STATE OF OKLAHOMA )
) ss.
COUNTY OF TULSA )

**AFFIDAVIT OF TAMMY A. HARRINGTON**

I, Tammy A. Harrington, of lawful age, being duly sworn upon oath, state:

1. I have personal knowledge of the facts set forth in this Affidavit.

2. I am Registered Nurse ("RN"). I have a B.S.N. degree from Langston University.

3. I was employed by Correctional Healthcare Companies, Inc. ("CHC") / Correctional Healthcare Management, Inc. ("CHM") / Correctional Healthcare Management of Oklahoma, Inc. ("CHMO") from October 2007 until March 20, 2012.

4. From June 5, 2011 through March 20, 2012, I served as CHC/CHM/CHMO's Director of Nursing ("DON") at the Tulsa County Jail. Prior to the time I was promoted to the position of DON, I worked as a sick call nurse at the Jail from August 2008 through June 2011. Prior to that, I worked in the infirmary from October 2007 through August 2008.

5. In my experience at the Jail, I witnessed numerous inadequacies in the health care provided to inmates, including those with mental health issues. These inadequacies increased the risks to the health and safety of inmates at the Jail. In many cases, inadequate care was the cause of injuries and illnesses of inmates housed in the Tulsa County Jail. These increased risks, injuries and illnesses (as described below) were a result of indifference to inmate care on the part of CHC/CHM/CHMO's supervisors and nursing staff alike. During my years at the Jail, I observed an utter lack of leadership and supervision at the top of CHC/CHM/CHMO, which trickled down to the to the clinical



NCCHC audit process, Pam Hoisington directed me, and other nurses, to go through Jail medical charts and records to find records of care that complied with NCCHC standards. The purpose of this exercise was to find records to provide to the NCCHC that would satisfy the auditors. However, the records and care provided at the Jail were so deficient that it would take up to eight hours every week just to find compliant charts. The medical documentation at the Jail was terrible. The great majority of the records at the Jail were woefully incomplete and did not even come close to complying with NCCHC criteria. By spending hours to locate and pull the few compliant records at the Jail for the auditors, CHC/CHM/CHMO was able to give the false impression that the documentation was good.

8. During the 2010 NCCHC audit process, Chris Rogers actually asked me to doctor medical charts by backdating undocumented information. I refused. Medical records staff assisted with locating and compiling charts to be removed. At one point during the 2010 NCCHC audit process, I saw medical charts being carried out of the Jail. Pam Hoisington kept a cabinet of "acceptable" records in her office to provide to the NCCHC auditors.

9. I remember that CHC/CHM/CHMO failed the 2010 NCCHC audit. However, I do not recall any significant changes in medical or mental health policy or practice at the Jail after the 2010 NCCHC audit results were released. Overall, CHC/CHM/CHMO communicated no real concern about improving the deficient care being provided to the inmates. Instead, CHC/CHM/CHMO was concerned with simply maintaining "Triple Crown" accreditation.

10. During my entire tenure at the Jail, the Mental Health Team was understaffed and overwhelmed. The Mental Health Team repeatedly asked CHC/CHM/CHMO management for additional help, but help never came. The Jail had upwards of 1700 inmates, many of whom had serious mental health problems. Yet, there were only two full-time counselors to serve this population. It was impossible for the Mental Health Team to respond to requests for assistance in a timely manner. Dr. Harnish, the only psychiatrist at the Jail, was only there on a part-time basis. He spent most of his time trying to get caught up on prescriptions, and had very little time to actually see the inmates. Indeed, in my experience, Dr. Harnish rarely saw patients because he was so overwhelmed. At one point, I offered to help with Mental Health Team with the backlog, but CHC/CHM/CHMO would not let me help.

11. Because of the backlog of requests and inadequate staffing, there were often long delays, upwards of two to four weeks, in inmates seeing someone from the Mental Health Team.

12. In my experience, the Mental Health Team was not permitted to see inmates in the pods before 8:00am per Jail policy. And the DO's had authority to refuse entry into the pods at any time, for any reason.

13. Despite the 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. Even in those rare cases when referrals were made to Oklahoma Forensic Center, there was a wait of up to six months before the inmate would be transferred (if accepted). Even after inmates unsuccessfully attempted to commit suicide, they were kept inside the Jail. I remember one instance when an inmate

had slit his wrists and lived. They merely stitched the inmate up and put him back in a suicide cell. There was truly an attitude of indifference to the mental health needs of inmates at the Jail.

14. Inmates in need of urgent or emergent medical assistance for injuries, illness, or mental health issues were not seen for days -- and sometimes weeks -- due to the Jail's practices relating to triage. CHC/CHM/CHMO's definition of triage was not consistent with the accepted medical standard for triage. True triage requires that medical requests be reviewed and prioritized on the basis of severity and acuity. Within the Jail, there was a kiosk system in place (which only worked about 60% of the time) by which inmates submitted requests for medical or mental health attention electronically. The Oklahoma Jail Standards require that facilities triage such requests for medical or mental health within twenty-four (24) hours. CHC/CHM/CHMO bypassed and violated this requirement by having the kiosk system provide complaining inmates with a boilerplate, form "canned" response stating that someone would see the inmate within 24-48 hours. Indeed, by design, the kiosk system provided these boilerplate, canned written responses as a façade. This is not triage. There was no one at the Jail who actually evaluated and prioritized the sick call complaints in a timely manner. In fact, I know from experience and observation that Chris Rogers often would not even read the kiosk requests from inmates. Instead, she would simply see if the request was medical or mental health, and then provided the pre-determined, boilerplate written "response" without any evaluation of the request.

15. It was impossible for the medical staff to actually triage the kiosk medical and mental health requests within 24 hours because we were so severely understaffed and

psychiatrist was not on site full time. As such, inmates were not actually seen in person to address their complaints and there was no way to know how critical the complaints were. CHC/CHM/CHMO was well aware of this problem, but took no action to alleviate it.

16. During my tenure at the Jail, the booking / intake process was insufficient to provide adequate assessment of inmates' true medical and mental health needs. CHC/CHM/CHMO and TCSO emphasized quickly getting inmates through the booking process, as opposed to making sure that inmates were fully and adequately assessed. TCSO would make CHC/CHM/CHMO pay a fine for each inmate that took over two hours to get through booking, even through NCCHC requirement was four hours. This created an atmosphere under which the booking nurses rushed to get inmates through booking. The inmates were run through the booking process like "cattle in a chute". This was not a true medical "screening" process. There was very little actual assessment of medical or mental health needs which happened during the booking process. Rather, the process was simply a "check the box" procedure designed to quickly get the inmates through booking. The superficial and rushed "assessments" during booking created substantial risks that inmates with serious medical and mental health problems would not receive the treatment they needed in a timely manner.

17. Another troublesome practice within the Jail was the resuscitation of inmates who had died while in the Jail so that the Jail would not become a "crime scene" and the TCSO would not have to report a jail death. Nurses were specifically instructed by Chris Rogers and Pam Hoisington that inmates were not to die at the Jail. So, nurses

would resuscitate inmates who had died and EMSA would take them to the hospital so that the official pronouncement of death would occur off-site.

18. One inmate with a bowel obstruction (and known history of bowel obstruction and surgery for bowel obstruction) at the Jail was at serious risk of dying. I pleaded with Chris Rogers for two days to get Dr. Washburn to examine the inmate. However, Chris Rogers acted unconcerned and Dr. Washburn never examined the inmate. The inmate was ultimately sent to the ER, went straight to surgery and died several days later.

19. After an inmate named Lisa Salgado died at the Jail from a heart attack, it was discovered that her vital signs had not been recoded in the chart. After Ms. Salgado died, Chris Rogers instructed the nursing staff to doctor her medical records so that it would appear that Ms. Salgado's vitals had been taken and recorded. Chris Rogers routinely directed nursing staff to falsify, doctor and backdate medical records and charts in this manner.

20. In the late summer of 2011, there was an audit conducted by United States Immigration and Customs Enforcement ("ICE") at the Jail. As with other ICE audits, it seemed that CHC/CHM/CHMO and TCSO were given pre-warning that the auditors were coming. The ICE medical auditor found numerous, concerning violations. In particular, ICE determined that one nurse, Sara Jeffries, had repeatedly failed to provide timely care to inmates. As DON, I decided that the problem was serious enough that Nurse Jeffries should be "written up" / admonished for her substandard care. I believed, and continue to believe, that the dangerous conditions at the Jail would never improve unless and until those providing substandard care were held accountable. However, when

I provided the HSA, Chris Rogers, with the Jeffries write up, she tore it up and refused to hold Nurse Jeffries accountable. Chris Rogers and Nurse Jeffries happened to be close friends.

21. As DON, I made multiple attempts to write up disciplinary issues that were dismissed by the HSA with responses such as "if we wrote up every mistake, we'd have to write up everyone", or "we all make mistakes". There was no accountability for the poor care being provided. The poor care was simply accepted by CHC/CHM/CHMO and TCSO as standard.

22. After the ICE audit came out so poorly, CHC/CHM/CHMO never conveyed any intention to actually do anything to improve the medical and mental health care provided to inmates at the Jail. The only concern was maintaining the ICE contract as the Jail received 6 million dollars for housing ICE inmates.

23. On the morning of October 27, 2011, John Bell, a member of CHC/CHM/CHMO's Mental Health Team at the Jail, spoke with me about an inmate housed in a suicide cell. I now know that this inmate was Elliott Williams. Mr. Bell was very concerned that Mr. Williams' physical condition was worsening. I directed Mr. Bell to immediately have Dr. Washburn assess the inmate. Mr. Bell indicated that he would do so. At around 11:00am, Mr. Williams was found unresponsive in his cell. I asked Mr. Bell if he had asked Dr. Washburn to assess Mr. Williams, and Mr. Bell indicated that he had. However, even after being informed of Mr. Williams' worsening condition, Dr. Washburn failed to perform any hand's-on physical evaluation.

24. After Mr. Williams' death, I was interviewed by a man named David Smith. Mr. Smith represented to me that he was part of CHC/CHM/CHMO's "internal

affairs", or IA. Mr. Smith asked me to document any issues that may have contributed to the death of Mr. Williams, and other issues of concern at the Jail that were brought to light during the interview. During the interview, I was critical of Dr. Washburn, Chris Rogers and the nursing staff. Mr. Smith assured me that my concerns would be taken seriously and provided to the owner of CHC/CHM/CHMO. I noted several long-standing deficiencies that I believed contributed to Mr. Williams' death, including the fact that nurses and mental heath staff were failing to notify DON and HSA of inmates needing to be seen by a physician, medical personal failing to make rounds and check on inmates in holding cells and chronic delays in responding to serious medical and mental health needs. However, the most significant "change" I noticed after I spoke with Mr. Smith is that my actions were highly scrutinized by management, until I was ultimately terminated in March of 2012. Every time I complained about the poor care being provided to inmates at the Jail, in a sincere hope that things would get better, I was marginalized, ignored, and ultimately forced out.

25. On January 2, 2012, upon a mental health request to see an inmate housed in medical for suicide watch with deep lacerations in both wrists that had been sutured at hospital prior to intake in jail, Dr. Adusei stated "I won't see him unless he is septic". This was reported to Chris Rogers, but I did not observe any action taken.

26. On February 28, 2012, I requested multiple times for Dr. Adusei to send out an inmate in need of an NG tube with black output. I mentioned multiple times to Chris Rogers that Dr. Adusei refused to send inmate out. After getting the NG tube down, Dr. Adusei refused to send the inmate to the hospital.

27. In late 2011 or early 2012, Dr. Raymond Herr of CHC/CHM/CHMO came to the Jail to conduct a peer review of Dr. Washburn. Prior to Dr. Herr's arrival, Chris Rogers instructed me to locate and pull charts that would shine the best possible light on Dr. Washburn. Chris Rogers wanted to preselect the best possible charts to provide to Dr. Herr. Finding good charts was a difficult task. Dr. Washburn routinely failed to see inmates in a timely manner, and most of his charts reflected this. It was well known at the Jail that Dr. Washburn did not document well, manage his time well or like to see inmates. Starting in August 2011, I, or another nurse, was assigned to keep Dr. Washburn on task. I later told CHC/CHM/CHMO corporate that Chris Rogers had instructed me to pre-select the charts in this manner.

28. After Dr. Herr conducted his peer review of Dr. Washburn, I began documenting instances of inappropriate or substandard care provided by Dr. Washburn. I spoke at length with Beth Coulombe, of CHC/CHM/CHMO Human Resources, about the many instances of inadequate care I had observed and documented. While Ms. Coulombe initially seemed genuinely concerned about Dr. Washburn's competency, nothing of substance came as a result. Ms. Coulmbe recommended a conference call between myself, Chris Rogers, David Miller and David Jordan of CHC/CHM/CHMO. A conference call was held the next day between Chris Rogers, David Miller and David Jordan. I was shut out of the call. Chris Rogers informed me that they came to the conclusion that Dr. Washburn could be "salvageable", with no plans to replace him. In less than one week after this conference call, two inmates had to be admitted to ICU after nurses had requested for days, without success, to send them to the hospital.

29. I emailed a summary of my observations of poor care to Mya Donaldson, CHC/CHM/CHMO Contract Manager, but no action was taken. Instead, I was reprimanded by David Miller for sending the email to Ms. Donaldson.

30. After being promoted to the position of DON, I was never provided with orientation or training. I repeatedly asked Chris Rogers to provide me with orientation, but she refused. Chris Rogers provided almost no supervision at all to me, or anyone else at the Jail. This lack of leadership and supervision created an atmosphere of chaos and fostered indifference to inmate medical and mental health needs. Chris Rogers would not help me with the severe staffing shortages even after I was forced to work 24 hours straight.

31. After major or catastrophic events, I often saw Chris Rogers meeting with the TCSO Captains and/or Chiefs behind closed doors. I believed that -- as DON – I should have been privy to those meetings. I was not. In addition, TCSO impeded the ability of clinical staff to care for inmates with serious needs by maintaining power over hospital referrals and EMSA. It was inappropriate for TCSO to make these medical decisions.

32. I also believed that a nurse, Joy Smith, was having sex with an inmate in blind spots in the medical unit. She brought the inmate down to the treatment room almost every day at 5pm, without any medical reason or justification. The treatment room was not monitored by surveillance equipment. Despite being notified of this improper misconduct, CHC/CHM/CHMO and TCSO failed to investigate or take any remedial action.

33. I arranged hospice for an inmate (who was housed in medical between December 2007 and May 2008) who was believed to have advanced stage cancer. Because this inmate became severely oxygen-dependent within a month of being admitted to the infirmary, I requested that he be provided with oxygen during the entire release process. I put a note on his door, gave notes to the Sgt. and put notes in his chart that this inmate was to have oxygen during the release process. However, in utter indifference to this inmates' health and safety, the request for oxygen was denied. During the release process, due to the lack of oxygen provided by CHC and TCSO, the inmate became short of breath, was placed on a ventilator within 24 hours and died several weeks later.

Anything further, affiant saith not.

DATED this 2nd day of ~~March~~ April 2013.

Tammy A. Harrington

Signed and sworn to before me this 2nd day of ~~March~~ April 2013.

My Commission Expires:

(SEAL Notary Public Oklahoma OFFICIAL SEAL KENDRA RASH Comm. Exp. 02/05/2016 Commission # 03001503)

Notary Public