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

BRIDGET NICOLE REVILLA, *et al.,*	)
	)
Plaintiffs,	)
	)
v.	) Case No.: 13-CV-315-JED-TLW
	)
STANLEY GLANZ, *et al.,*	)
	)
Defendants.	)

PLAINTIFF CHRISTINE HAMILTON F/K/A CHRISTINE WRIGHT'S RESPONSE IN OPPOSITION TO DEFENDANTS STANLEY GLANZ AND VIC REGALADO'S MOTION FOR SUMMARY JUDGMENT (DKT. #251)

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COMES NOW the Plaintiff, Christine Hamilton f/k/a Christine Wright ("Plaintiff" or "Plaintiff Wright"), as Special Administrator of the Estate of Lisa Salgado ("Ms. Salgado"), deceased, and respectfully submits her Response in Opposition to Defendants Stanley Glanz ("Former Sheriff Glanz" or "Glanz") and Vic Regalago's ("Sheriff Regalado") (hereinafter, collectively referred to as the "TCSO Defendants") Motion for Summary Judgment (Dkt. #251) as follows:

Introductory Statement

Ms. Salgado was booked into Tulsa County Jail on June 25, 2011, where she died approximately three (3) days later. During her time at the Jail, Ms. Salgado encountered reckless and deliberate indifference to her serious, known and obvious medical needs. She suffered, and died alone in a jail cell, as a direct result. For days, Ms. Salgado exhibited clear symptoms of acute coronary syndrome (including extreme chest pain, nausea, vomiting, fainting and shortness of breath), consistent with her documented history of heart attack and stent placement. However, as detailed herein, responsible medical staff, including Defendant Phillip Washburn, M.D. ("Dr. Washburn") and Nurse Karen Metcalf ("Nurse Metcalf"), repeatedly disregarded the substantial risks to Ms. Salgado's safety, failing to provide or secure the medical care she so obviously needed. At around 7:00pm on June 28, 2011, Ms. Salgado was discovered in her cell. She was cold to the touch, her extremities were mottled; she had been dead, due to acute coronary syndrome, for some time. Despite her life-threatening illness, Ms. Salgado had been not been checked on in hours. Another tragic victim of the Tulsa County Jail's broken healthcare delivery system. Another victim of the long-established and well-documented "prevailing attitude of indifference" among the clinical staff.

The death of Ms. Salgado was no freak accident. On the contrary, her death was as foreseeable as it was preventable. For many years, Defendant Stanley Glanz was ***repeatedly and continuously put on notice, by multiple credible sources, of serious, grave and systemic deficiencies in the medical treatment provided*** to inmates at the Jail. Former Sheriff Glanz ignored explicit and dire warnings that his medical system was broken, taking either no remedial action whatsoever, or taking insincere half-measures intended only to temporarily placate auditors and accreditation agencies. Through their established policies, practices, and customs, Former Sheriff Glanz and the Tulsa County Sheriff's Office ("TCSO") disregarded known and substantial risks to the health and safety of inmates like Ms. Salgado.

The TCSO Defendants' Motion for Summary Judgment (Dkt. #251) should be denied.

LCvR 56.1(c) Statement of Facts

A. Response to Defendants' "Statement of Material Facts Not in Dispute"

Saint Francis Hospital

1-6. Ms. Salgado's condition on June 16, 2011, while at Saint Francis is largely irrelevant. Nonetheless, the Saint Francis records do reveal Ms. Salgado's history of serious, and life-threatening, health problems, and elevated risk factors. On June 16, 2011, Ms. Salgado presented at Saint Francis complaining of "nausea, vomiting and chest pain…." SFH Records (Ex. 1) at SFHS01103. Ms. Salgado was assessed as having "coronary artery disease…." *Id.* at 1107. It was specifically noted that Ms. Salgado had ***"a heart attack in the past"***, a "medical history … for ***stent placement"*** and a family history of ***"coronary artery disease."*** *Id.* at 1109 (emphasis added). Dr. Paul Beck, at

Saint Francis, noted that Ms. Salgado was experiencing chest pain and nausea, and that her electrocardiogram ("EKG" or "ECG") "revealed sinus rhythm." *Id.* at 1111. She was admitted to the Intensive Care Unit ("ICU"). *Id.*

7. Dr. Allen testified that he had not reviewed Ms. Salgado's records from Saint Francis. *See* Allen Depo. (Ex. 2) at 205:11 – 206:9. In any event, as noted by Dr. Allen, one of the causes of chest pain, nausea and vomiting is "coronary disease" which was one of Ms. Salgado's documented conditions. *Id.* at 210:1-11. Dr. Allen further testified that coronary disease is "not static", and that "yesterday's workup, short of a catheterization, doesn't exclude that today's chest pain could be acute coronary syndrome." *Id.* at 280:13 – 281:6.

Saint John Medical Center (Pre-June 25, 2011)

9-12. Ms. Salgado had a history at Saint John prior to June 23, 2011. For instance, in June of 2007, Ms. Salgado presented to Saint John and was assessed as having ***"chest pain"***, ***"[h]istory of myocardial infarction in 11/2005 with stent placement"***, ***"[c]oronary artery disease"***, "[t]ype 1 diabetes", "alcoholism" and "Hypercholesterolemia". Saint John Records (Ex. 3) at SJS00028 (emphasis added). Drs. Greta Warta and David Brewer ordered a ***"cardiac catheterization"*** to be performed the morning of June 25, 2007. *Id.* at 31 (emphasis added).

In November 2009, Ms. Salgado was hospitalized again at Saint John. *See, e.g.*. Saint John Records (Ex. 3) at SJS00117. Ms. Salgado's "past medical history significant for coronary artery disease" and "myocardial infarction" was documented. *Id.* Significantly, it is noted that a stress test showed ***"scar tissue" from her previous myocardial infarction.*** *Id.* (emphasis added).

Despite Defendants' attempts to minimize Ms. Salgado's condition, providers at Saint John reported Ms. Salgado's serious risks for acute coronary disease. When Ms. Salgado presented at Saint John on June 23, 2011, medical staff noted her complaints of chest pain, that she had a ***"heart attack at the age of 34"*** and had taken "3 nitro [that] morning with no relief." Saint John Records (Ex. 3) at SJS00588 (emphasis added). Ms. Salgado was experiencing "shortness of breath, nausea and vomiting." *Id.* Her history of "coronary artery disease and previous coronary stents" was documented. *Id. See also id.* at 593 ("The patient is a 40 year-old white female with a past medical history of ***coronary artery disease status post myocardial infarction*** at age 34") (emphasis added). "Borderline" EKG's were recorded on June 23 and 24, 2011. *Id.* at 577.

On June 24, 2011, Dr. Tommy Nguyen recorded the following assessment and plan:

> Chest pain, her TIMI is 4, based on:
>
> 1. ***Coronary artery disease risk factors***
> 2. Aspirin use
> 3. ***Known coronary artery disease with stenosis***
> 4. ***Greater than 2 episodes of angina***
>
> ***This may or may not be cardiac related but based on her risk factors, and no record of any myocardial perfusion scintigraphy (MPS) done, she probably warrants a myocardial perfusion scintigraphy (MPS) to be done at this inpatient setting.*** We will continue to follow CPEUs and EKGs. We will start the patient on cardioprotective meds.

Saint John Records (Ex. 3) at SJS00595 (emphasis added).[1] Dr. Shah, Plaintiff's expert in cardiology, agrees that, based on her symptoms and history, Ms. Salgado should have received a noninvasive nuclear stress test, or some type of ischemia testing, prior to

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[1] "TIMI" is a risk assessment tool for patients with unstable angina and non-ST elevation MI.

leaving Saint John. *See, e.g.,* Shah Depo. (Ex. 4) at 105:4 – 106:17. However, as noted by Dr. Shah, Ms. Salgado received no such testing prior to leaving Saint John, against medical advice. *Id.*

13. Contrary to Defendants' assertion that Saint John's physicians "determined that Salgado did not have acute coronary syndrome", it is clear that acute coronary syndrome was not definitively ruled out prior to her discharge. *See* LCvR 56.1(c) Statement(A)(9-12), *supra.*

14. Dr. Allen clarified that because Ms. Salgado did not receive the "definitive test of either a profusion imaging study or a cardiac catheterization" at Saint John, Ms. Salgado "could have been in acute coronary syndrome" while at Saint John from June 23 through 24, 2011. Allen Depo. (Ex. 2) at 214:20 – 215:8. Of course, Dr. Allen was retained to opine as to the care, or lack thereof, that Ms. Salgado received at the Tulsa County Jail. *Id.* at 7:15-18. Her care at Saint John is far less relevant. In any event, ***Defendants' own expert concluded that the healthcare system, including the Jail's healthcare system, and Saint John, "failed" Ms. Salgado.*** Kassabian Depo. (Ex. 5) at 186:7 – 187:2 (emphasis added).

June 24, 2011 Arrest

15-19. Ms. Salgado's arrest and criminal charges are irrelevant and inadmissible. *See, e.g.,* FRE 401, 402, 403 and 609. Nevertheless, it is noteworthy that while the Broken Arrow Police Department ("BAPD") had the good sense to take Ms. Salgado to a hospital, as shown *infra*, the Tulsa County Sheriff's Office ("TCSO") and Correctional Healthcare Companies, Inc. ("CHC") failed to send Ms. Salgado to a hospital despite all indications that she was experiencing an acute coronary event.

Saint John Medical Center (June 25, 2011)

20-24. Ms. Salgado was brought back to Saint John, by BAPD, on the morning of June 25, 2011, because she would not have "any insulin in jail." Saint John Records (Ex. 3) at SJS00700. Ms. Salgado's "discharge summary" from Saint John, dated June 25, 2011, documents that her most current EKG demonstrated "T-wave inversions in certain leads" and that she had been placed on all "cardioprotective medications." *Id.* at SJS00564. Ms. Salgado's discharge instructions, indicated that "[t]he ***exact cause*** of [her] chest pain [wa]s ***not certain."*** *Id.* at 708 (emphasis added). The discharge instructions further provided to "watch for warning signs", and to get prompt medical attention if any of the following were to occur: (1) "[a] change in the type of pain: if it feels different, becomes more severe, lasts longer, or begins to spread into your shoulder, arm, neck, jaw or back"; (2) "[s]hortness of breath or increased pain with breathing"; and (3) "[w]eakness, dizziness, or fainting." *Id.* at 709. *See also* Shah Depo. (Ex. 4) at 166:11 – 167:13. As shown *infra*, Ms. Salgado exhibited *<u>all</u> of these warning signs* while at the Tulsa County Jail, but her serious turn for the worse was disregarded.

25. Dr. Shah testified that Saint John's discharge of Ms. Salgado on the morning of June 25th was appropriate because she had no "increase or acceleration in her symptoms" and she was not presenting with "acute chest pain" at that time. Shah Depo. (Ex. 4) at 144:12 – 145:12.

Booking at the Tulsa County Jail (Morning of June 25, 2011)

26-28. Upon being booked into the Jail, Ms. Salgado filled out, or was assisted in filling out, several forms. On one such form, Ms. Salgado indicated that she had attempted suicide in the past, was currently taking medication for mental health or

emotional problems and had been hospitalized in the past for mental health or emotional problems. *See* TCSO Records (Ex. 6) at GLANZ-Revilla05412. According to the TCSO's own form, Ms. Salgado's answers should have prompted a mental health referral. *Id.* However, there is no indication that such a referral was made. *Id.*

Contrary to Defendants' assertions, Ms. Salgado's "Intake Screening Form" specifies that she had been treated in a hospital, clinic or emergency room within the "last **3 days"**. TCSO Records (Ex. 6) at GLANZ-Revilla05416 (emphasis added). Yet, there is no evidence that anyone at the Jail communicated this information to a health care provider.

29. During the medical screening, on the morning of June 25, Ms. Salgado reported a number of "medical problems", including "cardiac" and hypertension, as well as recent hospitalization for chest pain. *See* Jail Medical Records (Ex. 7) at GLANZ-Revilla05495. Yet, the screening nurse did not place Ms. Salgado in the medical unit nor refer Ms. Salgado to be seen by a physician. *Id.* at 5497.

30. Unfortunately, the validity of any "vital signs" information in Ms. Salgado's medical records cannot be taken at face value. As Nurse Tammy Harrington, the Jail's former Director of Nursing, states in her Affidavit:

> After an inmate named Lisa Salgado died at the Jail from a heart attack, it was discovered that her ***vital signs had not been recorded 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.

Harrington Aff. (Ex. 8) at ¶ 19 (emphasis added).

31-35. Admit.

Medical "Care" at the Jail – June 25, 2011

36-39. Though Defendants fail to mention it, at 2:43 and 2:44pm on June 25, Ms. Salgado was given an electrocardiogram (also referred to as an "ECG" or "EKG"). *See* Jail Medical Records (Ex. 7) at GLANZ-Revilla05515. For reasons unexplained, Ms. Salgado's EKG results were not "uploaded" into her electronic medical chart until July 14, 2011, ***weeks <u>after</u> her death.*** *Id.* at 5514. The record further states: "[EKG] has been reviewed? ***N/A."*** *Id.* Even more troubling, the EKG results were not included ***at all*** in the copy of Ms. Salgado's medical records produced by the CHC Defendants. *See* CHC Medical Records (Dkt. #244-5). In any event, Ms. Salgado's EKG results from 2:43pm were ***"abnormal"***. *See* Jail Medical Records (Ex. 7) at GLANZ-Revilla05515 (emphasis added).

As Dr. Allen observes, "[t]here is no discussion of her significant cardiac risks, nor any entry [in the medical records] to reflect that the abnormal EKG has been reviewed by a physician." Allen (Verified) Report (Ex. 9) at 17. Defendant Phillip Washburn, M.D. ("Dr. Washburn") was the Jail's medical director, and staff physician, at the time Ms. Salgado was housed there. *See* Washburn Depo. (Ex. 10) at 34:9-19; 67:12 – 68:2; 157:17-18. Dr. Washburn ***admits*** that: (A) Ms. Salgado's EKG was abnormal; (B) that there is no indication, in the medical records, that her abnormal EKG had been reviewed by a physician; and (C) while Ms. Salgado was seen by Dr. Washburn, "there was no notation on the medical record of his assessment." *Id.* at 201:1-24. Dr. Washburn has no specific memory of reviewing Ms. Salgado's EKG results, *does not know why he didn't note his review of the EKG results* and cannot explain why the EKG results were not uploaded to the chart until weeks after Ms. Salgado's death. *Id.* at 160:25 – 162:13.

Dr. Washburn further ***admits*** that, as a matter of practice, he ***never actually reviews EKG results*** himself, but relies on nurses to read the results to him. *Id.* at 164:25 – 165:13. According to Dr. Washburn, this practice of not actually reviewing EKG results is "better than nothing." *Id.*

40. Again, there is evidence that Ms. Salgado's vital sign entries were falsified at the direction of Defendant Chris Rogers. *See* LCvR 56.1(c) Statement(A)(30), *supra.*

41. Dr. Allen's opinions are focused on the inadequate care Ms. Salgado received, including the failure to review or consider the abnormal EKG, on June 26 through the 28, 2011. *See* Allen (Verified) Report (Ex. 9) at 16-21. Despite some confusion, created by Defendants own poor record-keeping, it is clear that the EKG of Ms. Salgado was taken, but not documented, on June 25, 2011. *See* LCvR 56.1(c) Statement(A)(36-39), *supra.*

Medical "Care" at the Jail – June 26, 2011

42-46. On the afternoon of June 26, 2011, Jail nursing staff generated a "problem oriented record". *See* Jail Medical Records (Ex. 7) at GLANZ-Revilla05500-5507. According to nursing staff, Ms. Salgado was observed ***hyperventilating and rubbing her chest.*** *Id.* at 5506. She complained of ***nausea, shortness of breath and increased chest pain***, describing it as an ***"11" on a scale from one to ten.*** *Id.* at 5505. She further reported that the chest pain was radiating into her neck. *Id.* These are all "warning signs" according to Ms. Salgado's discharge instructions from Saint John. Saint John Records (Ex.3) at 708-709. However, Ms. Salgado was not sent to the hospital nor seen by a physician. Rather, medical staff responded by giving her a "bag to breathe into", and Ms. Salgado was returned to her cell. *See* Jail Medical Records (Ex. 7) at GLANZ-

Revilla05506. Ms. Salgado reported to nursing staff that she was too weak to hold the paper bag up to her mouth. *Id.* When reviewing this portion of the medical records during his deposition, ***Dr. Washburn laughed***, and asserted that Ms. Salgado was exaggerating her symptoms. *See* Washburn Depo. (Ex. 10) at 156:8-23.

47. The chest pain described by Ms. Salgado on June 26 was ***not*** consistent with the pain during her prior hospitalizations. Rather, the pain had increased in severity, was radiating to her neck and was accompanied by severe shortness of breath and hyperventilation. *See* LCvR 56.1(c) Statement(A)(42-46), *supra.*

48-52. *See* LCvR 56.1(c) Statement(A)(30, 42-46), *supra.*

53. The mere fact that Ms. Salgado did not vomit during her brief June 26 visit to the medical unit does not excuse medical staff's apparent decision to disregard her complaints of nausea and vomiting.

54. According to Dr. Shah, Dr. Washburn's order for nitroglycerine indicates concern about a "cardiac etiology." Shah Depo. (Ex. 4) at 189:12-14. Further, because Ms. Salgado's chest pain persisted for 15 minutes and after three doses of nitroglycerine, she was, "by definition", suffering from ***"unstable angina."*** *Id.* at 190:16 – 192:4 (emphasis added). *See also* Jail Medical Records (Ex. 7) at GLANZ-Revilla 05505-07; and Drug Admin. Log (Ex. 11) at GLANZ-Revilla 05407 (indicating that pain only resolved after 30 minutes and 4 doses of nitro). Thus, it was at this point, on the afternoon of June 26, 2011, that Ms. Salgado should have been sent to a facility with "more advanced care". Shah Depo. (Ex. 4) at 189:12-14. As Dr. Shah explains, Dr. Washburn's order (over the phone) for nitroglycerine and aspirin evinces his knowledge of "cardiac pain", and Ms. Salgado's continuing symptoms of pain "would be an

indication to say this person has a ***high risk for having unstable angina or acute coronary syndrome*** and, therefore, warrants monitoring and additional therapy." *Id.* (emphasis added). However, no such monitoring or additional therapy was provided. Instead, Ms. Salgado was simply returned to her pod. *See* Jail Medical Records (Ex. 7) at GLANZ-Revilla05506.

55-58. While Nurse Hudson notes that an EKG was ordered and performed on June 26, 2011, there is ***no evidence*** of any June 26 EKG results in the records. Rather, the ***only*** EKG results in record are dated June ***25***, 2011. *See* Jail Medical Records (Ex. 7) at GLANZ-Revilla 5514-16. The June 25 EKG results, the failure to upload them (until weeks after Ms. Salgado's death) and failure to document any review of them are discussed above. *See* LCvR 56.1(c) Statement(A)(36-39), *supra.*

59. *See* LCvR 56.1(c) Statement(A)(30), *supra.*

60-61. *See* LCvR 56.1(c) Statement(A)(54), *supra.*

62. Dr. Allen is highly critical of Defendants' failure to provide appropriate evaluation and care to Ms. Salgado on June 26, 2011, despite the "clear and significant risks for acute coronary syndrome…." Allen (Verified) Report (Ex. 9) at 20. Dr. Allen opines that the decision to keep Ms. Salgado in the Jail, as opposed to sending her to the hospital, was "reckless." *Id.* at 20-21.

63-64. *See* LCvR 56.1(c) Statement(A)(30), *supra.*

65. *See* LCvR 56.1(c) Statement(A)(54), *supra.*

Medical "Care" at the Jail – June 27, 2011

66. There is a note that Ms. Salgado was "refer[red]" to see Dr. Washburn at around 3:50 pm on June 27, 2011, for complaints of nausea and vomiting. Jail Medical

Records (Ex. 7) at GLANZ-Revilla05507. However, Dr. Washburn does not document actually seeing her and does not note any assessment or impressions. *Id.* Indeed, Dr. Washburn ***admits*** that he did ***not*** note seeing or assessing Ms. Salgado on June 27, 2011. *See* Washburn Depo. (Ex. 10) at 167:11 – 169:11. ***In fact, Dr. Washburn does not know whether he saw Ms. Salgado on June 27, 2011.*** *Id.* Thus, there is a genuine issue of fact as to whether Dr. Washburn actually saw Ms. Salgado on June 27, 2011. Moreover, Dr. Washburn did not enter ***any*** note into Ms. Salgado's chart until June 29, 2011, the day ***after*** her death. *See* Jail Medical Records (Ex. 7) at GLANZ-Revilla05491. According to Defendants' own expert, it ***"looks bad"*** that Dr. Washburn failed to document any care or treatment of Ms. Salgado until after her death. *See, e.g.,* Kassabian Depo. (Ex. 5) at 31:22 – 34:25; 37:8-13; 96:12-25 (emphasis added). As Dr. Kassabian (Defendants' expert) explains, it is "important" for physicians to enter ***daily*** progress notes because such notes "communicat[e] to other caregivers what [the doctor's] impressions are or what should be done with a patient". *Id.* at 31:22 – 32:16. Dr. Allen similarly testified:

> Again, what's missing here, and it is critical -- you cited earlier that I'm critical of Dr. Washburn for not writing a note. ***I'm more than critical. Chest pain*** is one of those complaints, particularly in someone with a history of known coronary disease, that ***always must be treated urgently and completely to make sure, as best one can reasonably make sure, that it is not acute coronary syndrome.***

Allen Depo. (Ex. 2) at 259:8-15 (emphasis added).

67-72. While Nurse Metcalf noted that she assessed Ms. Salgado at 10:24am on June 27, 2011, this note is factually inaccurate. As Nurse Metcalf ***admits***, she did ***not*** assess Ms. Salgado at 10:24am; rather, she saw Ms. Salgado at 7:00am. *See* Metcalf Depo. (Ex. 12) at 91:16-20. Thus, the information in the chart (Jail Medical Records (Ex. 7) at GLANZ-Revilla05494) does ***not*** reflect Ms. Salgado's vital signs at 10:24am on

June 27. *See* Metcalf Depo. (Ex. 12) at 91:16-20. Further, while Nurse Metcalf notes that Ms. Salgado was "seen" by Dr. Washburn on June 27, Dr. Washburn believes this note may be "wrong". *See* Washburn Depo. (Ex. 10) at 169:8-11. Again, Dr. Washburn does not know whether he saw Ms. Salgado on the 27th. *Id.* at 167:11 – 169:11.

In any event, at 7:00am, Ms. Salgado was again reporting nausea, vomiting and chest pain. *See* Jail Medical Records (Ex. 7) at GLANZ-Revilla05494. Yet, there is ***no evidence*** in the chart that Nurse Metcalf went back and checked on Ms. Salgado at ***any time*** during her ***12 hour shift.*** *See* Metcalf Depo. (Ex. 12) at 98:9 – 100:3. Indeed, there is no evidence in the electronic chart that ***any*** nurse, or other medical provider, assessed Ms. Salgado after 7:00 am (falsely reported as 10:24am) on June 27. *See* Jail Medical Records (Ex. 7) at GLANZ-Revilla05494. There is no evidence that Ms. Salgado's "high risk for having unstable angina or acute coronary syndrome" was being addressed in any way.

Additionally, because Ms. Salgado's abnormal EKG results were not documented in the chart until *after* her death, nursing staff had no knowledge of the EKG results. *See, e.g.,* Metcalf Depo. (Ex. 12) at 121:10-22; 121:24 – 123:14. Nurse Karen Metcalf was on day shift at the Jail (7:00am to 7:00pm) on June 27 and 28, 2011. *See, e.g.,* Metcalf Depo. (Ex. 12) at 78:7-10; 90:7-9, 112:25 – 113:9, 121:10-13, 159:23-24; Jail Medical Records (Ex. 7) at GLANZ-Revilla05494; CHC Medical Records (Dkt. #244-5) at LS00006. Nurse Metcalf testified that, had Ms. Salgado's abnormal EKG results been documented in the records, she would have viewed her symptoms – *e.g.,* chest pain, nausea and vomiting – differently, because ***"sometimes some of these symptoms can be impending***

heart problems." *See, e.g.,* Metcalf Depo. (Ex. 12) at 121:10-22; 121:24 – 123:14 (emphasis added). *See also* Kassabian Depo. (Ex. 5) at 31:22 – 32:16.

There are also serious questions about the competency of Nurse Metcalf. ***According to Defendants' own expert, Dr. Keith Kassabian, due to Nurse Metcalf's documented performance problems, including a history of falsifying medical records, he would not have permitted Metcalf to provide care or treatment to Ms. Salgado at all.*** Kassabian Depo. (Ex. 5) at 55:24 – 56:4; 81:12-21; 99:9-16. *See also* Excerpts From Metcalf Disciplinary File (Ex. 13).

73. Contrary to Defendants' assertion, it is unclear, at best, when Ms. Salgado was admitted to the Jail's medical unit. One table in the chart seems to indicate that she was "admitted to the unit" at 3:50 pm on June 27, 2011. *See* Jail Medical Records (Ex. 7) at GLANZ-Revilla05507. Still, a hand-written "DOCTORS ORDER" form, which is ***not*** signed by a doctor, states that she was admitted to medical at 6:10 pm on June 27, 2011. *See* Dkt. #244-5 at LS00026. Yet another hand-written form appears to show that she was admitted at 7:00pm on the 27th. *See* Infirmary Admission Record (Ex. 14) at GLANZ-Revilla05342. Defendants' own expert witness, Dr. Kassabian, could not determine, from the records, when Ms. Salgado was admitted to the medical unit. *See* Kassabian Depo. (Ex. 5) at 122:12 – 123:13. Overall, Dr. Kassabian found that Defendants' records were confusing and "hard to follow…." *Id.* at 83:11 – 84:16.

74. Doxycycline is an antibiotic. *See* Shah Depo. (Ex. 4) at 214:4-7. Thus, it is axiomatic that oxycycline is not a cardioprotective medication. Again, there is no evidence that Ms. Salgado's "high risk for having unstable angina or acute coronary syndrome" (*Id.* at 189:12-14) is being addressed in any way.

75. Ms. Salgado's symptoms, on June 27, 2011, were much more serious than "generalized pain" and vomiting. First, as shown *supra*, at 7:00am, Ms. Salgado was continuing to report chest pain, in addition to nausea and vomiting. Moreover, a detention officer, Joshua Walker, observed Ms. Salgado after she had reportedly ***fallen down "flat on her face".*** Incident Report (Ex. 15) at GLANZ-Revilla05286 (emphasis added). Officer Walker found Ms. Salgado to be in ***"pain and unresponsive"***. *Id.* (emphasis added). Officer Walker "notified" the nurse of these observations. *Id.* Still, there is no documentation of these serious changes in Ms. Salgado's condition anywhere in the medical record. *See* Jail Medical Records (Ex. 7) at GLANZ-Revilla05489 – 5547. Among the "warning signs" set forth in Ms. Salgado's discharge instructions -- from Saint John -- were "[w]eakness, dizziness, or fainting." Saint John Records (Ex. 3) at SJS00709. Nevertheless, the report that Ms. Salgado had fallen flat on her face and was unresponsive was completely disregarded by responsible medical staff.[2]

76-77. As discussed above, there is evidence that Ms. Salgado's "vital signs" information was falsified. *See* LCvR 56.1(c) Statement(A)(30), *supra.* The hand-written vital signs information is particularly suspect. As Nurse Metcalf testified, it was the practice to ***"always"*** place vital signs information into the computerized, electronic, medical record. Metcalf Depo. (Ex. 12) at 75:10-23. The ***only*** time she had ever placed handwritten vital signs into a chart was in Ms. Salgado's chart. *Id.* Nurse Metcalf ***admits*** that these handwritten vitals were placed in Ms. Salgado's paper file ***after*** she was found

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2 As noted in Plaintiff's Response to CHC's MSJ, the failure to provide assistance for Ms. Salgado, after she was found unresponsive, was a violation of CHC Clinical Protocol. Plaintiff adopts and incorporates her Response to CHC's MSJ herein.

unresponsive in her cell, and ***after*** EMSA arrived. *Id.* at 74:4 – 75:23, 80:22 – 81:1. Nurse Metcalf further testified that she was instructed to provide these handwritten vital signs after Ms. Salgado had been found unresponsive in her cell. *Id.* It is also noteworthy that the handwritten vital signs ***do not appear anywhere*** in the official copy of Ms. Salgado's medical records produced by Former Sheriff Glanz. *See* Jail Medical Records (Ex. 7) at GLANZ-Revilla05489 – 5547.

78. The "Security Check" form, which is ***not*** dated, bears the initials of Joshua Walker, *i.e.,* "JW". *See* Security Check Form (Ex. 16) at GLANZ-Revilla05452. Again, Officer Walker found Ms. Salgado to be in pain and unresponsive after she had reportedly fallen flat on her face. *See* LCvR 56.1(c) Statement(A)(75), *supra.*

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79. *See* LCvR 56.1(c) Statement(A)(75, 78), *supra.*

80-81. The ***only*** notes in Ms. Salgado's medical record, dated June 28, 2011, are: (A) a note from Nurse Amanda Bowman (at 1:02pm) verifying Ms. Salgado's medications "at OSU last visit 4/11/11"; and (B) a note from Nurse Susan Pinson (at 8:44pm) that was entered ***after*** Ms. Salgado was found to be "cyanotic", with "mottled" extremities, without "spontaneous respirations", with no pulse and pronounced dead. *See* Jail Medical Records (Ex. 7) at GLANZ-Revilla05491-94. Nurse Metcalf -- who was on shift on June 28 -- did ***not*** enter ***any*** note concerning Ms. Salgado into the medical record. *See* Metcalf Depo. (Ex. 12) at 113:11-22, 114:8-12, 116:1-5.

82-83. The electronic medical record indicates that, while Ms. Salgado's blood glucose was taken at 4:20am and 5:08pm, her blood pressure, pulse, temperature, respiration and "pulse OX" were ***not*** recorded on June 28. *See* Jail Medical Records (Ex.

7) at GLANZ-Revilla05490. Indeed, there is no record of these vital signs, in the electronic medical chart, from 7:00am on June 27 through the time that Ms. Salgado was pronounced dead on June 28, 2011 (at approximately 8:00pm). *Id.* at 5490-5494. The purported vital signs data relied upon by Defendants is handwritten, and ***not even dated June 28, 2011.*** *See* Handwritten Record (Ex. 17) at GLANZ-Revilla05343. Further, again, there is evidence that Ms. Salgado's vital sign data was falsified. *See* LCvR 56.1(c) Statement(A)(30), *supra.* Therefore, there is no evidence, in the medical record, and certainly no credible evidence, that Ms. Salgado's vital signs were taken on June 28, 2011.

84. While Dr. Washburn claims to have seen Ms. Salgado on June 28, 2011, there is no contemporaneous note documenting this. *See* Jail Medical Records (Ex. 7) at GLANZ-Revilla05491. Rather, Dr. Washburn's ***only*** note concerning Ms. Salgado was entered on June 29, 2011, the day ***after*** Ms. Salgado died in the Jail. *Id.* Dr. Washburn cannot explain why he did not record his purported assessment of Ms. Salgado until the day after her death and a day after he (allegedly) saw her. *See* Washburn Depo. (Ex. 10) at 137:10-13, 137:22 – 138:2. Dr. Kassabian, ***Defendants'*** expert, testified that Dr. Washburn's failure to document any care or treatment of Ms. Salgado until after her death ***"looks bad"***. *See, e.g.,* Kassabian Depo. (Ex. 5) at 31:22 – 34:25; 37:8-13; 96:12-25 (emphasis added). As Dr. Allen states: "The documentation of Dr. Washburn is incriminating. … His only note on the record, written post-mortem, appears to document the fact that he was ***oblivious to her significant cardiac risks***, signs and symptoms." Allen (Verified) Report (Ex. 9) at 21 (emphasis added). "There is description by recollection of a incomplete medical history with ***no mention of her cardiac history or***

recent hospitalization, no mention of chest pain or shortness of breath, and cursory and incomplete physical exam." *Id.* at 19 (emphasis added). There is no mention of the abnormal EKG in Dr. Washburn's "late note". *See* Jail Medical Records (Ex. 7) at GLANZ-Revilla05491. Incredibly, Dr. Washburn does not even mention that Ms. Salgado died in her cell. *Id.*

In addition to these significant omissions of fact, the limited information Dr. Washburn chose to record in the post-mortem note is inconsistent with the other evidence. For instance, while Dr. Washburn reports "no diarrhea or vomiting", TCSO's own investigator found, on the evening of June 28, that Ms. Salgado's toilet ***"contained what appeared to be vomit"*** and that nursing staff reported that she ***"had been vomiting regularly."*** Incident Report (Ex. 15) at GLANZ-Revilla-5279 (emphasis added). In this regard, Dr. Washburn ***admits*** that "persistent pain" and "persistent vomiting" are "serious" and "obvious" health care concerns. Washburn Depo. (Ex. 10) at 87:22 – 88:7.

Moreover, Dr. Washburn ***admits*** to serious concerns about Ms. Salgado's condition that were not documented by him, or any other healthcare provider, at the Jail. In fact, ***Dr. Washburn admits that Ms. Salgado should have been sent to a hospital prior to her death.*** *See* Washburn Depo. (Ex. 10) at 221:22 – 223:25. Dr. Washburn received verbal reports from nursing staff, over the course of a day, on two to three occasions, that Ms. Salgado had ***"crashed"*** or was ***"crashing"***. Washburn Depo. (Ex. 10) at 221:22 – 223:25. Yet, Dr. Washburn did not send Ms. Salgado to the hospital nor even bother to document these serious changes in her condition. The following excerpt from Dr. Washburn's deposition is illustrative of his indifference:

> Q. In reviewing Ms. Salgado's chart, based on what we know today, ***at what point in time***, if ever, do you believe ***Ms. Salgado should have been***

> ***sent from David L. Moss to the hospital emergency room?***
> ***
> A. Well, sometime that evening ***when she crashed again on us.***
>
> Q. (By Mr. Smolen) When did she crash the first time?
>
> A. Oh, gosh. I don't know. ***She was up and down. They'd tell me she's bad***, and I'd run down there, and she was up talking. It was just up and down like that.
>
> ***
> Q. (By Mr. Smolen) Okay. ***You don't note that in the record about those occurrences of you coming down and her crashing*** and then reports of her getting better and then ***reports that she's getting worse,*** you don't document that, correct?
>
> ***
> ***A. Apparently not.***
>
> Q. (By Mr. Smolen) Why?
> ***
> ***A. I don't know why.***

Id. (emphasis added).

85-87. Ms. Metcalf's version of the June 28 events is not credible. Defendants' own expert testified that he would probably: (A) question Nurse Metcalf's reports; and (B) ***not*** accept her notes at face value. *See* Kassabian Depo. (Ex. 5) at 102:19 – 103:12. The ***only*** June 28 documentation Nurse Metcalf provides regarding Ms. Salgado is in a ***post-mortem*** "witness statement". *See* Incident Report (Ex. 15) at GLANZ-Revilla05282. She did ***not*** document ***any*** assessment or care of Ms. Salgado, on June 28, prior to her death, in the actual medical record. *See* Jail Medical Records (Ex. 7). There is specific evidence that Ms. Salgado's records were falsified. *See* LCvR 56.1(c) Statement(A)(30), *supra.* And there are repeated documented instances of Nurse Metcalf falsifying records. *See* Metcalf Disciplinary File (Ex. 13). Under this backdrop, a reasonable jury could, and should, disregard Nurse Metcalf's post-mortem witness statement. *See also* LCvR

56.1(c) Statement(A)(76-77, 80-83), *supra.* In the absence of any credible evidence to the contrary, a reasonable jury could conclude that Nurse Metcalf ***utterly failed to monitor or assess Ms. Salgado's condition*** on June 28, 2011.

Nonetheless, even if one were to take Nurse Metcalf's post-mortem witness statement at face value, the statement is still evidence that the "care" she provided was inadequate. According to her post-mortem witness statement, Nurse Metcalf checked on Ms. Salgado three times over the course of her 12-hour shift, at 3:00pm, 5:30pm and 7:00pm. *See* Incident Report (Ex. 15) at GLANZ-Revilla05282. Nurse Metcalf reports that Ms. Salgado did not eat her supper, and that at 5:30pm, she observed, from outside of Ms. Salgado's cell, that her eyes were closed. *Id. See also* Metcalf Depo. (Ex. 12) at 146:16 – 147:7. Nurse Metcalf made no attempt to enter Ms. Salgado's cell to check on her. *Id.* Then, at 7:00pm, at the end of Nurse Metcalf's shift, Nurse Paul Wallace arrived and asked to enter Ms. Salgado's cell because she ***"didn't look good."*** *See* Incident Report (Ex. 15) at GLANZ-Revilla05282 (emphasis added).

88-91. When Nurse Wallace arrived at the Jail at 7:00pm, Nurse Metcalf told him that "everybody was okay…." Wallace Depo. (Ex. 18) at 46:2 – 47:24. Nurse Metcalf did not tell Nurse Wallace anything about Ms. Salgado. *Id.* In any event, Nurse Wallace quickly determined that Ms. Salgado was ***not*** okay. *Id.* Nurse Wallace walked through the medical unit to check on the patients, and noticed that Ms. Salgado did not look good. *Id.* He banged on her cell door; Ms. Salgado did not respond. *Id.* He yelled to try to get Ms. Salgado's attention; again, she did not respond. *Id.* Nurse Wallace asked a detention officer to let him in Ms. Salgado's cell. *Id.* When Nurse Wallace entered the cell, he continued talking to Ms. Salgado, asking her if she was okay; there was no response. *Id.*

He kicked her bed, but Ms. Salgado did not respond. *Id.* Nurse Wallace observed that Ms. Salgado was pale, diaphoretic and was not moving. *Id.* At around 7:24pm, Nurse Wallace yelled for another nurse, Nurse Pinson, and they began CPR to try and revive Ms. Salgado. *Id.* at 51:15-24. *See also* Incident Report (Ex. 15) at GLANZ-Revilla05283. Nurse Pinson observed that Ms. Salgado was "cyanotic", her extremities were "mottled", she was not breathing and had no pulse. *Id.* This evinced a prolonged period of time that Ms. Salgado had gone without oxygen. Wallace Depo. (Ex. 18) at 54:14 – 55:2. Ms. Salgado's body was already cold to the touch. Incident Report (Ex. 15) at GLANZ-Revilla at 05276. Her skin was grey. Wallace Depo. (Ex. 18) at 55:10-15. Nurse Wallace believes that Ms. Salgado may have been dead for ***"awhile"*** at the point he entered her cell. *Id.* at 56:14-24.

EMSA arrived at around 7:40pm. Incident Report (Ex. 15) at GLANZ-Revilla at 05283. Additional efforts to revive Ms. Salgado were unsuccessful. *Id.* At 8:00pm, EMSA terminated its efforts to resuscitate Ms. Salgado. *Id.* TCSO subsequently reported to the Oklahoma State Department of Health ("OSDH") that Ms. Salgado died in the Jail on June 28, 2011. *See* OSDH Report (Ex. 19) at GLANZ-Revilla05337.

92. Dr. Allen is highly critical of the care, or lack thereof, that Ms. Salgado received at the Jail, referring to it as ***"reckless"***, and finding that her clear risks of acute coronary syndrome were disregarded. *See, e.g.,* Allen (Verified) Report (Ex. 9) at 20-21. Dr. Allen specifically opines that the "inadequate care provided to Ms. Salgado by the Tulsa County Jail contributed to and more probably than not was the cause of her death." *Id.* Dr. Shah believes that, by June 26, Ms. Salgado should have been sent to a hospital as she was "at high risk for having unstable angina or acute coronary syndrome and,

therefore, warrant[ed] monitoring and additional therapy." Shah Depo. (Ex. 4) at 189:12-14. Defendants' own expert concluded that the healthcare system, including the Jail's healthcare system, ***"failed"*** Ms. Salgado. Kassabian Depo. (Ex. 5) at 186:7 – 187:2 (emphasis added). Dr. Washburn even admits that Ms. Salgado should have been sent to a hospital after she had "crashed" several times at the Jail. Washburn Depo. (Ex. 10) at 221:22 – 223:25.

93. The Medical Examiner determined that the probable cause of Ms. Salgado's death was "atherosclerotic and hypertensive cardiovascular disease." ME Report (Ex. 20) at GLANZ-Revilla05453. Dr. Shah testified to "a reasonable degree of certainty that [the] most likely the cause of [Ms. Salgado's] death was an acute coronary syndrome." Shah Depo. (Ex. 4) at 240:14-16 Dr. Allen opines "to a degree of certainty" that "it's more likely than not that she died of something related to cardiovascular disease…." Allen Depo. (Ex. 2) at 197:7-17.

94-95. These facts, while uncontested, are irrelevant as a matter of law. *See, e.g., Farmer v. Brennan*, 511 U.S. 825, 842-43 (1994).

B. Additional Facts Precluding Summary Judgment

1. When Dr. Washburn took the job of medical director, he had no experience in running a clinic or managing nursing staff. *See* Washburn Depo. (Ex. 10) at 40:15 – 41:4. When he was hired, Dr. Washburn did not understand what his role was as medical director, and no one at the Jail explained the position to him or provided him with any training with respect to the performance of the medical director role. *Id.* at 33:10-23. In fact, Dr. Washburn was not even aware that he had been hired as medical director until after he began working at the Jail. *Id.* at 34:9-19. Dr. Washburn does not

recall any protocols at the Jail pertaining to inmate care. *Id.* at 15:13-16. As medical director, Dr. Washburn was responsible for the training and supervision of nursing staff; but he had a "problem" with that, and he informed CHC that he had a problem with training and supervision of nursing staff. *Id.* at 80:8-22.

2. 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. 21) 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. The Tulsa County Sheriff's Office is ***required***, under a Settlement Order with the Department of Justice, to maintain compliance with NCCHC standards. *See* Settlement Order (Ex. 22) at 19; and Signature Pages (Ex. 23). The Settlement Order is, itself, evidence of long standing, and serious, problems with TCSO's delivery of medical care to inmates.

3. Sheriff Glanz relies exclusively on NCCHC accreditation as evidence that his medical system is adequate. *See* Glanz Depo. (Ex. 24) 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. 25) 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. *Id.* 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.

4. 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. 26). Despite the efforts to conceal and alter the facts, the Tulsa County Jail failed the 2007 NCCHC audit. *See, e.g.,* Maloy Depo. (Ex. 25) 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. 27) (emphasis added).

5. NCCHC issued its final audit report for the 2007 accreditation period on

November 9, 2007. See Harrison Depo. (Ex. 21) 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". *Id.* at 50:17-23; 52:8-20; 62:4-17 (emphasis added).

6. 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. (Ex. 24) 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. (Ex. 28) at 176:14-17.

7. 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. 25) at 123:25 – 124:10. Pam Hoisington, by this time Health Services Administrator ("HSA") at the Jail, drafted the written action plans. *Id.* 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. 21) at 54:9-16.

8. In August of 2009, the American Correctional Association ("ACA") conducted a "mock audit" of the Jail. *See* Gondles Report (Ex. 29) at 007. The ACA's mock audit revealed that the Jail was non-compliant with "mandatory health standards" and "substantial changes" were suggested. *Id.* Based on these identified and known "deficiencies" in the health delivery system at the Jail, the Jail Administrator sought input

and recommendations from Elizabeth Gondles, Ph.D. ("Dr. Gondles"). *Id.* at 1 and 7. Dr. Gondles was associated with the ACA as its medical director or medical liaison. *See* Robinette Depo. (Ex. 30) at 35:10-21. After reviewing pertinent documents, touring the Jail and interviewing medical and correctional personnel, on October 9, 2009, Dr. Gondles generated a Report, entitled "Health Care Delivery Technical Assistance" (hereinafter, "Gondles Report"). *See* Gondles Report (Ex. 29). The Gondles Report was provided to the Jail Administrator, Michelle Robinette. *Id.* at 001; Robinette Depo. (Ex. 30) at 48:9-16. As part of her Report, Dr. Gondles identified numerous "issues" with the Jail's health care system, as implemented by Defendant CHM. *See, e.g.,* Gondles Report (Ex. 29) at 007, 10-19. After receiving the Gondles Report, Chief Robinette held a conference -- to discuss the Report -- with the Undersheriff, Administrative Captain and CHC/CHM. Robinette Depo. (Ex. 30) at 50:20-24.

9. Among the issues identified by Dr. Gondles, as outlined in her Report, were: (a) understaffing of medical personnel due to CHM misreporting the average daily inmate population; (b) deficiencies in "doctor/PA coverage"; (c) a lack of health services oversight and supervision; (d) failure to provide new health staff with formal training; (e) delays in inmates receiving necessary medication; (g) nurses failing to document the delivery of health services; (h) systemic nursing shortages; (h) failure to provide timely health appraisals to inmates; and (i) 313 health-related grievances within the past 12 months. *See, e.g.,* Gondles Report (Ex. 29) at 007, 10-19. Dr. Gondles concluded that "[m]any of the health service delivery issues outlined in this report are a result of the ***lack of understanding of correctional healthcare issues by jail administration*** and contract oversight and monitoring of the private provider." *Id.* at 22. Based on her findings, Dr.

Gondles "strongly suggest[ed] that the Jail Administrator establish a central Office Bureau of Health Services" to be staffed by a TCSO-employed Health Services Director ("HSD"). *Id.* According to Dr. Gondles, without such an HSD in place, TCSO could not properly monitor the competency of the Jail's health staff or the adequacy of the health care delivery system. *Id.*

10. Nonetheless, TCSO leadership chose ***not*** to follow Dr. Gondles' recommendations. *See, e.g.,* Robinette Depo. (Ex. 30) at 71:20 – 72:7; Weigel Depo. (Ex. 31) at 53:6 – 54:14. TCSO did ***not*** establish a central Office Bureau of Health Services nor hire the "HSD" as recommended. *Id.*

11. On March 12, 2010, at 12:03 pm, an inmate at the Jail was found to have altered level of consciousness and breathing difficulties. *See* AMS-Roemer Report, 11/8/11 (Ex. 32) at GLANZ-EW3050. The inmate had ***documented chest pain over the past week.*** *Id.* The Jail's physician at the time, Dr. Andrew Adusei, arrived at around 12:25pm. *Id.* The inmate subsequently went into ***cardiac arrest*** and EMSA was called at 12:45pm with apparent arrival at 1250. *Id.* The inmate ***died*** from a pulmonary embolus. *Id.* The Jail's own internal medical auditor later found that the delay in calling EMSA may have contributed to the inmate's death. *Id.* at GLANZ-EW3050-51.

12. ***Another*** ***inmate died*** at the Jail, after going into ***cardiac arrest***, on June 17, 2010. AMS-Roemer Report, 11/8/11 (Ex. 32) at GLANZ-EW3051. The Jail's internal auditor found "several standard of care issues in the care of this inmate." *Id.* Specifically, the auditor noted a lack of monitoring even "after ***considerable risk*** of continued rise in her [blood level potassium] which could lead to cardiac arrest…." *Id.* (emphasis added). The auditor further noted "***inadequate system protocols***, and [a lack

of] real time auditing of protocols, for treatment, monitoring, referral." *Id.*

13. On October 28, 2010, Assistant District Attorney Andrea Wyrick wrote an email to Josh Turley, TCSO's "Risk Manager". *See* Wyrick Email (Ex. 33). In the email, Ms. Wyrick voiced concerns about whether the Jail's medical provider, Defendant CHMO, a subsidiary of CHC, was complying with its contract. *Id.* Ms. Wyrick further made an ominous prognosis: "This is very serious, especially in light of the three cases we have now — what else will be coming? It is one thing to say we have a contract .. to cover medical services and they are indemnifying us … It is another issue to ***ignore any and all signs we receive of possible [medical] issues*** or violations of our agreement with [CHC] for [health] services in the jail. The bottom line is, ***the Sheriff is statutorily … obligated to provide medical services."*** *Id.* (emphasis added).

14. NCCHC conducted a second audit of the Jail's health services program in 2010. *See* 2010 NCCHC Report, 11/12/10 (Ex. 34) at Glanz.02 00069-89. After the audit was completed, the NCCHC placed the Tulsa County Jail on probation. *Id.* at 00069.

15. 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. 34). 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.

16. Sheriff Glanz only read the first two or three pages of the 2010 NCCHC. *See* Glanz Depo. (Ex. 24) 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. 8) at ¶ 9.

17. On December 14, 2010, yet ***another*** inmate ***died*** from a ***cardiac arrest*** at the Jail. *See* AMS-Roemer Report, 11/8/11 (Ex. 32) at GLANZ-EW3051. The inmate had a noted history of coronary artery bypass graft and heart attacks and had been prescribed Metoprolol. *Id.* Only two attempts were made, by Jail medical staff, to verify the Metoprolol prescription. *Id.* Then, attempts to confirm the prescription were abandoned. *Id.* As Jail's medical auditor found, "[t]he main concern in this inmate's care relates to the ***lack of follow up*** on his metoprolol medication." *Id.* (emphasis added). As the auditor concluded, "[i]f inmate had been on this medicine, ***his chances of having a fatal cardiac event would have been significantly decreased."*** *Id.* (emphasis added).

18. As documented throughout this Response, Ms. Salgado died, on June 28, 2011, from acute coronary syndrome, due to the deliberate indifference and negligence of

responsible medical and detention staff.

19. On September 29, 2011, the Immigration and Customs Enforcement ("ICE") reported U.S. Department of Homeland Security's Office of Civil Rights and Civil Liberties' ("CRCL") 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. 35) at Glanz.02 00066 (emphasis added); *See also* Memo from Lillard to Edwards, 9/26/11 and CHC Attachment (Ex. 36).

20. Sheriff Glanz saw the ICE-CRCL Audit Report. *See* Glanz Depo. (Ex. 24) at 153:16-23. Nonetheless, it is unclear what, if any, policies or practices changed at the Jail since the ICE-CRCL Report was issued. *Id.* at 162:25 – 163:13. *See also* Harrington Aff. (Ex. 8) at ¶ 22.

21. An inmate named Elliott 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. *See, e.g., Burke v. Glanz,* No. 11-CV-720-JED-PJC, 2016 WL 3951364 (N.D. Okla. July 20, 2016). Similar to Ms. Salgado, Mr. Williams exhibited obvious symptoms of serious, and emergent, health care needs that were disregarded by responsible medical and detention staff. *Id.*

22. On November 18, 2011, Advanced Medical Systems ("AMS")/Howard Roemer, M.D. ("Roemer" or "Dr. Roemer"), 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/Roemer Report, 11/8/11 (Ex. 32) at GLANZ-EW3053-54. AMS/Roemer specifically commented on no less than six (6) inmate deaths, spanning from 2009 through December 2010, finding deficiencies in the care provided to each. *Id.* at GLANZ-EW3050-51, 3053. Once again, there is no evidence that any specific practices or policies changed at the Jail as a result of AMS/Roemer's findings. *See, e.g.,* Glanz Depo. (Ex. 24) at 182:13 – 183:10.

23. As part of its ongoing auditing function, and well after Ms. Salgado's death, AMS/Roemer continued to find serious deficiencies in the delivery of care at the Jail. *See, e.g.,* Corrective Action Review (Ex. 37) at CHM1935 – 1941; Response to 2012 Audit (Ex. 38) at CHM1969 – 1971. For instance, AMS/Roemer 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. 37) at CHM1935 – 1938. 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. 38) at CHM1971 (emphasis added).

24. The former Director of Nursing at the Jail, Tammy Harrington, R.N., 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. 8) at ¶ 6. During her years working at the Jail, Nurse Harrington observed, *inter alia*: (a) a chronic failure to triage inmates' requests for medical and mental health assistance; (b) a "check the box" intake/booking process that did not provide true medical and mental health screening and put inmates at substantial risk; (c) doctors refusing/failing to see inmates with life-threatening conditions; (d) CHC's Health Services Administrator ("HSA"), Defendant Chris Roger, repeatedly instructing staff to doctor and falsify medical records; (e) a chronic lack of supervision of clinical staff; and (g) repeated failures to alleviate known and significant deficiencies in the health services program at the Jail. *See generally* Harrington Aff. (Ex. 8). *See also* Mason Aff. (Ex. 39).

25. BOCC and TCSO continued to contract with CHC even after Ms. Salgado's and Mr. Williams' deaths 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. 40). Despite his knowledge of the many identified problems with the Jail's health services program, Sheriff Glanz rated CHC as a nine (9) on a scale from one to ten (10), as a medical provider. *See* Glanz Depo. (Ex. 24) at 17:11-16.

26. Sheriff Glanz and TCSO took over operations of the Jail on July 1, 2005. Glanz Depo. (Ex. 24) at 13:4-7. The CHC Defendants were under contract to provide medical and mental health care services to inmates at the Jail at all pertinent time periods. See, e.g., Health Services Contract (Ex. 41) at GLANZ0192-201; Resp. to RFP, 4/26/10 (Ex. 42) at GLANZ0111.

ARGUMENT

I. FORMER SHERIFF GLANZ AND SHERIFF REGALADO ARE *NOT* ENTITLED TO SUMMARY JUDGMENT ON PLAINTIFF'S CONSTITUTIONAL CLAIMS

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

It is well-established that officials, such as Former 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." *Dodds,* 614 F.3d at 1199.

A claim against a state actor in his official capacity, such as Sheriff Regalado, "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). *See also see Kentucky v. Graham,* 473 U.S. 159, 166 (1985) ("[A]n official-capacity suit is, in all respects other than name, to be treated as a suit against the entity."). To hold a county liable under § 1983, a plaintiff must demonstrate (1) the existence of a municipal policy or custom by which the plaintiff was denied a constitutional right and (2) that the policy or custom was the moving force behind the constitutional deprivation (i.e. "whether there is a direct causal link between [the] policy or custom and the alleged constitutional

deprivation"). *See City of Canton v. Harris*, 489 U.S. 378, 385 (1989); *Monell v. Dep't of Soc. Servs. of City of New York*, 436 U.S. 658, 694 (1978); *Bryson v. City of Okla. City*, 627 F.3d 784, 788 (10th Cir. 2010) (citations omitted).

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 the TCSO Defendants' 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.

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. The TCSO Defendants Possessed Responsibility for Unconstitutional Policies or Customs That Caused the Constitutional Injuries

Tellingly, the TCSO Defendants do not even challenge the existence of unconstitutional policy or custom in this case. Rather, they simply assert that Ms. Salgado "did not suffer any [underlying] deprivation of her constitutional rights." MSJ at 33. As shown, *infra*, there is ample evidence of an underlying violation of Ms. Salgado's constitutional rights. In any event, the significance of the TCSO Defendants' failure to challenge the existence of an unconstitutional policy or custom cannot be overstated. As

discussed *supra*, the presence of a policy or custom is vital to Plaintiff's claims against the TCSO Defendants. Defendants have apparently recognized that challenging the existence of a policy or custom would be futile. Indeed, the evidence in this regard is overwhelming. *See* LCvR 56.1(c) Statement(B), *supra.*

As this Court previously determined in *Burke v. Glanz,* No. 11-CV-720-JED-PJC, 2016 WL 3951364, at *23 (N.D. Okla. July 20, 2016):

> [B]ased on the record evidence construed in plaintiff's favor, a reasonable jury could find that, in the years prior to Mr. Williams's death in 2011, then-Sheriff Glanz was responsible for knowingly continuing the operation of a ***policy or established practice of providing constitutionally deficient medical care*** in deliberate indifference to the serious medical needs of Jail inmates like Mr. Williams.

(emphasis added). The Court specifically found evidence of a policy or custom of "failing to provide medical care in response to serious medical needs of Jail inmates, failing to provide Jail staff with proper training and supervision regarding inmate medical needs, and continuing to adhere to a constitutionally deficient system of care for detainees with serious medical needs." *Burke,* 2016 WL 3951364, at *27. With respect to causation, the *Burke* Court determined that "[t]he record … supports a finding that the foregoing practices were the 'moving force' behind the violations of Mr. Williams' constitutional rights" and that "[t]he jury could also find that the County, via the former Sheriff and other TCSO officials, was on notice as to the problems with the Jail's medical care system and, had they taken any timely remedial steps to abate the resulting risks, Mr. Williams' condition would not have deteriorated and his death would have been avoided." *Id.* at *28.

Plaintiff has presented much of the same evidence of a "constitutionally deficient system of care" here as Ms. Burke presented in her case. *See* LCvR 56.1(c)

Statement(B), *supra.* In fact, here, Plaintiff had strengthened the evidence of a policy or custom. For instance, in the case at bar, Plaintiff discusses three inmates who all died in 2010 from cardiac arrest. *See* LCvR 56.1(c) Statement(B)(11-12, 17), *supra.* With minimally adequate care, each of these deaths could have been prevented. *Id.* These deaths, which preceded Ms. Salgado's, are specific evidence of a pattern of dangerously deficient care for inmates with heart disease. And Ms. Salgado's suffering and death, in June if 2011, tends to prove these deficiencies were not alleviated in a timely manner, and that the failure to alleviate those deficiencies was a moving force behind her suffering and death. *See also* Allen (Verified) Report (Ex. 9) at 20-21. Plaintiff has also presented the "Gondles Report", which was not available to Ms. Burke. *Id.* at 8-10. The Gondles Report provides additional evidence of known and systemic problems with the Jail's medical system and of the Jail administration's failure to address substantial risks to the health and safety of inmates like Ms. Salgado. *Id.* In addition, Plaintiff has provided evidence of failure to train and/or supervise Dr. Washburn and Nurse Metcalf.

Overall, in light of the fact that the TCSO Defendants do not challenge the existence of a policy or custom, the Court need not even address the issue here. Nevertheless, should the Court choose to rule on the matter, it should have little difficulty in affirming that the evidence here, which is virtually identical evidence presented in *Burke*, is sufficient to establish genuine disputed facts as to the presence of an unconstitutional policy or custom which was a moving force behind her suffering and death.

2. Plaintiff Has Presented Significant Evidence of the TCSO Defendants' (and Their 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). Pretrial detainees, like Ms. Salgado, 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).

"Because it is difficult, if not impossible, to prove another person's actual state of mind, whether an official had knowledge may be inferred from circumstantial evidence." *DeSpain v. Uphoff,* 264 F.3d 965, 975 (10th Cir. 2001). For instance, "the existence of an obvious risk to health or safety may indicate awareness of the risk." *Rife v. Oklahoma*

Dep't of Pub. Safety, No. 16-7019, 2017 WL 280700, at *6 (10th Cir. Jan. 23, 2017) (citing *Farmer v. Brennan,* 511 U.S. 825, 842 (1994)). "[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,* 511 U.S. at 843.

The TCSO Defendants concede that Ms. Salgado's medical condition was sufficiently serious. MSJ at 22. Thus, Plaintiff has met the objective component.

Further, despite the TCSO Defendants' arguments to the contrary, Plaintiff also easily establishes the subjective component. In essence, it is the TCSO Defendants' position that because Ms. Salgado received *some* medical care, while housed at the Jail, Plaintiff cannot possibly establish deliberate indifference. This argument is fundamentally flawed numerous respects. While it may be true that Jail medical personnel treated *some* of Ms. Salgado's symptoms, there is evidence, sufficient to defeat summary judgment, that her most dire and life-threatening symptoms of acute coronary syndrome, were repeatedly, and recklessly, disregarded.

a. Underlying Violations

Typically, courts will not hold a municipality or supervisor liable without proof of an "underlying constitutional violation by [one] of its officers." *Olsen v. Layton Hills Mall,* 312 F.3d 1304, 1317–18 (10th Cir. 2002). In this case, there is substantial evidence of underlying violations of Ms. Salgado's constitutional rights, such that summary judgment is inappropriate.

First, Ms. Salgado's symptoms of acute coronary syndrome, including chest pain, were not taken seriously, and were disregarded. It is well established, as a

matter of Tenth Circuit authority, that chest pain is a symptom that must be treated seriously and urgently by responsible medical personnel. In *Sealock v. Colorado,* 218 F.3d 1205, 1211–12 (10th Cir. 2000), the Court found evidence of deliberate indifference, sufficient to survive summary judgment, where a nurse knew of an inmate's unexplained chest pain, but failed to call an ambulance. Similarly, in *Mata v. Saiz,* 427 F.3d 745, 758–59 (10th Cir. 2005), the Court reasoned that "[s]ince Ms. Mata produced evidence that Ms. Weldon was aware of Ms. Mata's medical condition as well as the seriousness of unexplained severe chest pain …, a jury could reasonably find that Ms. Weldon's alleged inaction on that date demonstrated deliberate indifference to Ms. Mata's serious medical needs."

Here, by the second day of her stay at the Jail, **June 26, 2011**, Ms. Salgado was complaining of extreme, increasing and radiating chest pain. In addition, she was hyperventilating, rubbing her chest and complaining of nausea. Ms. Salgado asserted that she was so weak that she couldn't lift a paper bag (which Dr. Washburn later scoffed at). These are all well-known symptoms of unstable angina or acute coronary syndrome. Dr. Washburn was called, and clearly recognized that the risk of cardiac etiology. Ms. Salgado's continuing symptoms, even after multiple doses of nitroglycerine, were indicative of a "***high risk*** for having unstable angina or acute coronary syndrome" (Shah Depo. (Ex. 4) at 189:12-14), emergent and life-threatening conditions. Yet, she was not seen by a physician nor sent to a hospital. Rather, she was sent back to her pod with a paper bag to breathe into. *See, e.g.,* LCvR 56.1(c) Statement(A)(42-62), *supra.* This, in

and of itself, was deliberate indifference. *See, e.g., Sealock* and *Mata.*[3]

The following day, **June 27**, Ms. Salgado was referred to see Dr. Washburn, but apparently never actually saw him. *See* LCvR 56.1(c) Statement(A)(66), *supra.* In any event, at 7:00 in the morning, Ms. Salgado was continuing to report chest pain, nausea and vomiting. Still, though the nurse assigned to Ms. Salgado, Nurse Metcalf, recognized that she had "symptoms [of] impending heart problems", Metcalf did not document checking on Ms. Salgado for the remainder of her 12-hour shift. *Id.* at (A)(67-72). Moreover, a detention officer observed Ms. Salgado in pain and ***unresponsive*** after reportedly falling down flat on her face. *Id.* at (A)(75). And while the officer "notified" the nurse of these observations, the serious and dire changes in Ms. Salgado's condition were neither documented nor otherwise addressed. These facts too, are indicia of deliberate indifference to Ms. Salgado's obvious symptoms of acute coronary syndrome.

There are no notes, dated **June 28, 2011,** in the medical record documenting that ***any*** medical provider assessed Ms. Salgado's condition at all prior to her death. From the period of 12:00 am through 8:44pm, despite her known, obvious and serious risks of acute coronary syndrome, no health professional at the Jail recorded ***any*** observation of Ms. Salgado, good or bad. *See, e.g.,* LCvR 56.1(c) Statement(A)(80-83), *supra.* While nurses had observed Ms. Salgado "vomiting regularly", this is not recorded in the medical record, and thus, disregarded. *Id.* at (A)(84). There is no evidence, certainly no ***credible*** evidence, that Ms. Salgado's vital signs were taken at any time, prior to her being found unresponsive on June 28, 2011. *Id.* By the time any nurse bothered to check on Ms. Salgado, at around 7:00pm, she was cold to the touch, pulseless and without

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[3] Also, while it is claimed that she was given an EKG on June 26, there are no June 26 EKG results in the record.

respiration. She had been dead "awhile". *Id.* at (A)(88-91). Predictably, Ms. Salgado had died from acute coronary syndrome. *Id.* at (A)(93). While Dr. Washburn noted seeing Ms. Salgado, he did not report his alleged, and self-serving, assessment of her until June 29, 2011, the day ***after*** her death. *Id.* at (A)(84). Defendants' own expert opines that this post-mortem note "looks bad". *Id.* Dr. Allen finds it "incriminating". *Id.* And even what Dr. Washburn chose to note, albeit post-mortem, demonstrates that he was "oblivious to [Ms. Salgado's] significant cardiac risks, signs and symptoms…." *Id.*

This is not simply a case of a "missed diagnosis" as the Defendants would have this Court believe. And the mere fact that Defendants were treating Ms. Salgado's diabetes is of no consequence in the face of evidence that her symptoms of acute coronary syndrome were being disregarded. There is significant evidence of repeated failure to provide Ms. Salgado with proper monitoring, diagnostic and palliative care, despite clear symptoms of a life threatening and emergent coronary condition. This is evidence of deliberate indifference.

<u>Second</u>, key diagnostic testing results (*e.g.,* the EKG) were either totally ignored or disregarded. Ms. Salgado's abnormal EKG results, dated June 25, 2011, which provide further reason for concern, were not "evaluated by the physician" as Defendants assert. MSJ at 29. Dr. Washburn does not reference the EKG in his post-mortem note, and admittedly did not actually review or read the EKG results. One nurse, Nurse Metcalf, testified that she would have viewed Ms. Salgado's symptoms more urgently had the abnormal EKG results been timely placed in the record. *See, e.g.,* LCvR 56.1(c) Statement(A)(36-39, 55-58, 67-72), *supra.* However, they were not. Dr. Washburn and CHC's failure to review, communicate or document the abnormal EKG

results is additional evidence that substantial risks to Ms. Salgado's health were disregarded.

<u>Third,</u> Dr. Washburn *admits* that Ms. Salgado should have been sent to the hospital after she repeatedly "crashed" at the Jail. During one of the more bizarre portions of Dr. Washburn's deposition, he admitted to receiving several reports, from nursing staff, that Ms. Salgado was "crashing" and getting worse. *See, e.g.,* LCvR 56.1(c) Statement(A)(84), *supra.* Of course, neither he, nor any of the nurses, took the time to document these "crashing" episodes in the medical record. *Id.* Nonetheless, Dr. Washburn acknowledges that Ms. Salgado should have been transported to a hospital after she "crashed again" in the evening. *Id.* Dr. Washburn does not, however, explain why he failed to report, in the record, Ms. Salgado's "crashing" episodes, or why she was not sent to the hospital. This is an admission of deliberate indifference. *See, e.g., Self v. Crum,* 439 F.3d 1227, 1232–33 (10th Cir. 2006) ("If a prison doctor … responds to an obvious risk with treatment that is patently unreasonable, a jury may infer conscious disregard.").

<u>Fourth,</u> there is evidence that Ms. Salgado's medical record was falsified. "While falsification of medical records does not constitute a separate claim, it may support [an] Eighth Amendment claim if determined to be relevant…." *Van Riper v. Wexford Health Sources, Inc.,* 67 F. App'x 501, 504, fn. 6 (10th Cir. 2003) (citing *Green v. Branson,* 108 F.3d 1296, 1304 (10th Cir. 1997)). Here, the falsification of Ms. Salgado's records is clearly relevant to -- and indicative of -- deliberate indifference. Specifically, there is evidence that Defendant Chris Rogers instructed nursing staff to place false vital signs into Ms. Salgado's medical record, ***after*** she had been found dead.

See, e.g., LCvR 56.1(c) Statement(A)(30), *supra.* This calls into question the validity and reliability of the entire medical record and also tends to show that responsible medical staff were covering up their failure to provide appropriate health care to Ms. Salgado. This specific instance of falsification is also consistent with evidence of a pattern of similar misconduct by Ms. Rogers, Nurse Metcalf and even Sheriff Glanz. *See, e.g.,* LCvR 56.1(c) Statement(A)(30)(85-87); (B)(3), *supra.*

Fifth, Ms. Salgado's significant history of cardiac arrest and stent placement was disregarded. It is also apparent that responsible medical personnel, Dr. Washburn, in particular, ignored, and failed to take into account, Ms. Salgado's medical history of severe heart disease, including myocardial infarction. This, too, is evidence of deliberate indifference. *See Plemmons v. Roberts,* 439 F.3d 818, 825 (8th Cir.2006) (holding that a 20 minute delay in providing treatment was deliberate indifference because jailers did not acknowledge prisoners' severe symptoms and ignored a history of heart attacks); *Easter v. Powell,* 467 F.3d 459, 464-65 (5th Cir.2006) (allegation that prison nurse ignored complaints of severe chest pain despite her awareness that inmate had a history of cardiac problems held sufficient to state a claim for deliberate indifference and overcome defense of qualified immunity).

b. Supervisory (Glanz) and Official Capacity (Regalado) Liability

There is also evidence of deliberate indifference at the supervisory (Glanz) and municipal (Regalado) levels. "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). 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." *Barney v. Pulsipher,* 143 F.3d 1299, 1307 (10th Cir. 1998).

As thoroughly set forth herein, there is an established unconstitutional municipal policy or custom of deficient medical and mental health care provided to inmates like Ms. Salgado. The evidence further establishes that Sheriff Glanz and TCSO 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 and CHC 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 charts, and defrauding medical auditors.

Despite knowing of "vast problems with the Jail's medical system", Sheriff Glanz took no discernable action to alleviate the substantial risks to inmates. 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 Ms. Salgado's and Mr. Williams' deaths 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. Sheriff Glanz's knowing failure to remedy this unconstitutional health services system constitutes deliberate indifference to the serious medical needs of inmates like Ms. Salgado. And the fact that Glanz, and Regalado (as his successor in office), had no direct contact with Ms. Salgado is irrelevant. *See, e.g., Tafoya,* 516 F.3d at 916; *Farmer,* 511 U.S. at 843 (finding

liability even though the prison official "did not know that *the complainant* was especially likely to be assaulted *by the specific prisoner* who eventually committed the assault") (emphases added); *Burke,* 2016 WL 3951364, at *25.

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

II. FORMER SHERIFF GLANZ IS *NOT* ENTITLED TO QUALIFIED IMMUNITY

"When the defendant has moved for summary judgment based on qualified immunity, [courts] 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." *Henderson v. Glanz,* 813 F.3d 938, 952 (10th Cir. 2015) (citing *Estate of Booker v. Gomez,* 745 F.3d 405, 411 (10th Cir. 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,* 745 F.3d at 411 (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 the Tenth Circuit, to show that a right is clearly established, the plaintiff must point to "a Supreme Court or Tenth Circuit decision on point, or the clearly established weight of authority from other courts must have found the law to be as the plaintiff maintains." *Estate of Booker,* 745 F.3d at 427; *see also McInerney v. King,* 791 F.3d 1224, 1236-37 (10th Cir. 2015). The law is also clearly established if the

conduct is so obviously improper that any reasonable officer would know it was illegal. *See Hope v. Pelzer,* 536 U.S. 730, 739–42 (2002). As the Supreme Court recently observed, "'general statements of the law are not inherently incapable of giving fair and clear warning' to officers, *United States v. Lanier,* 520 U.S. 259, 271, 117 S.Ct. 1219, 137 L.Ed.2d 432 (1997), but 'in the light of pre-existing law the unlawfulness must be apparent,' *Anderson v. Creighton, supra,* at 640, 107 S.Ct. 3034." *White v. Pauly,* 137 S. Ct. 548, 552 (2017).

Here, there are Supreme Court or Tenth Circuit decisions on point and general statements of the law giving fair and clear warning that the conduct was unlawful. 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. "[T]here is little doubt that deliberate indifference to an inmate's serious medical need [violates] a clearly established constitutional right." *Mata,* 427 F.3d at 749. This principle also clearly "applies to pretrial detainees through the due process clause of the Fourteenth Amendment." *Howard v. Dickerson,* 34 F.3d 978, 980 (10th Cir. 1994). And, more specifically, it has been held, on numerous occasions, that a medical professional's failure to provide timely and necessary health care services for an inmate with obvious symptoms of acute heart disease, such as chest pain, violates the Constitution. *See Sealock,* 218 F.3d at 1211–12; *Mata,* 427 F.3d at 758–59. The Tenth Circuit has specifically held that falsification of medical records, coupled with a failure to provide necessary care, constitutes deliberate indifference. *Green v. Branson,* 108 F.3d 1296, 1304 (10th Cir. 1997). Furthermore, the Circuit has particularly declared that where, as here, "a prison doctor" like Dr. Washburn "responds to an obvious risk with treatment

that is patently unreasonable, a jury may infer conscious disregard." *See, e.g., Self v. Crum,* 439 F.3d 1227, 1232–33 (10th Cir. 2006). It was also clearly established that "when the pain experienced during [a] delay [in medical care] is substantial, the prisoner 'sufficiently establishes the objective element of the deliberate indifference test.'" *Kikumura v. Osagie,* 461 F.3d 1269, 1292 (10th Cir. 2006). The specific types of pain have included severe pain and worsening of heart condition (*Mata,* 427 F.3d at 752-54) and severe pains, cramps, vomiting (*Kikumura,* 461 F.3d at 1292-93). These authorities clearly established that the conduct of the medical professionals in this case, including Dr. Washburn and Nurse Metcalf, was unconstitutional.

And there is nothing novel about Plaintiff's claims concerning longstanding and systemic deficiencies in a Jail's medical program. The supervisory liability standard articulated in *Dodds v. Richardson* was established at the time Ms. Salgado's death. Specifically, with regard to supervisory liability claims, the *Dodds* Court found facts sufficient to satisfy the first prong of the qualified immunity test where the summary judgment evidence tended to show that the defendant there "may have deliberately enforced or actively maintained the policies" which caused the alleged Constitutional deprivation at issue. *Dodds,* 614 F .3d at 1203-04. 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. THE TCSO DEFENDANTS ARE NOT ENTITLED TO SUMMARY JUDGMENT ON PLAINTIFF'S STATE CONSTITUTIONAL CLAIM

Plaintiff's State law claims are brought against all Defendants under the Oklahoma Constitution, pursuant to *Bosh v. Cherokee Building Authority,* 2013 OK 9, 305 P.3d 994. More specifically, Plaintiff brings her State law claim for violation of Article II §§ 7 and 9 of the Oklahoma Constitution, which prohibit the infliction of cruel and unusual punishment of pretrial detainees. The TCSO Defendants argue that they are entitled to summary judgment because "Salgado was not denied medical attention during her stay at the jail in the medical unit." MSJ at 34. As established herein, however, there were numerous violations of Ms. Salgado's Constitutional rights such that the *Bosh* claim survives summary judgment.

WHEREFORE, premises considered, Plaintiff respectfully requests that this Court deny Defendants Stanley Glanz and Vic Regaldo's Motion for Summary Judgment (Dkt. #251).

Respectfully,

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CERTIFICATE OF SERVICE

I hereby certify that on the 8th day of February 2016, 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