IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF OKLAHOMA

ROBBIE EMERY BURKE, as the Special Administratrix of the Estate of Elliott Earl Williams, Deceased,	)	
Plaintiff,	)	
v.	)	Case No. 11-CV-720-JED-PJC
STANLEY GLANZ, SHERIFF OF TULSA COUNTY, *et al.*,	)	
Defendants.	)	

PLAINTIFF'S RESPONSE TO DEFENDANT STANLEY GLANZ'S MOTION FOR SUMMARY JUDGMENT

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases Cited — Page

Introductory Statement

> **"An inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met. In the worst cases, such a failure may actually produce physical torture or a lingering death..., the evils of most immediate concern to the drafters of the [Eighth] Amendment. In less serious cases, denial of medical care may result in pain and suffering which no one suggests would serve any penological purpose.... The infliction of such unnecessary suffering is inconsistent with contemporary standards of decency...."**

Estelle v. Gamble, 429 U.S. 97, 103 (1976) (citations and internal quotations omitted) (emphasis added).

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The case of Elliott Williams ("Mr. Williams") is one of those "worst cases" as described by the Court in *Estelle.* Indeed, *Chief Deputy Michelle Robinette*, who oversees the day-to-day operations of the Jail, *admits that Mr. Williams was subjected to* ***"inhumane"*** *treatment which* ***"lack[s]... human decency."*** Robinette Depo. (Ex. 1) at 194:12-33 (emphasis added); *see also id.* at 199:16 – 200:3; 247:16 – 248:4. It is no mere exaggeration to say that the continuing and unconscionable failure to treat Mr. Williams' serious, emergent and obvious mental health and medical needs produced "physical torture" and a "lingering death". Over the course of approximately six (6) days in October of 2011, Mr. Williams repeatedly came into contact with law enforcement officers, detention officers ("D.O.'s"), nurses, doctors and other health care providers. Each of these professionals had an opportunity and duty to help Mr. Williams. Any one of these professionals could have saved Mr. Williams' life. Yet, none of them bothered to take even the most minimal steps to address Mr. Williams' conspicuous medical needs and desperate pleas for help. Rather, as vividly displayed by the video recording of the

last fifty-one (51) hours of Mr. Williams' life, they chose to idly watch as he slowly and painfully died before their very eyes. *See* Cell #1 Video (Ex. 2).[1]

The death of Mr. Williams was no freak accident. On the contrary, his death was as foreseeable as it was preventable. For many years, Defendants Sheriff Stanley Glanz has been ***repeatedly and continuously put on notice, by multiple credible sources, of serious, grave and systemic deficiencies in the mental health and medical treatment provided*** to inmates at the Jail. Importantly, on September 29, 2011, ***less than one month before Mr. Williams' death***, U.S. Immigration and Customs Enforcement ("ICE") and U.S. Department of Homeland Security's Office of Civil Rights and Civil Liberties ("CRCL") reported their findings in connection with an audit of the Jail's medical system as follows:

- ***"CRCL found a prevailing attitude among clinic staff of indifference…."***
- "TCSO doctors are using 'standing orders' in violation of state and federal guidelines. CRCL opinion is that TCSO Nurses are providing medication prior to doctor approval outside of nurses' authority."
- "Nurses are undertrained. Not documenting or evaluating patients properly."
- "Found two ICE detainees with clear mental/medical problems that have not seen a doctor."

ICE-CRCL Report, 9/29/11, (Ex. 3) at Glanz.02 00066 (emphasis added).

Sheriff Glanz repeatedly ignored explicit and dire warnings that his medical system was broken, taking either no remedial action whatsoever, or taking insincere half-

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[1] Plaintiff has provided the Court with an edited version of the original cell #1 surveillance video. An explanation of the edited video is provided in the Affidavit of Jeremy Lamberton, a professional videographer and film editor. *See.* Lamberton Aff. (Ex. 55)

measures intended only to temporarily placate auditors and accreditation agencies. Through his established policies, practices and customs, Sheriff Glanz disregarded known and substantial risks to the health and safety of inmates like Mr. Williams. Over the years, untimely treatment, preventable deaths and grossly inadequate and unsupervised care became commonplace at the Jail. An attitude of utter indifference to inmate health set in, culminating in the barbaric treatment of Mr. Williams. Had Sheriff Glanz taken reasonable measures to fix the medical system in a timely manner, Mr. Williams would be alive today. Tragically, however, he fell victim to an established culture and system of deliberate indifference to the serious medical needs of inmates at the Tulsa County Jail.

Sheriff Glanz's Motion for Summary Judgment (Dkt. #224) should be denied.

LCvR 56.1(c) Statement of Facts

A. Response to Sheriff Glanz's "Statement of Material Facts Not in Dispute"

1. Admit.

2. The fact that Mr. Williams was married to a "foreign national", Elia Patricia Lara-Williams' ("Ms. Williams"), is utterly immaterial. Plaintiff has filed a Motion in Limine regarding Ms. Williams' immigration status, and hereby adopts and incorporates that Motion in Limine as if fully stated herein. *See* Dkt. #225. Defendant Wells' testimony regarding what Earl Williams allegedly said is inadmissible hearsay. *See* Fed. R. Ev. 801; 802. The entirety of Sheriff Glanz's Statement of Material Fact #2 constitutes irrelevant and inadmissible character evidence. *See* Fed. R. Ev. 401, 402, 403 and 404. More fundamentally, Sheriff Glanz misrepresents the deposition testimony cited. Nowhere in the transcript pages cited does Defendant Wells indicate that Ms. Williams had "left [Mr. Williams] and emptied his bank account", nor do the transcript

pages cited reflect that Mr. Williams had been "abusive" to his parents, as Sheriff Glanz represents to the Court. *See* Dkt. #224-1 at 56:9-11; 83:6 – 84:1; 166:9-18.

3. There is no evidence in this case that Mr. Williams was ever a threat to anyone but himself. The Arrest and Booking Report filled out by Defendant Wells indicates that when he approached Mr. Williams at the hotel parking lot (on October 21, 2011), it was ***"readily apparent*** that [Mr. Williams] was having a ***mental breakdown."*** Dkt. #222-3 at 7 of 21 (emphasis added). The Arrest and Booking Report further states that at various times prior to the arrest, Mr. Williams was: "rambling on about God", "eating dirt", "rambling on incoherently", stating that he was going to commit suicide and repeatedly asking the OPD officers shoot him. *Id.* at 7-8 of 21; and 20 of 21 **("[Mr. Williams] attempted to have officers kill him.")** (emphasis added). Under "Warning Indicators", Defendant Wells noted that Mr. Williams was "suicidal". *Id.* at 7 0f 21. The Arrest and Booking Report does not indicate that Mr. Williams ***ever*** threatened to harm anyone but himself. *Id.* at 7-9 of 21. Review of the Owasso Police Department ("OPD") video from the scene of the arrest further confirms that Mr. Williams never threatened to harm anyone but himself. *See* Dkt. #222-4; and 222-6. According to Dr. Steven K. Hoge, Plaintiff's expert in forensic psychiatry, Mr. Williams was ***"obviously, overtly, beyond a doubt, even to a lay person, severely mentally disturbed"*** at the scene of the arrest. Hoge Depo. (Ex. 4) at 162:21 – 164:5 (emphasis added).

4. Prior to Mr. Williams' arrest, OPD Officer Wolery "had Owasso Communications Officers contact COPES in an attempt to have them come to the scene and speak to" Mr. Williams. Dkt. #222-3 at 8 of 21. "COPES" is an acronym for "Community Outreach Psychiatric Emergency Services". *See* COPES Webpage (Ex. 5).

COPES is a mobile psychiatric service provided through Family and Children's Services. *Id.* In Defendant Wells' experience, after a call to COPES is made, COPES will send a professional out to the scene to speak with the individual in crisis and COPES will then "make a determination as to whether … in their more trained or valid opinion …there's a need for … detention." Wells Depo. (Ex. 6) at 74:8 – 75:3. After Officer Wolery requested COPES, Defendant Wells and Officer Wolery were "advised by Owasso Communications Officers that COPES had been notified and were enroute" to the scene. Dkt. #222-3 at 8 of 21; Wells Depo. (Ex. 6) at 76:1-6. Nonetheless, Defendant Wells did not wait for COPES to arrive. *See, e.g.,* Wells Depo. (Ex. 6) at 99:9 – 103:23. Rather, Defendants Wells and Sergeant H. D. Pitt decided to cancel COPES based, in large part, on their determination that Mr. Williams had become "aggressive". *Id.* Yet, according to the COPES Webpage, COPES "responds around the clock to … adults experiencing a severe emotional or behavioral disturbance or psychiatric emergency, including: … [t]hreats of suicide …. [s]uicidal thoughts… [and] ***[a]ggressive behavior….*** *"* *See* COPES Webpage (Ex. 5) (emphasis added).

In addition, Defendant Wells opted to pepper spray and arrest Mr. Williams -- for misdemeanor obstruction -- rather than transport Mr. Williams to the Tulsa Center for Behavioral Health ("TCBH"). *See, e.g.,* Wells Depo. (Ex. 6) at 94:3-20; 100:9-13; 101:20-23; 104:21-25; 111:20 – 112:2. TCBH is an inpatient adult psychiatric facility that is available -- 24 hours a day and 7 days a week -- to any person believed to be in a mental health or substance abuse crisis. *See* Price Depo. (Ex. 7) at 19:16 – 20:6; 22:21-24. Nonetheless, Defendant Wells concluded that TCBH was not an option for Mr. Williams based upon his purported "understanding through word of mouth" that TCBH

would not evaluate any individual who was "combative or aggressive." *See* Wells Depo. (Ex. 6) at 101:10-23. Defendant Wells does not recall who allegedly told him that TCBH would not evaluate combative or aggressive individuals. *Id.* at 111:6 – 112:15. In any event, Leah Price, Executive Director of TCBH, has testified that TCBH does, in fact evaluate and admit combative and aggressive individuals on a *routine basis. See* Price Depo. (Ex. 7) at 8:8-20; 16:8 – 17:11. Indeed, according to Executive Director Price, Defendant Wells' testimony that TCBH will not evaluate combative or aggressive individuals is ***simply untrue***. *Id.* at 18:6-24.

5. After the arrest, Mr. Williams was transported to OPD headquarters, pursuant to the OPD booking process. *See* Wells Depo. (Ex. 6) at 101:10-23. After arriving at OPD headquarters, Mr. Williams continued to exhibit behavior consistent with acute and severe psychosis. *See, e.g.,* Wells Depo. (Ex. 6) at 128:12 – 131:5; Hoge (Verified) Report (Ex. 8) at 13; Video of Owasso Cell (Ex. 9); Dkt. #224-4. Indeed, Defendant Wells directly observed Mr. Williams barking like a dog after having removed his pants in an Owasso holding cell. Wells Depo. (Ex. 6) at 128:12 – 131:5; *see also* Incident Report (Ex. 10) at GLANZ-EW3061. The "Intake Screening Form" completed by OPD indicates that when asked whether he was suicidal, Mr. Williams answered "yes." Dkt. #22-3 at 10 of 21. Still, *none of the responsible OPD officers ever <u>even attempted</u> to find a mental health care facility that would take Mr. Williams. See* Wells Depo. (Ex. 6) at 130:22 – 131:5. According to Dr. Hoge, Defendant Wells and the other responsible OPD officers "disregarded the acute mental health needs of Mr. Williams." Hoge (Verified) Report (Ex. 8) at 15.

6. Admit.

7-8. On October 22, 2011, Mr. Williams was transported to the Tulsa County Jail and escorted by two of the OPD Defendants -- Wells and Townsend -- into the Jail's pre-booking area. *See, e.g.,* OSBI Report (Ex. 11) at 17; 27[2]; Incident Report (Ex. 10) at GLANZ-EW3041; Tulsa Jail Pre-Booking Video (Ex. 12). While in the pre-booking area, Defendant Wells grabbed Mr. Williams' left wrist in an attempt to cuff him, and then put Mr. Williams in an arm bar hold to take him down. *See* Tulsa Jail Pre-Booking Video (Ex. 12); OSBI Report (Ex. 11) at 17; 27; Incident Report (Ex. 10) at GLANZ-EW3076-77. Suddenly, while Officer Wells' arm was wrapped around Mr. Williams' neck, Defendant Townsend swept Mr. Williams' feet from under him. Mr. Williams was taken down by his head and neck and slammed on the floor with Wells falling on top of him. *Id.* Video of the take-down shows Mr. Williams' ***head hitting the floor with significant force.*** *See* Tulsa Jail Pre-Booking Video (Ex. 12). After Mr. Williams was taken down in the booking area, it was ***"obvious"*** that he was ***"having a difficult time standing."*** Incident Report (Ex. 10) at GLANZ-EW3061 (emphasis added). According to Sheriff Glanz, after watching the surveillance video, his investigators were concerned that Mr. Williams had broken his neck when he was taken down in the pre-booking area. *See* Glanz Depo. (Ex. 21) at 45:14 – 46:16. Yet, no apparent effort was made to assess Mr. Williams or provide him with any medical care.

9. It is uncontested that Mr. Williams was "compliant with [TCSO] detention

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2 Chuck Jeffries of the Oklahoma State Bureau of Investigation ("OSBI") investigated the death of Mr. Williams. *See* Jeffries Depo. (Ex. 14) at 15:10-18. Mr. Jeffries prepared a Report (referred to herein as the "OSBI Report"), summarizing the investigation. *Id.* at 24:2-20. TCSO relied upon the OSBI Report in conducting its own internal investigation of Mr. Williams' death. *See, e.g.,* McKelvey Depo. (Ex. 15) at 31:23 – 34:1. The OSBI Report is the type of report that OSBI typically generates as part of its regular course of business. *See* Jeffries Depo. (Ex. 14) at 24:21-24.

staff" upon entering the Jail's slider area. Incident Report (Ex. 10) at GLANZ-EW3061. Mr. Williams never actually completed the booking process. *Id.* at GLANZ-EW3140; *see also* Housley Depo. (Ex. 13) at 34:16 – 37:4.

10. After being turned over to TCSO / Tulsa County Jail custody, Mr. Williams was escorted by detention staff to cell # 10, a holding cell in the booking area. *See, e.g.,* Incident Report (Ex. 10) at GLANZ-EW3061.

11-16. While Mr. Williams was in cell # 10, he rammed his head into the glass window on the cell door, bounced off and fell to the floor. *See, e.g.,* OSBI Report (Ex. 11) at 34; Incident Report (Ex.10) at GLANZ-EW3061. Mario Wilson, an inmate at the Jail, witnessed Mr. Williams hit his head and fall to the ground. *See* Incident Report (Ex.10) at GLANZ-EW3061. According to Sheriff Glanz's own investigation, Wilson informed corrections and nursing staff that Mr. Williams had been injured, but the staff ***"did not respond very quickly"***. *Id.* Wilson estimates that it took ***"a little over twenty" minutes*** for anyone to check on Mr. Williams. *Id.*

Almost immediately after hitting his head in cell # 10, Mr. Williams began complaining that he was paralyzed and could not stand or walk. For instance, D.O. Heather Byrd has reported that when she entered cell # 10 on October 22, Mr. Williams complained that his arms and legs were "numb" and that he could not stand up. OSBI Report (Ex. 11) at 6. When D.O. Jonathan Hall entered cell # 10, he found Mr. Williams lying on his back and reporting that he "couldn't move". *Id.* at 10. Mr. Williams notified D.O. Monica Holloway that he had rammed his head on the cell door and that he ***felt like his neck was broken.*** *Id.* at 13; *see also* Incident Report (Ex. 10) at GLANZ-EW3080 ("Holloway asked what was wrong and ***Elliot said that his neck felt like it was***

broke...."). Sergeant Jack Reusser also heard Mr. Williams say that he could not move. *See* Reusser Depo. (Ex. 16) at 56:3-14.

At approximately 3:00 am on October 22, 2011, Nurse Kimberly Hughes, who was employed by Correctional Healthcare Companies, Inc. ("CHC"), the Jail's medical provider, observed Mr. Williams in cell # 10; Mr. Williams made "verbal complaints to Nurse Hughes that he **'Broke [sic] his Neck.'"** Executive Summary D-11-026, from Cpl. McKelvey to Undersheriff Edwards, 3/2/12 (hereinafter "Executive Summary") (Ex. 17) at GLANZ-EW3143 (emphasis in original). *See also* OSBI Report (Ex. 11) at 14 (Mr. Williams stated to Nurse Hughes that he had ***"head butted the door"*** and ***"that he was paralyzed."***) (emphasis added); Incident Report (Ex. 10) at GLANZ-EW3082. Nurse Hughes massaged Mr. Williams' neck and left him in cell #10. *See, e.g.,* Incident Report (Ex. 10) at GLANZ-EW3082-83. Nurse Hughes did not document her encounter with Mr. Williams, though she concedes that she should have. *Id.* Further, Nurse Hughes reported to the oncoming nurse that Mr. Williams was "fine", despite his complaints of paralysis. *See* Hughes Disciplinary Action Report (Ex. 18).

By the time Captain Tommy Fike encountered Mr. Williams in cell # 10 later on in the morning of October 22, Mr. Williams had both urinated and defecated on himself. *See, e.g.,* OSBI Report (Ex. 11) at 9; Incident Report (Ex. 10) at GLANZ-EW3068; Fike Depo. (Ex. 19) at 51:8 – 54:15. It was clear to Captain Fike that Mr. Williams had mental health issues. Fike Depo. (Ex. 19) at 76:7-24. Captain Fike believed that Mr. Williams was "faking" paralysis. *Id.* at 90:8 – 91:11. Captain Fike remembers Mr. Williams stating that he was in ***"constant pain...."*** Incident Report (Ex. 10) at GLANZ-EW3097) (emphasis in original).

According to the Sheriff's own investigation, there were at least four (4) detention staff supervisors and three (3) nurses who interacted with Mr. Williams in cell # 10, ***"all [of whom] had knowledge of [Mr. Williams'] complaints of neck injury."*** Executive Summary (Ex. 17) at GLANZ-EW3144 (emphasis added). It is nonetheless uncontested that for ***"ten and a half (10 ½) hours, Mr. Williams was left untreated in holding cell #10."*** *Id.* at GLANZ-EW3143 (emphasis added).

Dr. Scott Allen, Plaintiff's correctional health expert, has opined that Mr. Williams' neck should have been stabilized as a "*minimal*" measure, but that "his neck [was] never stabilized and he [was] never evaluated properly nor sent to an outside hospital." Allen (Verified) Report (Ex. 20) at 21 (emphasis in original); *see also id.* at 27.

17. The evidence cited by Sheriff Glanz (i.e., p. 7 of the Incident Report) does ***not*** support the assertion that "[d]etention staff deferred to Nurse Hughes' medical impressions." *See* Dkt. #224-2 at 7. More fundamentally, and as discussed more fully *infra*, the question of whether detention staff relied on nursing staff with respect to medical decisions is utterly immaterial. *See, e.g.,* Glanz Depo. (Ex. 21) at 38:22-25 (Sheriff Glanz admitting that he is ultimately responsible for inmate healthcare); *see also Cox v. Glanz,* 2014 WL 903101, *7 (N.D. Okla. Mar. 7, 2014) (finding that Sheriff Glanz has recognized that he "is ultimately responsible for the health and safety of inmates and for ensuring that mental health treatment is provided to inmates.").

18. While detention staff and medical staff may have "checked" on Mr. Williams in cell #10, he was plainly not provided with ***any*** actual medical care, despite the obvious and emergent need. *See, e.g.* Executive Summary (Ex. 17) at GLANZ-

EW3143; Allen (Verified) Report (Ex. 20) at 27; Hoge (Verified) Report (Ex. 8) at 18; Incident Report (Ex. 10) at GLANZ-EW3065.

19. After Mr. Williams told D.O. Ed White that he could not move, at approximately 1:30 pm on October 22, D.O. White brought Nurse Faye Taylor to cell #10. *See* Incident Report (Ex. 10) at 3067. Nurse Taylor and D.O. White began talking to Mr. Williams and attempted to get Mr. Williams to respond. *Id.* However, Mr. Williams was "unable to get up", so Nurse Taylor called a medical emergency. *Id.* Nurse Taylor further observed that Mr. Williams was "not making any sense verbally...." *Id.*

20-22. After the medical emergency was called, Mr. Williams was placed on a gurney by detention staff and taken to the Jail's medical unit shower area so that the feces could be cleaned off of him. *See* Incident Report (Ex. 10) at GLANZ-EW3067-68. While being transported to the medical unit shower, Mr. Williams continued to exhibit behavior consistent with severe mental health problems and physical injuries. For example, Mr. Williams repeatedly insisted that something needed to be "cut" out of him and stated that he wanted nursing staff to kill him. *See, e.g.,* OSBI Report (Ex. 11) at 7; Williams Medical Records (Ex. 22) at p. 6/17. One of the nurses was "cussing" at Mr. Williams. Latham Depo (Ex. 23) at 20:11-15. The nurse was telling Mr. Williams that he should be "ashamed" of himself, to get his "nasty ass" in the shower and to ***"quit faking"***. *Id.* at 20:16 – 21:1 (emphasis added).

TCSO supervisors -- Captain Fike and Sergeant Hinshaw -- attempted to get Mr. Williams into the medical unit shower. *See, e.g.,* Incident Report (Ex. 10) at GLANZ-EW3067-68. Once again, Mr. Williams complained that he **"could not move"**. *Id.* at GLANZ-EW3068; GLANZ-EW3136-37 (emphasis in original). Captain Fike and

Sergeant Hinshaw ***"dumped Mr. Williams off of [the] gurney*** that was 2 to 3 feet high [into the shower] ***after [Mr. Williams] had been telling [Fike and Hinshaw] that he couldn't move and was paralyzed...."*** Robinette Depo. (Ex. 1) at 152:20-25 (emphasis added); *see also* Latham Depo (Ex. 23) at 6:8-10; 7:10-17; 19:9 – 27:9; Latham Interview Tr. (Ex. 24); Incident Report (Ex. 10) at GLANZ-EW3136-37. After Mr. Williams was in shower, Captain Fike and Sergeant Hinshaw "tore" or "tweaked" Mr. Williams' pants off and "rolled" him to get his shirt off. Incident Report (Ex. 10) at GLANZ-EW3068. According to Captain Fike, Mr. Williams ***"would not stand up*** but we did give him a shower anyway." *Id.* (emphasis added). When Fike and Hinshaw dumped Mr. Williams off the gurney into the shower, ***Mr. Williams hit his head***, which made an audible "smack" or "boom" sound. Latham Depo. (Ex. 23) at 24:11-23; Incident Report (Ex. 10) at GLANZ-EW3136-37. After Fike and Hinshaw dumped Mr. Williams into the shower they simply shut the door and left him there. *Id.* 25:3-15.

D.O. Christopher Leverich witnessed Mr. Williams lying face down in the shower; Mr. Williams was ***"screaming 'help me.'"*** Incident Report (Ex. 10) at GLANZ-EW3094 (emphasis in original). Mr. Williams was left alone and paralyzed in the shower for at least one hour. Latham Depo. (Ex. 23) at 26:20 – 27:7; Incident Report (Ex. 10) at GLANZ-EW3092.

23-25. In the late afternoon of October 22, Mr. Williams was moved from the shower area to cell # 26 -- which is also in the medical unit. *See, e.g.,* Incident Report (Ex. 10) at GLANZ-EW3069-70; 3090. D.O. Carmelita Norris and D.O. Dakota Walsh encountered Mr. Williams for the first time -- in cell # 26 – during the evening of October 22, 2011. *See* Incident Report (Ex. 10) at GLANZ-EW3104; 3106-07. Mr. Williams was

lying on his back naked in cell #26. *Id.* at 3107. D.O. Norris observed that Mr. Williams could not sit up, and she never saw Mr. Williams move his legs or walk. *Id.* at 3105. ***Mr. Williams informed D.O. Walsh that he was unable to move or drink water on his own.*** *Id.* at 3105-07. Mr. Williams asked for water and said, ***"look, there's that water in the cup, and I haven't drank [sic] it. I can't move."*** *Id.* at 3107 (emphasis added). Both Norris and Walsh claim that they asked Nurse Ray Stiles whether something was wrong with Mr. Williams, but that Nurse Stiles seemed unconcerned. *Id.* at 3106 – 3107.

At 11:11 pm on October 22, Nurse Stiles entered the following "progress note":

> "***[Mr. Williams] states he cannot walk***. However booking staff states he did not use wheel chair or any other walking aid when brought into jail. ***Continues to tell Nursing staff here that he just cannot walk***.... **Wants to be waited on."**

Medical Records (Ex. 22) at GLANZ-EW0093 (emphasis added). It was Nurse Stiles' perception that Mr. Williams "did not want to do anything for himself" and wanted the staff to "do everything for him." Stiles Depo. (Ex. 25) at 47:11-21. Dr. Allen criticizes Nurse Stiles' note, as well as other similar notes in the Medical Records, as reflecting an "apparent prejudicial and dismissive approach to Mr. Williams' complaints...." Allen (Verified) Report (Ex. 20) at 21. There is no record of Mr. Williams being provided with *any* medical examination or treatment on October 22. *See, e.g.,* Medical Records (Ex. 22) at GLANZ-EW0093.

Very little is known about what happened on October 23, 2011. Nurse Stiles was on duty on October 23. *See* Stiles Depo. (Ex. 25) at 58:16 – 59:8. At 6:27 am on October 24, which was toward the end of his shift that began on October 23, Nurse Stiles noted that Mr. Williams ***"continue[d] to state he [could not] walk o[r] move."*** Medical Records (Ex. 22) at GLANZ-EW0094 (emphasis added). Again, there is no

documentation that Mr. Williams was provided with any medical assessment or treatment of any kind. *Id.*

26. As discussed more fully *infra*, the question of whether detention staff relied on nursing staff with respect to medical decisions is utterly immaterial as Sheriff Glanz is ultimately responsible for the medical care provided to inmates at the Jail. *See, e.g.,* Glanz Depo. (Ex. 21) at 38:22-25. Furthermore, while Dr. Scott Allen, Plaintiff's correctional healthcare expert, testified that it was reasonable for detention staff to rely on the medical staff with respect to *medical* decisions, Dr. Allen further testified that the lack of care provided to Mr. Williams by detention staff with respect to feeding, toileting and fluids is ***"inhumane"***, ***"shocks the conscience"*** and was ***"undignified"***. *See, e.g.,* Allen Depo. (Ex. 26) at 187:1 -- 188:10 (emphasis added). Chief Robinette largely *agrees* with Dr. Allen. *See* Robinette Depo. (Ex. 1) at 194:12-33 (testifying that Mr. Williams received ***"inhumane"*** *treatment which* ***"lack[s]... human decency."***) (emphasis added).

27-29. Patricia Benoit, a purported "Licensed Marriage and Family Therapist" who was employed at the Jail, told TCSO investigators that some sort of examination -- an "arm drop" test -- of Mr. Williams was conducted on October 24, 2011 to determine "whether or not he was really ***paralyzed."*** Incident Report (Ex. 10) at GLANZ-EW3074 (emphasis in original). While there are three (3) notes from October 24 in Mr. Williams' medical records, ***none*** of those notes makes ***any*** mention of such an examination. *See* Medical Records (Ex. 22) at GLANZ-EW0094. In any event, even if such an "arm drop" test was performed on October 24, this "arm drop" test would not provide any

information as to whether Mr. Williams' ***legs*** were paralyzed. *See, e.g.,* Harnish Depo. (Ex. 27) at 49:6 – 50:4.

At 9:44 am on October 24, Nurse Charity Chumley merely reported that Mr. Williams was "lying on bed with out clothes [and] refusing to answer any questions" *Id.* At 12:36 pm on October 24, John Bell, Licensed Professional Counselor ("LPC"), reported his observations of Mr. Williams in cell # 26 as follows:

> "[Mr. Williams] would lie on bed and not respond to this writer's questions. [Mr. Williams] **acted as if paralyzed** saying **'I want water'."**

Id. (emphasis added). Mr. Bell further noted his plan to "[r]efer to Dr. [Stephen] Harnish for med review." *Id.* At the time, Dr. Harnish was employed part-time as the sole licensed psychiatrist at the Jail. *See* Harnish Depo. (Ex. 27) at 13:10-15; 25:3-13.

30. Plaintiff contests Nurse Stiles' claim that he saw Mr. Williams standing at the urinal in cell #26. First, Nurse Stiles' contemporaneous notes in the medical records make *no mention* of Mr. Williams standing. *See* Medical Records (Ex. 22) at GLANZ-EW0093-94. Second, Nurse Stiles' explanation for the lack of documentation is patently absurd. That is, Nurse Stiles claims that he documented seeing Mr. Williams standing at the urinal, but that this documentation "disappeared" from the medical records. *See, e.g.,* Stiles Depo. (Ex. 25) at 38:19 – 39:11; 43:9 – 44:9; 59:15 – 61:8. Third, while Nurse Stiles testified that he told TCSO investigator Jeremy Yerton about his notes "disappearing" from the computer system, this testimony is belied by actual transcript of the Yerton interview. *See* Stiles Depo. (Ex. 25) at 77:3 – 81:7; Stiles Int. Tr. (Ex. 28). Fourth, as Nurse Stiles readily acknowledges, he is the ***only witness in this case who claims to have seen Mr. Williams standing after he was taken to the medical unit.*** *See* Stiles Depo. (Ex. 25) at 60:18-23.

31. D.O. Leticia Glover reported that Mr. Williams was "yelling" "throughout the night...." of October 24. Incident Report (Ex. 10) at GLANZ-EW3093. D.O. Glover informed the Jail nursing staff that **Mr. Williams "wants something"** and asked the nursing staff to **"at least go down there and look at him."** *Id.* (emphasis added). However, none of the nurses bothered to check on Mr. Williams. *Id.* at GLANZ-EW3094.

32-37. On the morning of October 25, 2011, the Jail's "Mental Health Team", which included Mr. Bell, Ms. Benoit and Dr. Harnish, had a meeting. *See* Incident Report (Ex. 10) at GLANZ-EW3071; Harnish Depo. (Ex. 27) at 44:3 – 46:12. During this meeting, ***Dr. Harnish was informed that Mr. Williams was claiming to be paralyzed and was not moving.*** *See* Harnish Depo. (Ex. 27) at 45:4-9; *see also* OSBI Report (Ex. 11) at 11 (during this meeting, the Mental Health Team **notified** Dr. Harnish that Mr. Williams was **"alleging that he had run into the door and was paralyzed."**). Also during this meeting, there was a "concern" expressed that Mr. Williams was "faking" paralysis. *Id.* at 51:10-13. Nonetheless, Dr. Harnish did ***not*** order that Mr. Williams receive ***any*** type of medical examination to determine the pathology of the paralysis. *Id.* at 46:7-12. Dr. Harnish did ***not order*** that Mr. Williams receive ***a neurological examination*** to rule out a physical cause of the paralysis. *Id.* at 50:5 – 52:13. Instead, Dr. Harnish issued an order for Mr. Williams to be placed in a video-monitored cell. *Id.* at 98:23 – 99:1. ***The purpose of placing Mr. Williams in a video-monitored cell was to determine if he was "faking" paralysis.*** Robinette Depo. (Ex. 1) at 123:6-14 (emphasis added).

According to Dr. Allen, "[e]arly on, a working diagnosis of malingering appears

to be made"; and "[a]lthough ***malingering is a diagnosis of exclusion, meaning real pathology must first be ruled out by doing a thorough evaluation to exclude real pathology, no*** evident ***effort*** is made to medically assess [Mr. Williams'] complaints of leg paralysis." Allen (Verified) Report (Ex. 20) at 21 (emphasis added). Similarly, Dr. Hoge opines that "[i]n order to diagnose malingering, ***efforts need to be made to rule out the medical condition in question."*** Hoge (Verified) Report at 22 (emphasis added). Yet, as Dr. Hoge found, and the evidence reflects, "[n]o efforts were made by Dr. Harnish or by another clinician to do so." *Id.*

At approximately 8:27 am on October 25, 2011, two D.O.'s drug Mr. Williams on a blanket from cell # 26 to medical cell # 1, which is a video-monitored cell. *See, e.g.,* Cell #1 Video (Ex. 2); Harnish Depo. (Ex. 27) at 101:8-12.

At 8:39 am, a Styrofoam cup of water was placed in Mr. Williams' cell at his feet and out of his reach. *See, e.g.,* Cell #1 Video (Ex. 2). ***This was the only cup of water placed in cell # 1 from October 25 to the time that Mr. Williams died on October 27, 2011.*** *Id.*

At 9:07 am on October 25, Dr. Harnish entered cell # 1 and met with Mr. Williams for the first -- and last -- time. *See* Cell #1 Video (Ex. 2); Incident Report (Ex. 10) at GLANZ-EW3071; Medical Records (Ex. 22). The video shows Dr. Harnish speaking to Mr. Williams for approximately fifteen minutes. *See* Cell #1 Video (Ex. 2); Harnish Depo. (Ex. 27) at 91:19-20. At the time, Mr. Williams was lying flat on his back, immobile with only limited use of his arms. *See* Cell #1 Video (Ex. 2).[3]

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[3] Dr. Harnish did move the cup of water within Mr. Williams' reach, but did not assure that Mr. Williams could actually lift the cup, and did not provide him with any assistance in lifting the cup.

After meeting with Mr. Williams, Dr. Harnish noted that Mr. Williams: ***"claimes [sic] he cannot move"***, "claimed not to know where he is", ***demanded a bucket of water to drink*** and "admitted to having been at [Tulsa Center for Behavioral Health] in the past." Medical Records (Ex. 22) at GLANZ-EW00098. Without conducting or ordering any physical examination or assessment, Dr. Harnish simply chose to **"[d]oubt** [the] medical etiology of [Mr. Williams'] **claimed paralysis."** *Id.* (emphasis added). After speaking with Mr. Williams for around fifteen minutes, Dr. Harnish left Mr. Williams in cell #1 and never saw him again. *See* Cell #1 Video (Ex. 2); Medical Records (Ex. 22) at GLANZ-EW0098. Dr. Harnish's only "plan" was to "place [Mr. Williams in the] video monitored cell and respond to any medical/psychiatric condition as determined by ... monitoring." *Id.* As Dr. Allen has observed, the video monitoring was intended to "catch" Mr. Williams faking paralysis; however, the only thing caught on video was "glaring inhumanity and lack of professionalism" and the utter absence of medical care. Allen (Verified) Report (Ex. 20) at 29.

At 10:11 am on October 25, a food container was tossed onto the floor of cell #1 outside of Mr. Williams' reach. *See* Cell #1 Video (Ex. 2). Between 1:15 pm and 2:12 pm, Mr. Williams struggled, without success, to grab the cup of water and lift it to his lips. *Id.* No one ever entered cell # 1 to assist Mr. Williams with the cup of water. *Id.*

At 4:41 pm on October 25, a second food container was dropped onto the floor of cell # 1. *See* Cell #1 Video (Ex. 2). At 4:45 pm, Mr. Williams attempted to open the food container and once again attempted to lift the cup of water. *Id.* However, Mr. Williams was clearly incapable of performing these basic tasks on his own. *Id.* Still, no one provided Mr. Williams with any assistance. *Id.*

As Sheriff Glanz admits, his staff should have made sure that Mr. Williams was able to eat and should have assisted him with the cup of water. *See* Glanz Depo. (Ex. 21) at 73:4 – 74:13. Chief Robinette reviewed all fifty-one (51) hours of the video from cell #1 and determined that Mr. Williams was not properly fed or hydrated. *See* Robinette Depo. (Ex. 1) at 171:23 – 172:17. As Chief Robinette admits, ***"[n]one of [the] detention officers took the time to open the door to verify that he was eating or [to] assist him any."*** *Id.* (emphasis added).

At around 7 pm on October 25, Nurse Hughes reported for her shift in the medical unit. Incident Report (Ex. 10) at GLANZ-EW3083. Though she had first encountered Mr. Williams just three days prior in cell # 10, Nurse Hughes did not recognize him when she saw him for the second time in cell # 1. *Id.* Nurse Hughes opened the beanhole to cell # 1 and tried to talk to Mr. Williams, but Mr. Williams did not respond. *Id.* He was muttering incomprehensibly and lying still on his back. *Id.* When Nurse Hughes came back to cell #1 a second time, Mr. Williams was awake; he emphatically told Nurse Hughes that he needed water. *Id.* Nurse Hughes noted the cup of water on the cell floor and spoke to Mr. Williams through the beanhole, "get that cup." *Id.* Mr. Williams replied, "I can't, **I can't move."** *Id.* (emphasis added). Though Nurse Hughes again urged Mr. Williams to "grab the cup", it became clear that Mr. Williams simply "couldn't do it." *Id.* Nurse Hughes asked the D.O.'s on duty D.O.'s Steve Smith and Chrystal Rich, to open cell # 1 so that she could assist Mr. Williams. *Id.* at 3083-84. However, D.O.'s Smith and Rich ***refused to open the cell door*** for Nurse Hughes, citing an unspecified safety issue. *Id.* Nurse Hughes noted white residue on the side of Mr. Williams' mouth and told D.O.'s Smith and Rich that she was "worried" that Mr.

Williams could not get up and that he needed help. *Id.* Nonetheless, D.O.'s Smith and Rich would not open the door. *Id.* Ultimately, Nurse Hughes gave up and left, without ever providing Mr. Williams with any assistance. *Id.* Nurse Hughes failed to contact any of her supervisors or take any other action to ensure that Mr. Williams received any attention. *Id.*

No one entered Mr. Williams' cell on October 26. *See* Cell #1 Video (Ex. 2). At 7:26 am on October 26, Patricia Benoit, a marriage counselor and member of the Jail's "Mental Health Team", noted her observations and assessment of Mr. Williams: "[Inmate] still ***refusing to move*** or admit he can move"; ***"....psychosomatic paralysis."*** Medical Records (Ex. 22) at GLANZ-EW0095. Benoit never saw Mr. Williams move any part of his body, aside from his hands. *See* Incident Report (Ex. 10) at GLANZ-EW3122. Nonetheless, Benoit actually taunted Mr. Williams; specifically, Benoit told Mr. Williams that "***if he wanted to be bailed out*** by his parents....***he would have to walk*** to the car...." Medical Records (Ex. 22) at GLANZ-EW0095 (emphasis added). At this point, without any explanation, Mr. Williams had been detained at the Jail for (4) four days, on a minor offense, without bond being set.

At 7:49 am on October 26, Defendant Nurse Carmen Luca reported that Mr. Williams was "stating that **he cannot move and this begun (sic) a few days ago...."** Medical Records (Ex. 22) at GLANZ-EW0095 (emphasis added). Still, Nurse Luca provided no assistance or care for Mr. Williams. *Id.*; *see also* Cell #1 Video (Ex. 2).

At 11:12 am on October 26, Mr. Williams attempted -- without success -- to grasp and lift the one food container within his reach. *See* Cell #1 Video (Ex. 2). In the process, Mr. Williams accidentally knocked over the cup of water. *Id.* The cup was never

refilled or removed. *Id.* No one ever came to help Mr. Williams. *Id.*

38-43. At 5:10 am on October 27, 2011, the third, and final, food container was dropped onto the floor of cell # 1, this time through the bean hole. *See* Cell #1 Video (Ex. 2). Once again, the food container was dropped out of Mr. Williams' reach, and no one provided him with any assistance. *Id.*

At about 8:20 am on October 27, Mr. Bell, a member of the Jail's "Mental Health Team", went to cell # 1 and observed Mr. Williams through the beanhole. OSBI Report at 4; Cell #1 Video (Ex. 2). Mr. Bell noticed that Mr. Williams did not look well and had D.O.'s open the cell door. *Id.* at 4; *see also* Bell Depo. (Ex. 29) at 113:8-12. At the time, Mr. Bell was being "shadowed" by Dr. Khadga Limbu, a family medicine resident. Incident Report (Ex. 10) at GLANZ-EW3073. When Mr. Bell and Dr. Limbu entered the cell, Mr. Williams was lying on the floor with saliva pooled under his head. *See, e.g.,* Bell Depo. (Ex.29) at 113:13-16. Mr. Williams' speech was "unclear" and "mumbled". Medical Records (Ex. 22) at GLANZ-EW0096. Dr. Limbu observed that Mr. Williams had "stained vomitous on the side of his mouth" and that there were food containers on the floor which appeared to be "untouched". OSBI Report (Ex. 11) at 18. Dr. Limbu further noted that Mr. Williams' legs were not moving and that he was not responsive. *See* Incident Report (Ex. 10) at GLANZ-EW3117.

Dr. Limbu performed a "quick" physical examination of Mr. Williams, including a "planter reflex test", and noted that Mr. Williams "did not have much reflex." OSBI Report (Ex. 11) at 18; *see also* Incident Report (Ex. 10) at GLANZ-EW3117. Dr. Limbu was "really concerned" and believed that Mr. Williams "really needed a medical doctor to see him...." Incident Report (Ex. 10) at GLANZ-EW3117. Dr. Limbu was not

authorized to treat Mr. Williams as he was merely "shadowing the mental health team...." *Id.*

Mr. Bell and Dr. Limbu told Dr. Phillip Washburn that Mr. Williams needed to be seen. *See, e.g.,* Bell Depo. (Ex. 29) at 116:23 – 118:20; Incident Report (Ex. 10) at GLANZ-EW3073. At the time, Dr. Washburn served as the Jail's Medical Director. Incident Report (Ex. 10) at GLANZ-EW3074. Dr. Limbu specifically told Dr. Washburn that Mr. Williams looked sick, needed a CT scan and needed to go to the hospital. *Id.* at 3073; 3117-18. However, Dr. Washburn never checked on Mr. Williams. *See, e.g., id.* at 3120. Dr. Washburn has since claimed that he does not remember the conversation with Dr. Limbu and Mr. Bell about Mr. Williams, but admits that ***"[i]f it happened it was my bad."*** *Id.* at 3074 (emphasis in original). Dr. Washburn's explanation for what happened to Mr. Williams is that ***"[p]eople just die sometimes...."*** Washburn Depo. (Ex. 30) at 70:13 – 71:23 (emphasis added). *See also* Harrington Aff. (Ex. 31) at ¶ 23.

At 11:01 am on October 27, staff found Mr. Williams unresponsive in cell # 1. *See* Cell #1 Video (Ex. 2). Cosmetic attempts at CPR were made. *Id.* As observed by Dr. Allen, "the jail staff – both non-medical and medical - appear to have ***minimal to no competence in even basic life support."*** Allen (Verified) Report (Ex. 20) at 22-25 (emphasis added). Mr. Williams was pronounced dead at approximately 11:21 am. *See* Cell #1 Video (Ex. 2).

The Office of the Chief Medical Examiner has since determined that the cause of death was "complications of vertebrospinal injuries due to blunt force trauma." Autopsy / M.E. Report (Ex. 32) at 9. The Medical Examiner also noted an ancillary vitreous electrolyte analysis which showed a "dehydration pattern...." *Id.*

44-45. As an expert in orthopedics and spinal injuries, Dr. Khan cannot competently testify as to what Jail personnel "believed". However, Dr. Khan can, and has, opined that: (A) "[i]t was medically necessary for TCSO and CHC to stabilize Mr. Williams' cervical spine ***once he complained of neck pain, especially once he stated that he could not move his lower extremities.***"; (B) "[t]here were multiple times during [Mr. Williams'] incarceration when intervention should have and could have been performed to minimize the damage to Mr. Williams and the subsequent sequelae"; (C) "[i]t does not appear … that Mr. Williams was provided any assistance, medical or otherwise, by any employees of TCSO or CHC, after sustaining the traumatic cervical injury in the booking area on October 22, 2011"; and (D) "[h]ad TCSO and CHC stabilized Mr. Williams' cervical spine and timely referred him to an appropriate medical facility, ***his death would have been avoided.***" Khan (Verified) Report (Ex. 33) at 11-12 (emphasis added).

46-47. Dr. Hoge testified that detention and medical staff at the Jail: (A) knew that Mr. Williams was "complaining of paralysis"; and (B) disregarded known or obvious and substantial risks to Mr. Williams' health and safety. Hoge Depo. (Ex. 4) at 312:19 – 313:2 (emphasis added). Dr. Hoge further opines that ***"Dr. Harnish understood that Mr. Williams may have been injured and had actual paralysis"***, which should have been regarded as a medical emergency, yet no one on the mental health team contacted the medical team to assess Mr. Williams prior to the day of his death. Hoge (Verified) Report (Ex. 8) at 22 (emphasis added). Dr. Hoge opines that the mental health staff improperly diagnosed Mr. Williams as "malingering" without first ruling out actual paralysis. *Id.*

48. Dr. Allen worked in the field of correctional medicine for over fifteen (15) years, including three (3) years as "Medical Program Director" responsible for oversight

of the medical care at all adult jails and prisons in Rhode Island. *See* Allen (Verified) Report (Ex. 20) at 1. Dr. Allen co-founded the Center for Prisoner Health and Human Rights at Brown University. *Id.* He is currently a founding faculty member at the University of California-Riverside School of Medicine. *Id.* Dr. Allen has testified that -- of all the cases he is aware of -- the case-at-bar is ***"among the most, if not the most" inhumane and undignified*** treatment of an inmate in a correctional medical unit. Allen Depo. (Ex. 26) at 188:11 – 189:9. When defense counsel challenged Dr. Allen on this point, he testified as follows:

> Q. In the cases that you've reviewed as an expert and other cases in your role in the correctional healthcare community, you can't think of one, as you sit here today, that was more inhumane or more undignified?
>
> A. ***Well, no.*** I would say [one other] case would be in the same category ....

Id. (emphasis added). As Dr. Allen found, Mr. Williams' "*obvious needs* [we]re never taken seriously...." Allen (Verified) Report (Ex. 20) at 30. Dr. Allen further opines that this disregard of Mr. Williams' obvious needs is consistent with a "culture of inhumanity, neglect and disregard for the health and welfare of the inmates" at the Jail. *Id.* It is Dr. Allen's opinion that "***the medical care provided to Mr. Williams is so clearly inadequate as to amount to a refusal by the institution and its staff to provide essential care for a serious medical condition.***" *Id.* 28-29 (emphasis added).

49. Dr. Hoge is not competent to testify as to what the detention and medical staff "thought". Furthermore, the specific statement cited by Sheriff Glanz makes no mention of the Jail whatsoever. *See* Hoge Depo. (Ex. 4) at 303:18-23. What is more, Dr. Hoge made the statement in the context of his testimony that *Defendant Wells* did the "wrong thing" by failing to get Mr. Williams psychiatric care on an emergent basis,

despite Defendant Wells' knowledge that Mr. Williams "was seriously emotionally disturbed...." *Id.* at 301:10 – 303:4.

50-51. *See* Stat. of Fact(A)(38-43), *supra.*

52-53. Whether medical or detention staff physically caused Mr. Williams' vertobrospinal injuries is utterly immaterial. Plaintiff has not brought any excessive use of force claim. The claims in this case revolve around deliberate indifference to Mr. Williams' serious medial needs. Plaintiff further objects to Sheriff Glanz's reliance on the opinions of Ernest L'Heureux, M.D. Dr. L'Heureux was endorsed as an expert by Correctional Healthcare Companies, Inc. ("CHC"), Correctional Healthcare Management, Inc. ("CHM") and Correctional Healthcare Management of Oklahoma, Inc. ("CHMO") (hereinafter, collectively referred to as the "CHC"). *See* CHC Expert List (Ex. 34). Sheriff Glanz has ***not*** endorsed Dr. L'Heureux as an expert, or any other expert, and Plaintiff has settled her claims against the CHC. Thus, Sheriff Glanz should not be permitted to rely on Dr. L'Heureux's opinions.

54-55. *See* Stat. of Fact(A)(44-48; 52-53), *supra.* Dr. Khan also opines that Mr. Williams' injuries were aggravated when he was transported on a gurney, without a spine board or C-Collar, and dropped off of the gurney onto the concrete Jail floor. *See* Khan (Verified) Report (Ex. 33) at 12.

56. *See* Stat. of Fact(A)(48), *supra.*

57. Admit. Plaintiff adds that CHC was under contract to provide medical and mental health care services to inmates at the Jail from June 20, 2005 through November 1, 2013. *See, e.g.,* Health Services Contract (Ex. 35) at GLANZ0192-201; Resp. to RFP, 4/26/10 (Ex. 36) at GLANZ0111; Houston Depo. (Ex. 37) at 73:24 – 74:2. Sheriff Glanz

is ultimately responsible for the health and safety of inmates at the Tulsa County Jail. *See* Glanz Depo. (Ex. 21) at 38:22-25; *see also Cox v. Glanz,* 2014 WL 903101, *7 (N.D. Okla. Mar. 7, 2014).

58-60. TCSO's "Triple Crown" status -- and history of NCCHC accreditation -- is dubious at best. *See* Stat. of Facts(B)(3-7, 11-13), *infra.* Further, Dr. Allen found that multiple NCCHC standards were violated in this case. *See* Allen (Verified) Report (Ex. 20) at 13-19.

61-63. *See* Stat. of Fact(A)(57), *supra.*

B. Additional Facts Precluding Summary Judgment

1. The video of Mr. Williams from cell #1 shows that his legs did not move for the final fifty-one (51) hours of his life. *See* Cell #1 (Ex. 2). As Dr. Allen has observed: (A) "[n]o medical staff physician ever examines Mr. Williams despite a history of trauma and his inability to move his legs"; and (B) "[w]ithout any exam or outside evaluation, he is determined to be faking his physical illness, ***despite clear evidence to the contrary."*** Allen (Verified) Report (Ex. 20) at 11.

2. Before Sheriff Glanz took over operation of the Jail, and CHC took over the health services program, there was a "mental health diversion" program in place at the Jail. Glanz Depo. (Cox) (Ex. 39) at 34:22 – 35:4; 38:24 – 39:13. Prior to Sheriff Glanz and CHC taking over, the Tulsa County social services director was receiving about one-hundred (100) mental health referrals a month from the Jail through the mental health diversion program. *Id.* Since Sheriff Glanz took over the Jail, there have been very few, if any, mental health referrals. *Id.* In the experience of Tammy Harrington, former Director of Nursing ("DON") at the Jail, "[d]espite … inadequate mental health staffing

and delays in treatment, inmates with serious, even emergent mental health needs were rarely referred to mental health professionals outside of the Jail." Harrington Aff. (Ex. 31) at ¶13.

3. The National Commission on Correctional Health Care ("NCCHC"), a corrections health accreditation body, conducted an on-site audit of the Jail's health services program in 2007. *See, e.g.,* Harrison Depo. (Ex. 41) at 7:9-16; 36:1-10. The NCCHC standards are not "best practices" but are merely standards for an "appropriate healthcare delivery system for correctional facilities." *Id.* at 115:4-19. Part of the rationale behind the NCCHC mental health standards is to alleviate or reduce risks to inmate health and safety. *Id.* at 64:8-19.

4. Sheriff Glanz relies exclusively on NCCHC accreditation as evidence that his medical system is adequate. *See* Glanz Depo. (Cox) (Ex. 39) at 83:25 – 84:13. Before the NCCHC auditors arrived, Sheriff Glanz had a meeting with the department heads at the Jail. *See* Maloy Depo. (Ex. 41) at 122:18 – 123:5. During this meeting, Sheriff Glanz emphasized the importance of the NCCHC audit and stated that CHC would lose the contract with TCSO if the Jail failed the audit. *Id.* Sheriff Glanz and Chief Deputy Tim Albin told the department heads to keep any "problem" medical charts away from the NCCHC auditors. *Id.* at 188:9 – 189:3. Diane Maloy, medical records supervisor at the Jail, was instructed by CHC and TCSO to hide and falsify medical records and charts. *See* Maloy Depo. (Ex. 41) at 117:10 – 120:22; 189:22-24. Specifically, Ms. Maloy and nursing staff were instructed to create "dummy charts" by removing unaddressed sick calls from medical records, concealing charts of inmates who were ill and altering records after the fact. *Id.* CHC representative Pam Hoisington would go through the charts and

remove portions she felt were "damning". *Id.* at 192:9-21. These "dummy charts" were created by CHC for the specific purpose of passing the NCCHC audit. *Id.* at 120:23 – 121:1. When the NCCHC auditors arrived, CHC and TCSO provided the auditors with baskets of the doctored "dummy" charts in hopes that the auditors would review the dummy charts and the Jail would pass the audit. *Id.* at 121:2 – 122:18. During the audit process, TCSO actually moved certain inmates around the Jail, and even off the premises, so that they could not speak with the auditors. *Id.* at 189:4-18.

5. Despite CHC and TCSO's efforts to defraud the auditors, an early report (spring of 2007) from NCCHC documented incomplete health assessments, failure to perform mental health screenings, failure to fully complete mental health treatment plans, failure to triage sick calls and failure to conduct quality assurance studies. *See* "NCCHC Action Plans", 4/17/07 (Ex. 42). Despite the efforts to conceal and alter the facts, the Tulsa County Jail failed the 2007 NCCHC audit. *See, e.g.,* Maloy Depo. (Ex. 41) at 123:15-18. A September 1, 2007 email from Dennis Hughes, an officer at CHC, expressed "disappointment with the audit results", acknowledging that CHC had "let our staff down, our client down, and to a **lesser extent** our patients." Email from Hughes to Payas, 9/1/07 (Ex. 43) (emphasis added).

6. NCCHC issued its final audit report for the 2007 accreditation period on November 9, 2007. See Harrison Depo. (Ex. 40) at 48:6-7; 49:7-13. The final 2007 NCCHC report included the following findings: (A) "health needs identified during receiving screening are not addressed in a timely manner"; (B) "the follow up of inmates with mental health needs is *not* of *sufficient* frequency *to meet their needs*"; (C) "there was a *noted delay in responding to routine mental health-related requests* submitted by

the inmates". Harrison Depo. (Ex. 40) at 50:17-23; 52:8-20; 62:4-17 (emphasis added).

7. Despite the serious deficiencies found by the NCCHC as part of the 2007 audit process, Sheriff Glanz *cannot point to a single mental health policy or practice that has changed* at the Jail since 2007. *See* Glanz Depo. (Cox) (Ex. 39) at 163:2-9. Similarly, CHC is unaware of a single practice that CHC changed as a result of the 2007 NCCHC audit. *See* Jordan Depo. (Cox) (Ex. 44) at 176:14-17.

8. After failing the 2007 NCCHC audit, the NCCHC only required that CHC and TCSO formulate written action plans to address how the identified deficiencies would be corrected. *See* Maloy Depo. (Ex. 41) at 123:25 – 124:10. Pam Hoisington, by this time Health Services Administrator ("HSA") at the Jail, drafted the written action plans. Maloy Depo. (Ex. 41) at 123:25 – 124:22. While Ms. Hoisington wrote out the plans of correction, those plans were never implemented. *Id.* NCCHC never followed up to ensure that the action plans were being implemented and followed. Harrison Depo. (Ex. 40) at 54:9-16.

9. In August 2009, the Oklahoma State Department of Health ("OSDH") conducted an investigation into the death of another inmate, Charles Jernegan. *See, e.g.,* Report on Death Investigation (Ex. 45) at GLANZ0277. The underlying facts of Mr. Jernegan's death are well-known to the Court and publicly documented. *See, e.g., Cox v. Glanz,* 2014 WL 903101 (N.D. Okla. Mar. 7, 2014). As reported by OSDH, while Mr. Jernegan "*indicated a form of mental illness* on his screening....it appeared that ***the proper steps as required in the [Oklahoma] Jail Standards were <u>not</u> taken.***" Report on Death Investigation (Ex. 45) at GLANZ0277. (emphasis added). Sheriff Glanz has described the Oklahoma Jail Standards as "*bare minimum*" requirements. Glanz Depo.

(Cox) (Ex. 39) at 102:5-12 (emphasis added). As a result of its investigation, OSDH found that: (1) Mr. Jernegan was not properly detained; (2) Mr. Jernegan received an inappropriate medical evaluation; (3) Mr. Jernegan was not housed in an area for more frequent observation; and (4) CHC's policy regarding the timeliness of a mental health evaluation was in direct conflict with the Oklahoma Jail Standards. Report on Death Investigation (Ex. 45) at GLANZ0277. OSDH issued a Notice of Violation to the Jail on August 12, 2009. *See* Notice of Violation (Ex. 46) (GLANZ0270-72).

Neither Sheriff Glanz nor CHC changed any policies or practices at the Jail as a result of OSDH's findings of deficiencies and violations with respect to the care provided to Mr. Jernegan. *See* Jordan Depo. (Ex. 44) at 206:1-5; Glanz Depo. (Ex. 4) at 131:5-10.

10. Less than a year after Mr. Jernegan died after hanging himself at the Jail, another inmate died after hanging himself at the Jail under very similar circumstances. *See, e.g.,* AMS-Roemer Report, 11/8/11 (Ex. 47) at CHM0169. As with Mr. Jernegan, AMS-Roemer determined that that there was a failure to properly triage the acuity of this inmate's request for mental health care and that the assessment process may have been too superficial to identify his true suicide risk. *Id.*

11. NCCHC conducted a second audit of the Jail's health services program in 2010. *See* 2010 NCCHC Report, 11/12/10 (Ex. 48) at Glanz.02 00069-89. After the audit was completed, the NCCHC placed the Tulsa County Jail on probation. *Id.* at 00069.

12. The NCCHC once again found numerous serious deficiencies with the health services program at the Jail. *See, e.g.,* 2010 NCCHC Report, 11/12/10 (Ex. 48). As part of the final 2010 Report, NCCHC found, *inter alia*, as follows: "The [Quality Assurance] multidisciplinary committee does not identify problems, implement and

monitor corrective action, nor study its effectiveness"; "There have been several inmate deaths in the past year.... The clinical mortality reviews were poorly performed"; "The responsible physician does not document his review of the RN's health assessments"; "the responsible physician does not conduct clinical chart reviews to determine if clinically appropriate care is ordered and implemented by attending health staff"; "...diagnostic tests and specialty consultations are not completed in a timely manner and are not ordered by the physician"; "if changes in treatment are indicated, the changes are not implemented..."; "When a patient returns from an emergency room, the physician does not see the patient, does not review the ER discharge orders, and does not issue follow-up orders as clinically needed"; and "... potentially suicidal inmates [are not] checked irregularly, not to exceed 15 minutes between checks. Training for custody staff has been limited. Follow up with the suicidal inmate has been poor." *Id.* at Glanz.02 00074, 00076, 00080, 00083, 00084, 00086.

13. Sheriff Glanz only read the first two or three pages of the 2010 NCCHC Report. *See* Glanz Depo. (Cox) (Ex. 39) at 140:16 – 141:8. Sheriff Glanz is unaware of any policies or practices changing at the Jail since the 2010 NCCHC Report was issued, other than the retention of an auditor. *Id.* at 162:25 – 163:13. *See also* Harrington Aff. (Ex. 31) at ¶ 9.

14. As noted *supra*, on September 29, 2011, U.S. Immigration and Customs Enforcement ("ICE") and U.S. Department of Homeland Security's Office of Civil Rights and Civil Liberties ("CRCL") reported their findings in connection with an audit of the Jail's medical system as follows: ***"CRCL found a prevailing attitude among clinic staff of indifference...."***; "*Nurses are undertrained.* Not documenting or evaluating

patients properly."; "Found two ICE detainees with clear mental/medical problems that have not seen a doctor."; and "*TCSO nurse documented mental issues during intake but failed to refer to a provider*". ICE-CRCL Report, 9/29/11, (Ex. 3) at Glanz.02 00066 (emphasis added).

15. Sheriff Glanz saw the ICE-CRCL Audit Report. *See* Glanz Depo. (Cox) (Ex. 39) at 153:16-23. Nonetheless, it is unclear what, if any, policies or practices have changed at the Jail since the ICE-CRCL Report was issued. *Id.* at 162:25 – 163:13. *See also* Harrington Aff. (Ex. 31) at ¶ 22.

16. As documented throughout this Response, Mr. Williams died in the Jail, due to deliberate indifference to his serious medical needs, less than thirty (30) days after the ICE-CRCL Report was issued.

17. On November 18, 2011, Advanced Medical Systems ("AMS"), the Jail's retained medical auditor, issued its Report to Sheriff Glanz finding multiple deficiencies with the Jail's medical delivery system, including "[documented] deviations [from protocols which] ***increase the potential for preventable morbidity and mortality"*** and issues with "nurses acting beyond their scope of practice [which] increases the potential for preventable bad medical outcomes." AMS Report, 11/8/11 (Ex. 47) at CHM0171-72. AMS specifically commented on no less than six (6) inmate deaths, finding deficiencies in the care provided to each. *Id.* at CHM0168-69; 0171. Once again, there is no evidence that any specific practices or policies changed at the Jail as a result of AMS's findings. *See, e.g.,* Glanz Depo. (Cox) (Ex. 39) at 182:13 – 183:10.

18. As part of its ongoing auditing function, and well after Mr. Williams' death, AMS continued to find serious deficiencies in the delivery of care at the Jail. *See,*

e.g., Corrective Action Review (Ex. 49) at CHM1935 – 1941; Response to 2012 Audit (Ex. 50) at CHM1969 – 1971. For instance, AMS has found "[d]elays for medical staff and providers to get access to inmates", ***"[n]o sense of urgency attitude to see patients, or have patients seen by providers"***, failure to follow NCCHC and CHC policies "to get patients to providers", and ***"[n]ot enough training or supervision of nursing staff".*** Corrective Action Review (Ex. 49) at CHM1935 – 1938. The identified lack of "urgency" involved "*a mental health professional (MHP) not making a timely referral to the psychiatrist." Id.* at CHM1936. During an April 2012 audit, AMS found that nurses were not providing timely triage of mental health requests and that they needed "education in mental health sick call triage...." Ltr. frm. Herr to Roemer, 6/13/12 (Ex. 51) at CHM1973 – 1975. After conducting an audit on April 16, 2012, Dr. Roemer found "deficiencies in meeting [the] majority of action plans ... [of which] [s]everal ... are of *major concern as they involve high risk issues*." Response to 2012 Audit (Ex. 50) at CHM1971 (emphasis added).

19. The former Director of Nursing at the Jail, Tammy Harrington, has stated that the provision of quality care to the inmates was simply not a priority at the Jail and rates the care provided as three (3) on a scale from one (1) to ten (10), one being the lowest. Harrington Aff. (Ex. 31) at ¶ 6. During her years working at the Jail, Nurse Harrington observed, *inter alia*: (a) an understaffed and overwhelmed Mental Health Team; (b) long delays in responding to mental health requests; (c) a chronic failure to triage inmates' requests for medical and mental health assistance; (d) a "check the box" intake/booking process that did not provide true medical and mental health screening and put inmates at substantial risk; (e) doctors refusing/failing to see inmates with life-

threatening conditions; (f) CHC's Health Services Administrator ("HSA") repeatedly instructing staff to doctor and falsify medical records; (g) a chronic lack of supervision of clinical staff; and (h) repeated failures to alleviate known and significant deficiencies in the health services program at the Jail. *See generally* Harrington Aff. (Ex. 31). *See also* Mason Aff. (Ex. 52). Nurse Harrington was terminated shortly after documenting issues that may have contributed to Mr. Williams' death. *See* Harrington Aff. (Ex. 31) at ¶ 24.

20. BOCC and TCSO continued to contract with CHC even after Mr. Williams' death and after many other serious deficiencies with the Jail's medical program had repeatedly been brought to light. *See, e.g.,* Resolution, 6-25-12 (Ex. 53). Despite his knowledge of the many identified problems with the Jail's health services program, Sheriff Glanz rates CHC as a nine (9) on a scale from one to ten (10). *See* Glanz Depo. (Cox) (Ex. 39) at 17:11-16.

21. Dr. Harnish was only at the Jail twenty (20) hours a week at a payment rate of $300 an hour. *See* Harnish Depo. (Ex. 54) at at 6:2-19; 9:4-8. Though Dr. Harnish was the only psychiatrist on staff at the Jail, he had (and has) *no supervisory authority* over the Jail's mental health staff (aka "Mental Health Team"). *Id.* at 13:15-17.

ARGUMENT

I. SHERIFF GLANZ IS *NOT* ENTITLED TO SUMMARY JUDGMENT ON PLAINTIFF'S CONSTITUTIONAL CLAIMS

A. There is Substantial Evidence That Sheriff Glanz is Liable in His Official Capacity and in His Individual Capacity (Under A Supervisory Liability Theory)

It is well-established that officials, such as Sheriff Glanz, "may be held *individually liable for policies they promulgate, implement, or maintain that deprive persons of their federally protected rights." Dodds v. Richardson,* 614 F .3d 1185, 1207

(10th Cir. 2010) (emphasis added). "To establish a claim of supervisory liability under § 1983, a plaintiff must plead and prove that '(1) the defendant promulgated, created, implemented or possessed responsibility for the continued operation of a policy that (2) caused the complained of constitutional harm, and (3) acted with the state of mind required to establish the alleged constitutional deprivation.'" *Cox v. Glanz,* 2011 WL 6740293, *4 (N.D. Okla. Dec. 22, 2011) (quoting *Dodds,* 614 F.3d at 1199).

A claim against a state actor in his official capacity "is essentially another way of pleading an action against the county or municipality" he represents and is considered under the standard applicable to § 1983 claims against municipalities or counties. *Porro v. Barnes,* 624 F.3d 1322, 1328 (10th Cir. 2010). The *Dodds* Court, while recognizing the difference between supervisory liability and municipal liability, acknowledged the similarities between the standards. *Dodds,* 614 F.3d at n. 10. Under both standards, the plaintiff must plead and prove the existence of a municipal policy or custom and an affirmative causal nexus between the policy or custom and the constitutional injury. *Dodds,* 614 F .3d at 1202.

1. Sheriff Glanz Possessed Responsibility for Unconstitutional Policies or Customs That Caused the Constitutional Injuries

Sheriff Glanz argues that Plaintiff has failed to "identify an unconstitutional policy or custom...." MSJ at 19. On the contrary, there is abundant evidence that Sheriff Glanz possessed responsibility for the continued operation of unconstitutional policies or customs that create dangerous conditions at the Jail and caused the constitutional injuries. An unconstitutional policy may be established by proof of "an informal custom amounting to a *widespread practice that, although not authorized by written law or express municipal policy, is so permanent and well settled as to constitute a custom or*

usage with the force of law...." *Bryson v. City of Okla. City,* 627 F.3d 784, 788 (10th Cir. 2010) (emphasis added). Plaintiff may also establish Sheriff Glanz's liability through evidence of a "failure to adequately train or supervise employees, so long as that failure results from deliberate indifference to the injuries that may be caused." *Bryson,* 627 F.3d at 788. There is significant evidence in this case of both an informal custom of longstanding, systemic deficiencies in the care provided to inmates like Mr. Williams, as well as evidence of an unconstitutional failure to train and supervise employees.

The Tenth Circuit Court of Appeals recently reversed a grant of summary judgment in favor of the Oklahoma County Sheriff based, in part, on evidence that "tends to demonstrate longstanding, systemic deficiencies in the medical care that the [Oklahoma County] jail provided to detainees...." *Layton v. Bd. of County Com'rs of Oklahoma County,* 2013 WL 925807, *8 (10th Cir. Mar. 12, 2013). The *Layton* case involved allegations that an inmate at the Oklahoma County Jail died as a result of the Oklahoma County Sheriff ***and CHMO's*** deliberate indifference to his serious medical needs. The Court pointed to evidence that "detainees were not being seen for medical care in a timely manner, that medications were not being administered as directed" and "that follow-up care was not being provided to seriously ill detainees...." *Id.* The *Layton* Court specifically relied upon *deficiencies cited in audit reports* in determining that a "a reasonable jury could find that the County's willingness—demonstrated by inaction—to permit seriously ill inmates to remain unmonitored in their cells evinces deliberate indifference for purposes of establishing municipal liability." *Id.* at *9. Plaintiff has presented similar evidence in this case of longstanding, systemic deficiencies in the health care provided to inmates at the Jail, including Mr. Williams, and there is an

"affirmative link" between this unconstitutional custom and Mr. Jernegan's death. *See, e.g.,* Allen (Verified) Report (Ex.20) at 29-30; Hoge (Verified) Report (Ex. 8) at 23-24; *Rizzo v. Goode,* 423 U.S. 362, 371 (1976).

Indeed, this Court has recently found that virtually identical evidence presented by the plaintiff in *Cox v. Glanz* was sufficient to establish "genuine disputes of material fact as to whether there was a constitutional violation and whether there were settled, widespread practices at the Jail which amounted to a custom...." 2014 WL 903101 at *24. Since 2007, at the latest, multiple credible sources, including the NCCHC, Oklahoma Department of Health, U.S. Department of Homeland Security and the Sheriff's own independent medical auditor (AMS), *have repeatedly documented and put Sheriff Glanz on notice* of pervasive and systemic deficiencies in the mental health and medical treatment provided to inmates at the Jail. *See* Stat. of Facts (B), *supra.* Nonetheless, Sheriff Glanz has failed, repeatedly, to take any action to alleviate the known systemic deficiencies in deliberate indifference to the serious medical and mental health needs of inmates like Mr. Williams.

For instance, in 2007, the NCCHC auditors reported, *inter alia*, failure to perform mental health screenings, failure to fully complete mental health treatment plans, failure to triage sick calls, failure to address health needs in a timely manner, failure to provide follow up care for inmates with mental health needs and failure to timely respond to routine mental health requests. *See* Stat. of Facts (B)(5,6). NCCHC made these findings of serious and systemic deficiencies with the health care provided at the Jail *despite* the *Sheriff Glanz's efforts to defraud the auditors by concealing information and falsifying medical records and charts. Id.* at (B)(4-5). And Sheriff Glanz cannot point to any

healthcare policies or practices that were changed or improved at the Jail in response to the NCCHC's findings. *Id.* at (B)(7).

After investigating the circumstances surrounding Mr. Jernegan's death, the OSDH issued a Notice of Violation finding that those at the Jail entrusted with Mr. Jernegan's care had delayed any response to his mental health complaints and violated several provisions of the Oklahoma Jail Standards. *See* Stat. of Facts (B)(9), *supra.* Despite being notified of the deficiencies identified by OSDH, *Sheriff Glanz failed to change a single mental health policy or practice* at the Jail as a result of the OSDH findings. *Id.*

The 2010 NCCHC audit findings evince a continuing pattern of woefully inadequate and substandard care being provided at the Jail. *See* Stat. of Facts (B)(12). Indeed, the 2010 NCCHC Report shows that conditions had grown worse. Many of the same deficiencies that Mr. Williams later encountered -- in October 2011 -- were identified by the on-site auditors in 2010. For instance, NCCHC reviewers found a fundamental lack of supervision of medical staff, including a failure to "conduct clinical chart reviews to determine if clinically appropriate care is ordered and implemented by attending health staff...." *Id.* In Mr. Williams' case, there was no clinically appropriate care provided at all, and no physician supervision of the care provided. The NCCHC found that "...diagnostic tests and specialty consultations are not completed in a timely manner and are not ordered by the physician". Of course, Mr. Williams never received any of the diagnostic tests or specialty consultations he so obviously needed. In 2010, the NCCHC found that potentially suicidal inmates were not being sufficiently checked on and that staff was poorly trained. While Mr. Williams was purportedly on "suicide

watch", the video of cell #1 makes it abundantly clear that he was rarely checked on. After Sheriff Glanz read a few pages of the 2010 NCCHC Report, he made *no changes to policies or practices* at the Jail. *Id.* at (B)(14).

As noted above, on September 29, 2011, ICE and CRCL reported a number of troubling findings with respect to the Jail's medical system, including the finding of a "*prevailing attitude among clinic staff of indifference....*" ICE-CRCL Report (Ex. 37). (emphasis added). Sheriff Glanz read the ICE-CRCL Report, but cannot identify any specific policies or practices that changed as a result. Less than thirty (30) days after Sheriff Glanz received this Report, Mr. Williams died in cell #1 under truly inhumane and barbaric circumstances. There is no doubt that Mr. Williams fell victim to the very "prevailing attitude of indifference" identified by CRCL.

There is additional evidence, derived from nurses who worked at the Jail (including the former Director of Nursing), of serious and excessive delays in treatment, physicians refusing/failing to treat inmates with life-threatening conditions and continuing failure to supervise clinical staff. *See, e.g.,* Stat. of Facts (B)(19). All of these symptoms of a broken medical system were evident in Mr. Williams' case and contributed to his demise.

Even after Mr. Williams died, and Sheriff Glanz investigated the circumstances of his death, the Jail's internal medical auditor, AMS, continued to find inadequate supervision and training of medical staff, unnecessary delays in treatment and ***"no sense of urgency attitude to see patients"***. *See* Stat. of Facts (B)(18) (emphasis added). Still, Sheriff Glanz made no meaningful changes to his medical system and continued to give CHC high marks.

Overall, the evidence establishes a long-standing, continuous and unabated pattern of inadequate medical care of the type that resulted in Mr. Williams' death. There is evidence of a widespread practice of substandard care so permanent and well settled that it has the force of law. *Bryson,* 627 F.3d at 788. The evidence also establishes an unconstitutional failure too adequately train and supervise the medical staff. And there is a clear causal nexus between these unconstitutional policies / customs and Mr. Williams' death.

2. Plaintiff Has Presented Significant Evidence of Sheriff Glanz's (and His Subordinates') Deliberate Indifference

Under the Eighth Amendment, prisoners possess a constitutional right to medical care, and that right is violated when doctors or officials are deliberately indifferent to a prisoner's serious medical needs. *Estelle v. Gamble*, 429 U.S. 97, 103-04 (1976). The duty to provide medical care extends to inmates' psychiatric needs. *See, e.g., Riddle v. Mondragon,* 83 F.3d 1197, 1202 (10th Cir. 1996). Pretrial detainees, like Mr. Williams, who have not been convicted of a crime, have a constitutional right to medical and psychiatric care under the Due Process Clause of the Fourteenth Amendment with the standard for deliberate indifference at least as protective as for convicted prisoners. *See Bell v. Wolfish*, 441 U.S. 520, 545 (1979); *Martin v. Bd. of County Com'rs of County of Pueblo,* 909 F.2d 402, 406 (10th Cir. 1990).

In the cruel and unusual punishment context, "[d]eliberate indifference involves both an objective and subjective component." *Olsen v. Layton Hills Mall,* 312 F.3d 1304, 1315 (10th Cir. 2002) (quoting *Sealock v. Colorado,* 218 F.3d 1205, 1209 (10th Cir. 2000)) (internal quotation marks omitted). To satisfy the objective component, "the alleged deprivation must be 'sufficiently serious' to constitute a deprivation of

constitutional dimension." *Self v. Crum,* 439 F.3d 1227, 1230 (10th Cir. 2006). The subjective component requires evidence that the official "knows of and disregards an excessive risk to inmate health or safety." *Mata v. Saiz,* 427 F.3d 745, 751 (10th Cir. 2005). A civil rights defendant is deliberately indifferent where he "has knowledge of a substantial risk of serious harm to inmates . . . [and] fails to take reasonable steps to alleviate that risk." *Tafoya v. Salazar,* 516 F.3d 912, 916 (10th Cir. 2008). *See also Layton,* 2013 WL 925807 at *8 ("Appellants merely needed to present evidence that Mr. Holdstock faced a substantial risk of serious harm of which the prison officials were, or should have been, aware.").

"Although deliberate indifference is a subjective inquiry, a jury is permitted to infer that a prison official had actual knowledge of the constitutionally infirm condition ***based solely on circumstantial evidence, such as the obviousness of the condition."*** *Id.* (emphasis added). "[I]t does not matter whether the risk comes from a single source or multiple sources, any more than it matters whether a prisoner faces an excessive risk ... for reasons personal to him *or because all prisoners in his situation face such a risk."* *Farmer v. Brennan,* 511 U.S. 825, 843 (1994).

Sheriff Glanz concedes that "Mr. Williams' medical condition was serious...." MSJ at 13. Thus, Plaintiff has met the objective component.

Despite Sheriff Glanz's arguments to the contrary, Plaintiff also easily establishes the subjective component. Sheriff Glanz asserts that he cannot be held liable because: (1) none of his subordinates was deliberately indifferent to Mr. Williams' serious medical needs (MSJ at 13-18); and (2) Plaintiff has failed to demonstrate Sheriff Glanz's "personal participation" or "culpable state of mind" (MSJ at 21; 24). Both arguments lack

merit. **First,** there is ample evidence that Sheriff Glanz's subordinates were deliberately indifferent. Sheriff Glanz's argument that there was no underlying constitutional violation is ***pure sophistry.*** As Sheriff Glanz would have it, because some of his subordinates callously and recklessly *chose* to dismissively discredit Mr. Williams' claims of paralysis in favor of a "working diagnosis" of malingering, there was no deliberate indifference in this case.[4] In fact, Mr. Williams encountered *nothing but* indifference from the moment he was brought to the Jail. It is true, as Dr. Allen finds, that Mr. Williams' "*obvious needs* [we]re never taken seriously...." Allen (Verified) Report (Ex. 20) at 30. But this only exposes the "culture of inhumanity, neglect and disregard for the health and welfare of the inmates" at the Jail. *Id.* As Dr. Allen opines, "***the medical care provided to Mr. Williams is so clearly inadequate as to amount to a refusal by the institution and its staff to provide essential care for a serious medical condition.***" *Id.* 28-29 (emphasis added). The "working diagnosis" of malingering was made "despite clear evidence to the contrary." *Id.* at 11. Chief Robinette herself regards the treatment Mr. Williams received as "inhumane" and lacking "human decency." Robinette Depo. (Ex. 1) at 194:12-33 (emphasis added); *see also id.* at 199:16 – 200:3; 247:16 – 248:4.

For five (5) days, personnel, both medical and detention staff, at the Jail displayed contempt for Mr. Williams and his serious medical needs. Mr. Williams was left in a video-monitored cell *without once moving his legs* while telling anyone who would listen

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[4] It is clear that Dr. Harnish never fully committed to the "diagnosis" of malingering, choosing instead to place Mr. Williams in the video-monitored cell to determine *if* he would move. Nonetheless, it is equally clear that Dr. Harnish, and the rest of the medical staff, recklessly disregarded the substantial risks to Mr. Williams' health and safety by failing to secure any physical assessment, examination or treatment.

that he could not move, was paralyzed, and needed water and assistance. He received *no medical treatment or care whatsoever.* No one at the Jail even conducted an assessment to rule out a physical cause of Mr. Williams' paralysis. No one took any measures to protect Mr. Williams' neck and spine. Rather, they exacerbated his injuries by dumping him off of a gurney and dragging him around on a blanket.[5] No one would help him get a drink of water when he obviously could not so much as lift a Styrofoam cup. "An inmate 'need not show that a prison official acted or failed to act believing that harm *actually would befall an inmate*; it is enough that the official acted or failed to act *despite his knowledge of* a *substantial risk* of serious harm.'" *Mata v. Saiz,* 427 F.3d 745, 752 (10th Cir. 2005) (citing *Farmer,* 511 U.S. at 842) (emphasis added). And where such "'a risk is obvious so that a reasonable man would realize it, [the fact finder] might well infer that [the defendant] did in fact realize it.'" *Mata,* 427 F.3d at 752 (quoting *Garrett v. Stratman,* 254 F.3d 946, 950 (10th Cir. 2001). This case involves risks to Mr. Williams' health and safety that were excessive and so ***blatant and obvious*** that a reasonable man would realize it. What is more, these excessive and obvious risks were completely disregarded.

Further, not everyone at the Jail believed that Mr. Williams was faking or malingering. Yet, they *all* disregarded the known and excessive risks. For instance, Nurse Hughes, who clearly did not think Mr. Williams was faking, and believed something was truly physically wrong with him, simply gave up after detention staff refused to open the door to cell #1. Dr. Washburn could not be bothered when he was

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5 Sheriff Glanz attempts to draw a line between the detention staff and medical staff for the purposes of liability. However, there is plenty of blame to go around, and substantial evidence that both medical and detention staff were deliberately indifferent. *See, generally,* Stat. of Facts (A) (11-60), *supra.*

told -- by Dr. Limbu -- that Mr. Williams needed a CT Scan and needed to be sent to the hospital. Rather than take *any* responsibility for his role in the mistreatment of Mr. Williams, Dr. Washburn testified, ***"[p]eople just die sometimes...."*** Washburn Depo. (Ex. 30) at 70:13 – 71:23 (emphasis added). Sheriff Glanz himself acknowledges that the pre-booking video indicates that Mr. Williams may have broken his neck when he was taken down by the Owasso police officers. *See* Glanz Depo. (Ex. 21) at 45:14 – 46:16. Yet, no one came to his aid. Ultimately, Mr. Williams was left to die alone in the most excruciating and undignified manner imaginable. There is ample evidence that Sheriff Glanz's subordinates were deliberately indifferent.

Second, as established throughout this Response, Sheriff Glanz was himself deliberately indifferent. "The official's knowledge of the risk need not be knowledge of a substantial risk to a *particular* inmate, or knowledge of the particular manner in which injury might occur." *Tafoya,* 516 F.3d at 916 (emphasis in original).[6] "In the municipal liability context, '[t]he deliberate indifference standard may be satisfied when the [County] has actual or constructive notice that its action or failure to act is substantially certain to result in a constitutional violation, and it consciously or deliberately chooses to disregard the risk of harm.'" *Layton,* 2013 WL 925807 at *9 (quoting *Barney v. Pulsipher,* 143 F.3d 1299, 1307 (10th Cir. 1998)).

As thoroughly set forth herein, (*see, e.g.,* Argument I(A), *supra*), there is an established unconstitutional municipal policy or custom of deficient medical and mental

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6 Sheriff Glanz argues that he cannot be liable because he did not have any "knowledge of the extent of Williams' condition preceding his death...." or "personal participation" in the care provided to Mr. Williams. MSJ at 21. This argument must be rejected as misstating and misapplying the deliberate indifference standard articulated by the Tenth Circuit. *See, e.g., Tafoya,* 516 F.3d at 916.

health care provided to inmates like Mr. Williams. The evidence further establishes that Sheriff Glanz knew -- through actual or constructive notice -- of the substantial risks created by this system of substandard care, but "fail[ed] to take reasonable steps to alleviate th[ose] risk[s]." *Tafoya,* 516 F.3d at 916. Indeed, Sheriff Glanz actually took ***active steps to cover up and conceal the dangerous conditions*** at the Jail by hiding, falsifying and doctoring medical records and charts, and defrauding medical auditors. *Id.* As this Court recently held and reasoned:

> Even more troubling are the allegations that the Sheriff was present with his Undersheriff at a meeting prior to the 2007 NCCHC audit at which staff were advised to hide problem jail medical records and to otherwise interfere with the audit. ***If such evidence is believed, the jury could infer, from that meeting alone, that Sheriff Glanz was aware of vast problems with the Jail's medical care system....***

Cox, 2014 WL 903101 at *22 (emphasis added).[7] Despite knowing of "vast problems with the Jail's medical system", Sheriff Glanz took no discernable action to alleviate the substantial risks to inmates.[8] Significantly, Sheriff Glanz failed to remove or replace CHC as the medical contractor -- going so far as to rate CHC a "9 out of 10" -- even after Mr. Williams' death and in the face of overwhelming evidence that the "care" provided by CHC was wholly and dangerously inadequate. For years, Sheriff Glanz recklessly fostered a "prevailing attitude of indifference" among his subordinates at the Jail. *See* ICE-CRCL Report, 9/29/11, (Ex. 37) at Glanz.02 00066. Sheriff Glanz's knowing failure

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7 The evidence presented by Plaintiff concerning the NCCHC negates Sheriff Glanz's reliance upon TCSO's "Triple Crown" status as proof that he is not deliberately indifferent. *See, e.g.,* Stat. of Facts(A)(58-60); (B)(3-7, 11-13).

8 Sheriff Glanz argues that his hiring of AMS as outside auditor to review practices and processes "demonstrates the opposite of indifference." MSJ at 27. However, the mere retention of AMS cannot erase years of inadequate care, inaction by Sheriff Glanz and attempts to cover up deficiencies in the medical system. Further, the evidence establishes that Sheriff Glanz did little, if anything, to alleviate the continuing systemic problems identified by AMS.

to remedy this unconstitutional health services system constitutes deliberate indifference to the serious medical needs of inmates like Mr. Williams.

Sheriff Glanz specifically argues that he can insulate himself from liability in this case because he entered into a contract with CHC, a private healthcare provider, and relied on CHC to deliver adequate care to inmates and to train and supervise medical personnel. *See* MSJ at 22-25. This argument is demonstrably void of merit. It is well-established that "[c]ontracting out prison medical care ***does not relieve the State of its constitutional duty to provide adequate medical treatment*** to those in its custody, and it does not deprive the State's prisoners of the means to vindicate their Eighth Amendment rights." *West v. Atkins,* 487 U.S. 42, 56 (1988) (emphasis added). *See also Crooks v. Nix,* 872 F.2d 800, 804 (8th Cir. 1989) ("[W]here the duty to furnish treatment is unfulfilled, the mere contracting of services with an independent contractor does not immunize the State from liability for damages in failing to provide a prisoner with the opportunity for such treatment."). Despites his efforts to insulate himself from liability through the contract with CHC, Sheriff Glanz has recognized that he "is ultimately responsible for the health and safety of inmates and for ensuring that mental health treatment is provided to inmates." *Cox,* 2014 WL 903101 at *7. Sheriff Glanz cannot hide behind the contract with CHC.

In sum, the evidence establishes that Sheriff Glanz is liable in his individual and official capacities.

II. SHERIFF GLANZ IS NOT ENTITLED TO QUALIFIED IMMUNITY

"When the defendant has moved for summary judgment based on qualified immunity, [the court must] still view the facts in the light most favorable to the non-

moving party and resolve all factual disputes and reasonable inferences in its favor." *Estate of Booker v. Gomez,* --- F.3d ---, 2014 WL 929157, *3 (10th Cir. Mar. 11, 2014). At the summary judgment stage, courts will grant qualified immunity unless "the plaintiff can show (1) a reasonable jury could find facts supporting a violation of a constitutional right, which (2) was clearly established at the time of the defendant's conduct." *Estate of Booker v. Gomez,* 2014 WL 929157 at *3 (citing *Saucier v. Katz,* 533 U.S. 194, 201–02, (2001)). First, as shown *supra*, Plaintiff has, at the very least, shown that a reasonable jury could find facts supporting a violation of a constitutional right in this case.

Second, the constitutional rights violated were "clearly established" at the time of Sheriff Glanz's conduct. In determining whether a constitutional right is "clearly established" for the purposes of qualified immunity:

> The Supreme Court has held "a general constitutional rule already identified in the decisional law may apply with obvious clarity to the specific conduct in question, even though the very action in question has not previously been held unlawful." *Hope v. Pelzer,* 536 U.S. 730, 741 (2002) (quotations and alteration omitted). As this court has pointed out, "[t]he *Hope* decision shifted the qualified immunity analysis from a scavenger hunt for prior cases with precisely the same facts toward the more relevant inquiry of whether the law put officials on fair notice that the described conduct was unconstitutional." *Casey v. City of Fed. Heights,* 509 F.3d 1278, 1284 (10th Cir.2007) (quotations omitted).

Clark v. Wilson, 625 F.3d 686, 690 (10th Cir. 2010). Here, Plaintiff has raised bedrock constitutional Eighth Amendment / Cruel and Unusual Punishment principles that apply with obvious clarity to the conduct in question. An inmate's right to adequate medical care and to be free from deliberate indifference have been clearly established for decades. *See, e.g., Estelle*, 429 U.S. at 103-04. And there is nothing novel about Plaintiff's claims concerning longstanding and systemic deficiencies in a Jail's medical program. In addition, the supervisory liability standard articulated in *Dodds v. Richardson* was

established at the time Mr. Williams' death. Sheriff Glanz knew by his continuing failure to alleviate -- and efforts to cover-up -- known and long-standing deficiencies in his healthcare care delivery system, he was subjecting himself to constitutional liability. There is no doubt that Sheriff Glanz had "fair notice" that his fostering such a dangerously deficient medical system was unconstitutional. Sheriff Glanz is not entitled to qualified immunity.

III. PLAINTIFF'S CLAIMS ARE NOT DERIVATIVE CLAIMS

Sheriff Glanz's last argument regarding derivative claims is written as if Mr. Williams' widow and parents are named parties to this action. MSJ at 28-29. They are not. It is unfortunate that Sheriff Glanz fails to cite the Tenth Circuit's leading case on §1983 death claims, *Berry v. City of Muskogee, Okl.,* 900 F.2d 1489 (10th Cir. 1990). In *Berry*, the Tenth Circuit held that "federal courts must fashion a federal remedy to be applied to § 1983 death cases" and that "remedy should be a survival action, brought by the estate of the deceased victim...." *Berry,* 900 F.2d at 1506-07. Here, Plaintiff properly brought a survival action on behalf of the estate of the victim, Mr. Williams.

The *Berry* Court further determined that "appropriate compensatory damages" in § 1983 death cases "include[] medical and burial expenses, pain and suffering before death, loss of earnings based upon the probable duration of the victim's life had not the injury occurred, the victim's loss of consortium, and other damages recognized in common law tort actions." *Berry* at 1507 (emphasis added).[9] Plaintiff's claimed damages

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[9] Similarly, Oklahoma's wrongful death statute provides that "damages recoverable in actions for wrongful death ... shall include ... [t]he mental pain and anguish suffered by the decedent, which shall be distributed to the surviving spouse and children, if any, or next of kin in the same proportion as personal property of the decedent." 12 Okl. Stat. § 1053 (B).

in this matter are based primarily on the unimaginable pain and suffering that Mr. Williams endured as he lay dying for days, without food or water, while Sheriff Glanz's subordinates idly watched. In this case, any such damages will be awarded to Plaintiff on behalf of the Estate. Then it will be up to Plaintiff to distribute those damages as appropriate. It is not Plaintiff's intent to bring any derivative claims and summary judgment is not appropriate.

WHEREFORE, premises considered, Plaintiff respectfully requests that this Court deny Defendant Stanley Glanz's Motion for Summary Judgment (Dkt. #224).

Respectfully,

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CERTIFICATE OF SERVICE

I hereby certify that on the 27th day of March 2014, I electronically transmitted the foregoing document to the Clerk of Court using the ECF System for filing and transmittal of a Notice of Electronic Filing to all ECF registrants who have appeared in this case.

/s/ Robert M. Blakemore