or others, as predicted on the Certificate (Exhibit A).

B.) The standard of care in Illinois – for the plaintiff's documented condition – was involuntary commitment.

1.) All of the evidence presented in part A (above) indicates that the State had a duty of care to protect plaintiff's liberty and safety interests. More alarmingly, the State neglected to protect the liberty interests of the public From the plaintiff, whome he was predicted to harm if not involuntarily commited.

2.) Other IL statutes point to a hospital's duty to provide standard care. [215 ILCS 134/5] states that "a patient has the right to care consistent with professional standards of practice to assure quality nursing and medical practices." [740 ILCS 180/1] states that "failure to comply with standards of care is enough to show that the defendant's proximately caused the plaintiff's injury," and thus acted unconstitutionally.

3.) Federal courts agree on the importance of following standards within healthcare. In [Moore v. Duffy, 255 F.3d 543, 545 (8th Cir. 2001)] the court found that it is "clearly established" that medical treatment may so deviate from applicable standards of care as to evidence deliberate indifference. Another case found that when psychiatric standards of care were not followed, that it violated constitutional rights [Greason v. Kemp, 91 F.2d 829, 835 (11th Cir. 1991)].

4.) A locked psychiatric hospital is considered the standard facility equipped to stabilize and admit the plaintiff in his condition. Since he was not placed in a Facility consistent with his condition, plaintiff's constitutional rights were violated according to [Muhammed v. U.S., 6 F. Supp. 2d 582, 594 (N.D. Tex. 1998); see also 405 ILCS 5/3-605 (Exhibit 6)]

5.) The lower courts appear to be more interested in arguing that the

plaintiff did not have a "right" to be involuntarily hospitalized, rather than protecting his actual liberty interests. Interestingly, plaintiff has never argued that he had a "right" to be involuntarily committed, only that his condition warranted commitment, and that since he was in custody, it was their duty to protect his liberty interests (safety). In doing so, the courts have ignored plaintiff's actual argument that standards of care in psychiatry were objectively not followed, amounting to his constitutional rights being violated.

Point #4

According to the Emergency Medical Treatment and Labor Act [EMTALA, 42 USCS § 1395dd], both Cermak and Mt. Sinai had a duty to stabilize the plaintiff prior to being placed on house arrest.

A.) On his Motion For Rehearing, the plaintiff referenced EMTALA [42 USCS § 1395dd]. Both of the lower courts continue to insist that neither Cermak or Mt. Sinai had any responsibility to ensure that plaintiff was stabilized. EMTALA suggests otherwise:

1.) The Emergency Medical Treatment and Labor Act [42 USCS § 1395dd] was enacted by Congress in 1986, to ensure that anyone coming to an emergency room is stabilized and treated - regardless of their insurance, status, disposition, or ability to pay. EMTALA is referred to as the "anti-dumping" law, designed to prevent hospitals from discharging or transferring "unsavory"

patients who may or may not have the ability to pay. [see also: H.R. Rep. No. 241, 99th Cong., 1st Sess., Part I, at 27 (1985), reprinted in 1986 U.S. Code Cong. & Admin. News 579, 605]

2.) Despite this Act, the practice of "dumping" patients continues, especially within psychiatry. EMTALA was designed to eliminate the practice of hospitals from simply discharging or transferring patients with a medical emergency without proper provision of screening, or stabilization of their condition [Harry v. Marchant, 259 F.3d 1310, 14 Fla. L. Weekly Fed. C. 1061 (11th Cir. 2001)].

a.) This practice of "down-playing" mental health symptoms is a major problem in psychiatry due to its subjective nature. Hospitals are able to legally get away with dumping a patient via the "paper trail."

b.) While working as a psychiatric R.N. at St. Joseph's Hospital in Chicago, IL, the plaintiff witnessed multiple scenarios where this occurs. One scenario (witnessed numerous times) is where a suicidal, homicidal, or psychotic patient comes to the emergency room for help, and has either no insurance, or has insurance that is not accepted accepted at St. Joseph's. In many of these cases, the E.R. physician may simply "down-play" their subjective symptoms to not being "actively suicidal", which would require involuntary committment. Instead, these patients diagnosis is then lowered to only "Major Depression", while only having "passing thoughts" of suicide - and may then be justifiably discharged on paper.

c.) Another situation involves "unsavory" patients, who come to the E.R. with mental health symptoms and are just not liked very much for some reason - such as a bad attitude, cursing, yelling, racist, inappropriate, etc. These patients symptoms are often "down-played" as well.

d.) Comparative insurances is another problem within the private healthcare network. For example, Medicaid is known to only pay out the bare minimum to hospitals for those that have this insurance. Medicaid patients have a limit of how many "psychiatric days" that may be used monthly. Any number of days that goes over that in the hospital, usually have to be written off as a loss, due to these Medicaid patients' inability to pay.

One Medicaid scenario regularly occurs on locked psychiatric facilities: A patient walks in to the E.R. and states that he is actively suicidal. Medicaid is then known to approve of only 3-5 days of payment to a hospital with these symptoms, and then assumes that they are "cured" so they will pay no more.

Comparably, if a patient walks in to an E.R. with Blue Cross/Blue Shield insurance and is actively suicidal, they will usually be automatically admitted to the locked psych. facility. In these cases - with premium insurance - doctors will often find a reason to keep them longer than the initially approved 7-10 days approved.

e.) This issue of "down-playing" symptoms is particularly important in plaintiff's case. Not only did the plaintiff have no insurance at the time, but the Cook Co. Jail would have been paying the bill to Mt. Sinai, and could be expected minimal payments. The plaintiff would also have been considered a "less-than-desirable" patient, due to being in custody and recently leaving the jail, while also in handcuffs.

3.) According to EMTALA, the transfer of an unstable patient is to be certified by a physician. The transferring facility (Cermak) must confirm that the accepting facility (Mt. Sinai) is an "appropriate facility," and have

accepted the patient by "qualified personnel." [see 42 USCS § 1395dd]. As indicated on the Certificate (Exhibit A), the "appropriate facility" was an involuntary psychiatric ward, and the "qualified personnel" standards require a psychiatrist.

4) Regarding EMTALA, [405 ILCS 5/3-909] states that "an order of transfer entered under this section does not eliminate any obligations under the federal Emergency Transport and Active Labor Act (EMTALA) of the transferring facility (Cermak) toward the receiving facility (Mt. Sinai)." Thus, even though plaintiff was transferred to Mt. Sinai, Cermak still had a responsibility to ensure plaintiff's stabilization.

5) The plaintiff was not stabilized, placed in an appropriate facility, treated by qualified personnel, nor did he receive an appropriate screening. Private causes of action using [42 USCS § 1395dd] are proper in these scenarios, and both Cermak and Mt. Sinai can be sued. Under EMTALA:

a.) Hospitals may be fined up to $50,000 per violation.

b.) Physicians may be fined up to $50,000 per violation.

c.) Hospitals may be sued for personal injury in civil court for private cause of action.

Point #5

Plaintiff's case should not have been dismissed as only a difference of opinions between the physicians of Cermak and Mt. Sinai.

A) The District court aptly summed up the plaintiff's case when it stated,

"at issue here is the unilateral decision of the Mt. Sinai personnel - contrary to Cook County's directions - not to commit plaintiff for inpatient psychiatric treatment."

1.) Courts have repeatedly found that medical care claims cannot be dismissed as a mere difference of medical opinions.

a) [Jones v. Simek, 193 F.3d 485, 492 (7th Cir. 1999)] found that refusal to follow specialists recommendations as supporting a claim of deliberate indifference.

b.) [Miller v. Schoenen, 75 F.3d 1305 (8th Cir. 1996)] found that expert evidence combined with recommendations from outside hospitals that were not followed supported a deliberate indifference claim.

c.) [Hamilton v. Endell, 981 F.2d 1063, 1066-67 (9th Cir. 1992)] Found that when a physician overrode the specialist's recommendation, and that "by choosing to rely upon a medical opinion which a reasonable person would likely determine to be inferior, the prison officials took actions which may have amounted to the denial of medical treatment," and thus violated the plaintiff's constitutional rights.

d.) [Verser v. Elyea, 113 F. Supp 2d 1211, 1215 (N.D. Ill. 2000)] is an example where a physician "declined to follow the recommendations of an orthopedic specialist, which he is not," and that this claim could not be dismissed as a mere difference of opinions.

B.) Courts have found that when a Doctor refuses to carry out prescribed or recommended treatment, this meets the 'mental-state' element of a constitutional violation.

1.) In [Hunt v. Uphoff, 199 F.3d 1220, 1223-24 (10th Cir. 1999)] the court refused to dismiss allegations that one doctor denied treatment prescribed by another doctor, and that recommended treatments were not performed as mere difference of opinion [see also: Scott v. Ambini, 575 F.3d 642, 648 (6th Cir. 2009)].

2.) [Kaminsky v. Rosenblum, 929 F.2d 922, 927 (2d Cir. 1991)] Found that constitutional violations occurred for failure to act on the recommendation of immediate hospitalization.

Point #6

The lower courts failed to consider the significance of the Inpatient Certificate which was submitted by the plaintiff.

A.) The plaintiff asks this court to consider the legal implications of the Certificate (Exhibit A) - which is the crux of the plaintiff's complaint - since nothing may be proven until Discovery is opened.

1.) The lower courts have ignored the fact that plaintiff's objectively psychotic condition went objectively untreated. The plaintiff was documented to be dangerously psychotic, and yet he was released to house arrest despite the foreseeable consequences.

2.) With this knowledge, the doctrine of res ipsa loquitur may then be applied. In this doctrine, courts "must rely on the common knowledge of laypersons, if it determines that to be adequate, or upon

expert testimony, that the medical result complained of would not have ordinarily occurred in the absence of Negligence by the defendant." This doctrine only requires "proof of an unusual, unexpected or untoward medical result which ordinarily does not occur" to suffice. Any layperson may bear witness that plaintiff should not have been released from custody to house arrest prior to being stabilized on a locked facility in the dangerously psychotic state he was in.

3.) Courts have held that they should consider other documents that a pro se prisoner has filed, in addition to the complaint, in determining whether the person has stated a claim [see: Warren v. District of Columbia, 353 F.3d 36, 38 (D.C. Cir. 2004); Dellairo v. Garland, 222 F. Supp. 2d 86, 89 (D. Me. 2002); Preston v. New York, 223 F. Supp. 2d 452, 461 (S.D. N.Y. 2002)].

4.) The lower courts have made no comment on the Inpatient Certificate (Exhibit A), nor the expectation documented that plaintiff would hurt himself or others without committment.

a.) As noted previously, the lower courts both chose not to comment on the plaintiff's citing [Sanchez v. State of New York, 99 N.Y. 2d at 252] which clearly stated that "officials have a duty of care" to prevent harm that is "within the class of reasonably foreseeable hazards that the duty exists to prevent."

b.) Neither of the lower courts chose to acknowledge the plaintiff's citing [E.L., 316 Ill. App. 598, 249 Ill. Dec. 751, 736 N.E. 2d 1189 (1st Dist. 2009)], which acknowledged the State's duty to protect society from "the dangerously mentally ill." Documented to be dangerously ill, the State had a duty to protect society from him.

B.) By choosing to ignore the Inpatient Certificate itself, as well as the limitations that the State had placed on plaintiff's freedom, the lower courts have ignored plaintiff's liberty interest of receiving equal treatment and protection.

1.) Regarding the rights of the mentally ill, the plaintiff referenced the Americans With Disabilities Act [42 USC § 12101, et. seq.] as well as parts of the IL Mental Health Code [405 ILCS 5/2-100a].

a.) Plaintiff argued on his Appeal that if he had been a "free-world" patient (with mental illness), as compared to a Cook Co. Jail detainee (with mental illness), the standard of care for his condition is involuntary hospitalization, and he would have received this care. [see 405 ILCS 5/2-107.1 (4)(A-G); Exhibit E]

b.) Plaintiff also argued on his Appeal that he was not treated equally as other Cook Co. Jail detainees that are placed on house arrest, albeit in a stable, "sober-minded" mental health condition. Plaintiff reasoned that while he was in a psychotic state, he would never have been placed on house arrest.

c.) While invoking the Americans With Disabilities Act [42 USC § 12101, et. seq.], plaintiff also reasoned that if he had displayed a physical ailment - such as a broken leg - versus a mental health ailment, he would have been treated with an equally standard of care. Since he had not been involuntarily committed (the standard of care for his condition), he was discriminated against due to his disability.

2.) Federal courts agree on equal treatment and healthcare for detainees:

a.) [Humphreys v. State, 334 N.W. 2d 757, 759 (Iowa 1983)] found that medical personnel owe the same duty of care to prisoner-patients as they do to "free-world" patients.

b.) In [City of Cleburne, Tex. v. Cleburne Living Center, 473 U.S. 432, 439, 105 S. Ct. 3249 (1985)] the court interpreted the 14th Amendment that "all persons similarly situated should be treated alike."

3.) Plaintiff has absolutely zero recollection of even being setup on house arrest by the Cook Co. Sheriff's Dept., let alone any instructions that they gave him regarding his electric monitoring device. Confused and delusional, plaintiff attempted to contact the electric monitoring company to see if he could leave his house, but could not reach them. After several frantic 9-1-1 calls without questions answered, plaintiff decided it would be alright to leave his residence to purchase groceries.

Within 5 days after being placed on house arrest, plaintiff received a felony "Escape" charge, for leaving his house. He was never notified by the Police, and only days later received two more felony charges, where someone was injured.

Point #7

As on his Appeal, plaintiff re-iterates his claim that both Cermak and Mt. Sinai recklessly disregarded standard after-care planning, discharge, transfer protocols, and follow-up procedures.

A.) Standard after-care planning and follow-up protocols are a vital

continuation of preventative psychiatric treatment - whose goal is to prevent remission.

1.) As previously stated, these standard discharge procedures for the acutely mentally ill - and involuntarily committed - "are not mere technicalities," but are "essential tools to protect the liberty interests of persons alleged to be mentally ill" [Matter of DeLong, (3d Dist. 1997)]. The lower courts once again chose to ignore plaintiff's standards of care claims regarding his discharge and after-care process.

The lower courts also continue to insist that Cermak (i.e. the State) had no further obligation to the plaintiff after leaving the jail - even though it was proven that he was still in custody. IL statutes indicate that Cermak's psychiatrist, Physician's Assistant Balawender, and R.N. still had responsibilities to the plaintiff.

a.) [215 ILCS 134/40] indicates that Cermak's primary psychiatrist was still responsible for coordinating the after-care of the plaintiff, and to ensure that this care was followed.

b.) Other statutes indicate that both hospitals were working together to share information, treatment, after-care planning, and discharge. [see 405 ILCS 5/3-811; 405 ILCS 5/3-909; 215 ILCS 134/40(e); 215 ILCS 134/70(d); 215 ILCS 134/45.2]

2.) Prior to the plaintiff leaving Cook County Jail, Cermak's psychiatric experts had made an after-care plan for the plaintiff. Without his physical records being made available - refused by both Cermak and Mt. Sinai - these plans are indicated on the Inpatient Certificate issued by P.A. Balawender (Exhibit A):

a.) Plaintiff was to be involuntarily committed, under the care of a psychiatrist.

b.) As noted on his Appeal, not only does Cook County Jail's own handbook/manual, but Federal courts also declare that a 30-day supply of medications are to be supplied upon a psychiatric discharge from custody [see Wakefield v. Thompson, 177 F.3d 1160, 1164 (9th Cir. 1999)]. The lower courts appear to be under the assumption that by simply being transferred, neither Cermak or Mt. Sinai needed to provide these medications - even though he was still in custody. This attitude can be seen when the District court declared that "the County would have been justified in assuming that any follow-up care, including medications, would be determined, communicated, and provided to Plaintiff by (Mt. Sinai) hospital personnel."

c.) [405 ILCS 5/6-103.3] was made specifically to prevent situations such as plaintiff's - where a dangerously psychotic person is released without any follow-up, or third-party precautions being taken. This IL Mental Health Code statute gives protocols and measures that a hospital must take in case someone is still a danger to himself or others (i.e. plaintiff). In this event, a hospital has the duty to "notify the Department of Human Services and law enforcement" within 24 hours of the determination that someone is still dangerous. The plaintiff cited on his Appeal with no comment from the court that this never occurred.

d.) [405 ILCS 5/3-209] requires "assessment of the recipients needs, a description of the services recommended for treatment, the goals of each element of service... and designated the qualified professional responsible for the implementation of the (after-care) plan." Again, Cermak's plan was

for plaintiff to be transferred to a mental hospital, under the care of a psychiatrist, and for plaintiff's stabilization prior to his being placed on house arrest [see also 405 ILCS 5/3-605; Exhibit G].

B.) Cermak and Mt. Sinai's follow-up measures were dangerously inefficient.

1.) The lower courts have decided that Cermak's "contacting the plaintiff's father" were standard, acceptable after-care, and effective follow-up protocols for the plaintiff, who was alone in his residence, and still delusional, manic, paranoid, and agitated. On the morning of January 25, 2018 - within hours of both being transferred from Cermak, and getting discharged from Mt. Sinai - Cermak called plaintiff's Father (who lives a full 2½ hours away from Chicago), and informed him that his 40 year old son had not received the treatment that they had ordered, that plaintiff was still unstable, and that he was alone in his apartment.

a.) [215 ILCS 134/80] states that plaintiff's after-care would include "follow-up measures implemented to evaluate the effectiveness of the plan."

b.) Plaintiff's parents lived out-of-state, and were vacationing in Europe at the time of his release. Cermak relied on this one phone call as their sole determination of the effectiveness of their after-care plan. Furthermore, there was no way to assess plaintiff's mind-state, or to even confirm that he was safe in his apartment - since Cermak had even admitted to plaintiff's father that he had not received treatment at Mt. Sinai.

2.) Federal decisions agree that standard and efficient psychiatric follow-up, and after-care is essential for prevention measures.

a.) In [Protection & Advocacy, Inc. v. Murphy, 1992 U.S. Dist. LEXIS 3113, citing USCS § 1396 r(e)(7)(c)(ii)], the court found that "for those individuals requiring specialized services (i.e. plaintiff), the State must... arrange for a safe and orderly discharge, observing carefully delineated discharge rights, prepare and orient (the patient) for discharge, and ensure that (the patient) will receive specialized services."

b.) [Wakefield v. Thompson, (9th Cir. 1999)] found that healthcare officials are required to arrange for continuing treatment, and to follow-up inmates with known or suspected disorders. Failing to do so displays constitutional violations. [see also Clark-Murphy v. Foreback, 439 F.3d 280, 289-92 (6th Cir. 2006)]

Point #8

An expert witness may be seen as necessary to correctly establish psychiatry standards of care, and to corroborate plaintiff's claims.

A.) The plaintiff's primary argument in this civil action is that standards of care were not followed in his transfer, admission, after-care planning, follow-up, and even his placement on to house arrest itself. An expert witness must establish these standards.

1.) The lower courts appear to assume "expert" knowledge of psychiatric

standards of care - inserting their own opinions of what "reasonable" protocols are, rather than plaintiff's factually objective claims.

2.) As plaintiff pointed out in [People v. Delong (In re Delong), 289 Ill. App. 3d 842], the court found that the protocols involved in involuntary psych hospitalizations "are not mere technicalities," but are "essential tools..." meant to protect the plaintiff (and society). Thus, the standard protocols involved in an involuntary hospitalization, transfer, discharge, and after-care, are not just subjective opinions that a judge may interpret as not having merit. These standards are instead objective facts that must be taken as true.

3.) Since the plaintiff's complaint involves objective standards of care, courts have found that "a court reviewing a complaint must accept as true all allegations of material fact and construe them in the light most favorable to the plaintiff" [see Resnick v. Hayes, 213 F.3d 443, 446 (9th Cir. 2000); Gomez v. USAA Fed. Sav. Bank, 171 F.3d 794, 795-96 (2d Cir. 1999)].

4.) Due to the complicated, and appearingly-subjective nature of these standards, Federal tort decisions agree that an expert witness is necessary to establish them:

a.) In [Willis v. Palmer, 100 Fed. R. Evid. Serv. (CBC) 622, 2016 U.S. Dist. LEXIS 68384 (N.D. Iowa May 25, 2016), the plaintiff was civilly committed. The court in [Willis] required expert testimony to aid in the prompt and just adjudication of the matter because the questions presented were "complex and involved questions of medicine, psychiatry, and other behavioral sciences" and because plaintiff was indigent.

b.) Courts in Illinois have indicated that [Miranda v. County of Lake, 900

F.3d 335, 352-54 (7th Cir. 2018)] is the relative "gold standard" for determining constitutional healthcare claims in this state, as noted in their responses. In [Miranda], the court found that proximate cause "must be established by expert testimony," and that "an expert's opinion on the connection between a delay in treatment (of the mentally ill plaintiff in that case) and an injury must be supported in order to be submitted to the jury." In [Miranda], a psychiatry expert (James Gilligan) was necessary to confirm that medical failures had occurred, which led to further injury.

c.) The plaintiff presented an Inpatient Certificate (Exhibit A) which clearly stated the need for his involuntary committment. As previously noted, the court in [Hamilton v. Endell, 981 F.2d 1063, 1066-67 (9th Cir. 1992)] found that only expert evidence along with a recommendation from an outside hospital that was not followed (already provided with Exhibit A) - were necessary to support a deliberate indifference claim.

B.) An expert opinion is necessary to differentiate between deliberate indifference and Negligence.

1.) As previously stated, plaintiff pointed out ~~that~~ the District court acknowledged that mistakes may have been made in his healthcare treatment, by suggesting medical malpractice or Negligence, rather than deliberate indifference - as plaintiff claims. It now becomes an issue of whether or not Cermak and Mt. Sinai had the requisite 'mental state' which indicates that the consequences of lack of treatment were recklessly disregarded.

Plaintiff pointed out several times to the lower courts that the

Certificate issued (Exhibit A) clearly stated that if he was not involuntarily committed, he was "reasonably expected" to harm someone else or himself, and that his mental health would deteriorate. Both lower courts ignored this fact.

2.) Courts have found that "whether an instance of medical misdiagnosis resulted from deliberate indifference or negligence is a factual question requiring exploration by expert witness." [Rogers v. Evans, 792 F.2d at 1058; see also Miltier v. Beorn, 896 F.2d 848, 852 (4th Cir. 1990); Mandel v. Doe, 888 F.2d 783, 790 (11th Cir. 1989); Medcalf v. State of Kansas, 626 F.Supp 1179, 1190 (D. Kan. 1986)]

C.) Interpreting healthcare standards without an expert witness may even be considered an impossible task for the plaintiff - indicating the potential for prejudice.

1.) The court in [People v. DeLong (In re DeLong)] found that "it is impossible to tell the extent to which the respondent (plaintiff) was prejudiced by the State's failure to comply with the procedural safeguards of the IL Mental Health Code [405 ILCS 5/100 et. seq.]. Nevertheless, there is a strong potential for prejudice, and important liberty interests are involved."

With the "strong potential for prejudice" noted in the [DeLong] case (similar to plaintiff's claims), the court found that "the burden is upon the State to affirmatively demonstrate that it has complied with the mandates of the IL Mental Health Code."

2) It may even be considered an impossible task for a pro se litigant to interpret these healthcare standards without an Expert opinion. In [Boring v. Kozakiewicz, 833 F.2d at 473-74], one judge wrote that "the inhumanity of this paradoxical rule of law alone suggests a serious flaw."

3.) [USCS Fed. R. Civ. Proc. R26, Part I of S (subsection (b)(4)] states that "a prohibition against discovery of information held by expert witnesses produces in acute forms the very evils that discovery has been created to prevent."

4.) The problem with the lower courts inserting their own subjective opinions on healthcare standards is that only an "expert opinion" may dictate whether they were followed - which may only happen once the Discovery process has opened. Since the plaintiff's factual allegations must be regarded as true, he should then be permitted to prove that his medical treatment received "so deviated from professional standards that it amounted to deliberate indifference" [Smith v. Jenkins, 919 F.2d 90, 93 (8th Cir. 1990)].

Conclusion

Wherefore, the plaintiff moves this honorable court to grant the Writ of Certiorari, and reverse the lower courts decision to dismiss without a Discovery process ever being opened. Plaintiff asks this court to remand this case back to the lower courts to decide and to further litigate.

The plaintiff humbly requests this court to appoint an attorney due to the complex mental health issues presented, and to advocate for plaintiff - who has legitimate mental healthcare claims. Plaintiff asks this court to acknowledge the Protection and Advocacy For the Mentally Ill Act [42 USCS § 10801] (Exhibit D) to advocate for him, and to

investigate this issue further. Finally, plaintiff asks this court under [706 Fed. R. Evid.] to appoint an Expert witness who may legitimize plaintiff's standards of care claims:

Respectfully submitted,

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Dated June 10, 2021

Oath

I swear under the penalty of perjury, that the above statement is true and correct to the best of my ability.

Dated June 10, 2021

Signed Jeff Ferguson
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