INVESTIGATIVE REPORT

COOK COUNTY

JOHN SPIEKER

ALISON MCINTYRE

JULY 25, 2025

CONFIDENTIAL
SUBJECT TO ATTORNEY / CLIENT PRIVILEGE

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COOK COUNTY
INVESTIGATIVE REPORT

I. BACKGROUND OF INVESTIGATION

This is a report of an investigation into allegations of employee misconduct against John Spieker, Behavioral Health Supervisor, and Alison McIntyre, Director of Public Health and Human Services. The investigation was authorized by Dyan Ebert, labor counsel for Cook County.

II. DOCUMENTS REVIEWED

Documents reviewed are attached to this report as exhibits or are incorporated by reference below.

Documents reviewed and considered in support of the following findings and conclusions, but not attached to this report, include:

- Cook County Investigative Report, dated June 6, 2025, with related exhibits;
- Correspondence and communication with Dave Lee, analysis of documents and interview transcripts, and time keeping records;
- Client files, case notes, and SSIS entries for various adult and [redacted] matters, including: [redacted], [redacted], [redacted], [redacted], [redacted], and [redacted];
- John Spieker personnel file and information regarding performance management;
- Financial and time reporting information and Cook County SSIS Time Entry Protocol, as well as departmental documents, procedures, and rules;
- Email from [redacted] "Statutes regarding training for Behavioral/Mental Health Staff;"
- Emails regarding AMH Case Manager position;
- Organizational charts; and
- Email from [redacted] regarding disparate treatment between [redacted] and [redacted] timekeeping records and information.

III. INVESTIGATION

Investigative interviews were conducted as follows: [redacted], [redacted], [redacted], and [redacted] were interviewed on June 27, 2025, at the Cook County Courthouse in Grand Marais, Minnesota. [redacted] was interviewed by video conference via Microsoft Teams on June 27 as well. On July 9, 2025, [redacted] and [redacted] were interviewed by video conference via Microsoft Teams. Finally, individual interviews were conducted on July 14, 2025, with John Spieker and Alison McIntyre by video conference via Microsoft Teams. The record was closed on July 25, 2025.

This report was developed in conjunction with Dave Lee, former Health and Human Services (HHS) Director for Carlton County, who served as the subject matter expert for this investigation.

IV. FINDINGS AND CONCLUSIONS

1. [redacted], [redacted], documented a volume of conversations and concerns that started to flood in about the leadership, work environment, and client handling in the Public Health and Human Services (PHHS) department at Cook County. The level of concern prompted [redacted] to place Director of Public Health and Human Services Alison McIntyre and Behavioral Health Supervisor John Spieker on paid administrative leave on June 10, 2025, pending an investigation. [redacted] summarized the reports to her in Exhibit A.

2. The reports, in summary, allege:

   a. That expenses in PHHS are up, and the revenue capture is down.

      i. That employees are not capturing their billable time properly on SSIS, and as a result, reimbursement and revenue are negatively impacted. Employees are expected to capture 90% of their time on SSIS, yet many employees fall far below this standard and capture only a small portion of their time.

      ii. That Flex Funds have been spent inappropriately and without appropriate monitoring/oversight.

      iii. [redacted] was hired into a team Spieker supervises and quit in less than three months due to [redacted] concerns with Spieker's supervisory style. [redacted] had not completed the required 40 hours of training before [redacted] time could be submitted for reimbursement. As a result, the County was not able to seek reimbursement for any of [redacted] work during [redacted] employment.

   b. That the morale in the teams that Spieker supervises is low, has a high rate of turnover, and has struggled with Spieker at the helm. Spieker lacks expertise in the programs that he supervises, and he does not engage professionally with his team. Spieker has poor relationships inside and outside of PHHS.

      i. That many employees repeatedly reported concerns about Spieker to McIntyre, and she took no meaningful steps to address or seek redress of the concerns.

   c. That many client matters have been mishandled by Spieker under McIntyre's leadership resulting in financial consequences to Cook County and potential harm to clients:

      i. [redacted], [redacted], was kept in an expensive placement for longer than necessary due to Spieker's failure to complete necessary paperwork, resulting in over $500,000 in costs to the County. The County was later able to recover some of this loss from the client's estate, but this would not have been necessary if Spieker had been proficient in his position.

ii. [redacted] and [redacted] were given permission by Spieker to [redacted] but Spieker did not notify the parent/guardian of the children, the Children's Mental Health supervisor, or the [redacted], resulting in law enforcement getting involved [redacted]. The situation negatively impacted the relationship between PHHS and the [redacted], who is no longer taking Cook County placements.

iii. Spieker placed [redacted] in a series of metro placements for [redacted], where [redacted] ultimately absconded and was missing for 48 hours. [redacted] Spieker failed to file the necessary paperwork regarding the matter and failed to work with [redacted] to develop a safety plan that would have kept [redacted] in the [redacted] home, where [redacted] was safer.

iv. An [redacted], was "lost" by PHHS for at least two weeks following a transfer between facilities that lacked appropriate supervision, communication, and follow-through by Spieker.

v. [redacted] was mishandled in relation to a potential commitment matter.

vi. Spieker allowed [redacted] to be home alone for five days without adult supervision despite knowing that [redacted].

Revenue and Expenses

3. [redacted] is a [redacted] at PHHS. [redacted] works with [redacted] and [redacted] for the department. [redacted] has raised concerns to [redacted] supervisor about Spieker. [redacted] describes Spieker as "clueless" in terms of his knowledge of his role. Under Spieker's supervision, [redacted] has noticed that the County has missed out on revenue due to Spieker not training staff on SSIS entry, his employees not having appropriate training or guidance on what time can be captured and submitted for reimbursement, and lack of follow-through by Spieker. Spieker would frequently ignore [redacted] emails, so [redacted] started copying [redacted] supervisor on communications with Spieker.

4. [redacted] was unable to seek reimbursement for any of [redacted] work during [redacted] employment with Cook County because Spieker had not made sure that [redacted] completed the required 40-hour training. [redacted] believes this mistake cost the County between $15,000 to $25,000.

5. [redacted] understands that workers are expected to capture at least 90% of their time in SSIS, as this data serves as the foundation for seeking reimbursement. [redacted] has been informed by [redacted] supervisor that some employees are recording only a small percentage of their time, which hinders [redacted] ability to process revenue for PHHS.

6. [redacted] had concerns about how a previous employee was using Flex Funds, but that employee has since quit, and [redacted] feels that this area is improving now.

7. Overall lack of concern for budget management was raised by [redacted] due to increased expenses and decreased revenue in the last several years. In 2023, the department was 303% of budget on expenses and 64% on revenue. In 2024, the department was 199% of budget on expenses and 34% on revenue. An overall lack of urgency and concern by McIntyre surrounding staff accountability for staff time, monitoring of placement expenses, and a lack of active case management to draw down Targeted Case Management (TCM) income, which is a significant revenue source for the PHHS.

8. Spieker and McIntyre failed to actively hold staff accountable for their time entry, which has greatly impacted administrative reimbursement revenue. There is little accountability for revenue capture, follow-through on training, and overall critical management of expenses by McIntyre.

Work Conditions and Atmosphere Under Spieker's Supervision

9. [redacted] is the [redacted] at PHHS. [redacted] describes the work environment as "the most negative and unprofessional place I have ever worked in my entire life." [redacted] tries to shield [redacted] team from the teams supervised by Spieker because [redacted] expects more from [redacted] team in terms of professionalism and respectful treatment of one another, as well as of clients. [redacted] does not want [redacted] team picking up Spieker's poor habits. [redacted] has found that Spieker makes "demands" without collaborating, belittles others, is "authoritarian" despite not knowing the underlying rules and procedures, and fails to support his team when they ask for support or training. [redacted] observed him yelling at both staff and clients.

10. Other witnesses interviewed, particularly those directly supervised by Spieker, consistently described him as a negative and toxic force within PHHS who would rebuff efforts to collaborate amongst teams and established a "my way or the highway" persona. Multiple employees expressed a desire to leave Cook County employment or had already quit or transferred to a different team, due to a desire to distance themselves from Spieker.

11. In a nearly two-hour interview with Spieker reviewing the weight of concern surrounding him and his performance, he took no personal responsibility. Instead, with each instance of concern, he explained that others were at fault, others had failed to inform him of necessary information, others had made mistakes, the circumstances were out of his control, etc.

12. Spieker's behaviors, leadership, and supervisory style have caused direct harm to PHHS.

McIntyre's Supervision of Spieker, Spieker's Proficiency in Its Position

13. Nearly every witness interviewed in connection with this investigation reported repeatedly going to McIntyre to raise concerns about Spieker and to request her intervention.

14. [redacted] Spieker now supervises. [redacted]. When Spieker was hired, [redacted] noted that he freely discussed his lack of experience in supervising adult mental health case management and children's mental health case management. [redacted] worked diligently to attempt to coordinate teams and communicate with Spieker, but he rejected [redacted] attempts. [redacted] noticed that he struggled to learn new information and often disregarded policies, procedures, and laws. [redacted] reported [redacted] concerns to McIntyre multiple times and saw no changes in Spieker's behavior.

15. McIntyre acknowledges that many people came to her to report concerns surrounding Spieker. Despite these repeated and consistent reports, McIntyre passed Spieker out of probationary status, failed to advance any defined action plan for improvement, did not issue discipline, and did not formally arrange for any additional training or mentoring for Spieker. McIntyre's lack of leadership and passive approach to supervising Spieker has caused direct harm to PHHS.

Client Matters

16. [redacted]:

a. [redacted] was in the [redacted] in [redacted] when [redacted] and [redacted] were involved with the [redacted]. [redacted] came into work on a Monday to learn for the first time about [redacted] and how Spieker had managed their needs. Spieker had allowed [redacted] to seek [redacted] with the [redacted] over the weekend, but he had not notified the other teams, [redacted], or the [redacted]. He had not followed the internal procedures surrounding the matter and had not completed necessary paperwork. *See* Exhibit B. As a result, law enforcement became involved in responding to a [redacted] report, which impacted relationships with [redacted] and the [redacted]. Spieker denies any misjudgment or wrongdoing in this matter.

b. The County's involvement with [redacted] has been longstanding and complicated. When [redacted] could no longer stay with the [redacted] family, Spieker moved [redacted] to a series of placements [redacted]. Spieker rejected help from [redacted] team. [redacted] signed a voluntary placement agreement allowing the move, but Spieker did not file the agreement with the court. Ultimately, [redacted] was moved multiple times between facilities [redacted], and [redacted] left the last facility, ultimately going missing for 48 hours. When [redacted] turned up, [redacted] is adamant that Spieker should have instead worked with [redacted] to develop a safety plan that

would have allowed [redacted] to remain at home in [redacted]. Spieker denies any misjudgment or wrongdoing in this matter.

17. [redacted]:

a. Concerns were raised by multiple witnesses regarding the handling of [redacted], [redacted], and [redacted]. In each of these instances, Spieker denied any misjudgment or wrongdoing.

b. Costs surrounding the impatient care for [redacted], shocked [redacted] and [redacted]. The costs were upwards of $50,000 per month (when normally inpatient care is closer to $4,000 per month). The lack of aggressive monitoring and lack of urgency surrounding [redacted] placement led to increased expenditures of hundreds of thousands of dollars.

c. The decision making surrounding client files for [redacted] and [redacted] were also alarming to [redacted] as normal processes and procedures were not followed and client outcomes were less than ideal.

18. [redacted]:

a. [redacted] was raised as a file of concern by [redacted]. Spieker gave [redacted] permission to stay home alone [redacted] met with Spieker to share [redacted] frustrations with the situation and how he should not have allowed [redacted] to remain at home alone [redacted] with [redacted]. [redacted] shared that, statutorily, [redacted] could not be left home alone. Spieker argued with [redacted] that he had handled the situation properly regardless of statutory law. Spieker denies any misjudgment or wrongdoing in this matter.

19. Spieker is not wholly responsible for the situations that transpired in the above client matters. However, the consistent theme throughout these examples is of Spieker not collaborating with other teams for the betterment of clients, Spieker not following (or not understanding) rules, procedures, and laws, and instead acting out of instinct, rejecting feedback from coworkers on how to improve, and ultimately resulting in less than ideal client outcomes. Spieker's handling of the above client matters fell below the standard of proficiency and care expected of him. Cook County PHHS's value statement is: "We are committed to accountability, respect, integrity, honesty and partnership." In his interview, Spieker took no responsibility for any of his work in the above matters. He failed to act with accountability, respect, integrity, or partnership.

a. The position description for the Behavioral Health Services/Clinical Supervisor details the duties and responsibilities of Spieker's position. Spieker failed to carry out many of the duties detailed in the position description. *See* Exhibit F(a).

20. As the Department Head, McIntyre's passive supervision of Spieker also played a part in what transpired in the above client matters. She was well aware of Spieker's lack of experience in the public sector when he was hired. Concerns were brought to her on a consistent basis by PHHS employees, and she did not take an active part in addressing the concerns. As a result, McIntyre's lack of urgency, oversight, and care contributed to the poor client outcomes.

    a. The position description for the Director of Public Health and Human Services details the duties and responsibilities of McIntyre's position. McIntyre failed to carry out the duties detailed in the position description that surround oversight, monitoring and management. *See* Exhibit G(a).

Dated: July 25, 2025

By 

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