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

CHRISTINE WRIGHT, as Special Administrator of the Estate of LISA SALGADO, deceased,	)	
Plaintiff,	)	Case No.: 13-CV-315-JED-TLW
v.	)	
CORRECTIONAL HEALTHCARE COMPANIES, INC., *et al.*	)	
Defendants.	)	

DEFENDANT, CORRECTIONAL HEALTHCARE COMPANIES, INC.'S MOTION FOR SUMMARY JUDGMENT ON ALL CLAIMS OF PLAINTIFF CHRISTINE WRIGHT

COMES NOW Defendant, Correctional Healthcare Companies, Inc. (hereinafter referred to as the "Defendant", "CHC", or "CHC Defendants"[1]) and pursuant to Rule 56 of the Federal Rules of Civil Procedure, moves for summary judgment on all claims asserted by the Plaintiff Christine Wright, as Special Administrator of the Estate of Lisa Salgado, deceased. In support of this Motion, Defendant offers the following brief.

[1] Correctional Healthcare Management of Oklahoma, Inc. and Correctional Healthcare Management, Inc. merged into Defendant Correctional Healthcare Companies, Inc. and are no longer in existence. Defendant incorporates and adopts by reference to the separate Motion for Summary Judgment on behalf of CHM and CHMO on that issue.

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STATEMENT OF THE CASE

This suit arises from the unforeseeable death of inmate Lisa Salgado while she was incarcerated at David L. Moss Criminal Justice Center (hereinafter, "DLM") in Tulsa, Oklahoma in June of 2011. Plaintiff Christine Wright, as Special Administrator of the Estate of Lisa Salgado, brings this action under 42 U.S.C. § 1983 and Oklahoma state law and alleges, *inter alia*, that Ms. Salgado's death was the direct result of the CHC Defendants' alleged deliberate indifference to Ms. Salgado's serious medical needs. In addition to her 42 U.S.C. § 1983 claim for deliberate indifference, Plaintiff also alleges that the CHC Defendants were negligent in their care and treatment of Ms. Salgado during her June 2011 incarceration at DLM. This Motion addresses only the claims asserted against the CHC Defendants.

During her incarceration in June 2011 at DLM, Ms. Salgado was appropriately screened by the jail staff and the correctional healthcare providers to determine her medical complaints and needs. Each of Ms. Salgado's medical complaints, signs, and symptoms that she exhibited or complained of were being treated by the medical and nursing staff at DLM. Despite all of her medical needs being responded to by correctional healthcare providers, on June 28, 2011, Ms. Salgado suffered an unforeseeable death, the cause of which remains a mystery.

STATEMENT OF UNCONTROVERTED FACTS

1. At the time of her death on June 28, 2011, Lisa Salgado was 40 years old. (Exhibit 1, *Death Certificate*).

2. Prior to her incarceration at DLM, Ms. Salgado had been seen at two different hospitals on three separate occasions in the days immediately preceding her booking into the jail. (Exhibit 3, *Lisa Salgado's Medical Records from St. Francis Hospital,* SFHS01103-1105; Exhibit 4, *Medical Records from St. John Medical Center,* SJS00563-564, SJS00697, 700).

3. In each of those hospitalizations, she complained of chest pain similar to that which she complained of at the jail. (Exhibit 3, SFHS01103-1104; Exhibit 4, SJS00563-564, 697, 700; Exhibit 5, *CHC Medical Records*, LS00040-41).

4. In each of those hospitalizations, Ms. Salgado was diagnosed with non-cardiac chest pain. (Exhibit 3, SFHS01103; Exhibit 4, SJS00598 and 704).

5. An EKG performed on Ms. Salgado on June 16, 2011 at St. Francis Hospital showed no signs of an acute myocardial injury. (Exhibit 3, SFHS01198, 1204-1206).

6. Prior to her discharge from St. Francis Hospital on June 18, 2011, physicians further ruled out myocardial infarction with serial cardiac enzymes. (Exhibit 3, SFHS01103).

7. Five days later, on June 23, 2011, she presented to St. John Medical Center with similar complaints of chest pain. (Exhibit 4, SJS00563-564, 596).

8. Ms. Salgado's lab work at St. John Medical Center on June 23, 2011 revealed no biochemical evidence of myocardial injury. (Exhibit 4, SJS00604).

9. On June 24, 2011, Ms. Salgado was seen by a cardiologist, who noted that her chest pain was atypical for angina and suggestive for chest wall or musculoskeletal pain, that she had no EKG changes, and that he had ruled out myocardial infarction with serial negative cardiac enzymes. (Exhibit 4, SJS00598).

10. After being told that she would not receive IV morphine, Ms. Salgado left St. John Medical Center against medical advice (AMA) on June 24, 2011, stating that if she did not get the morphine there, then she would go elsewhere. (Exhibit 4, SJS00563-564, 630, 700).

11. Prior to leaving against medical advice, physicians determined that Ms. Salgado did not have acute coronary syndrome and she was stable for discharge. (Exhibit 4, SJS00564).

12. After leaving St. John Medical Center against medical advice, Ms. Salgado was

involved in a motor vehicle accident on June 24, 2011. (Exhibit 5, LS00042; Exhibit 6, *Arrest and Booking Data*, GLANZ-Revilla05340).

13. Ms. Salgado was arrested by the Broken Arrow Police Department late in the evening of June 24, 2011 for driving under the influence, driving under suspension, and failing to maintain insurance. (Exhibit 6, GLANZ-Revilla05298).

14. Early in the morning of June 25, 2011, Ms. Salgado was taken back to St. John Medical Center by the Broken Arrow Police Department to be medically cleared for chest pain and insulin. (Exhibit 4, SJS00697, 700).

15. Ms. Salgado underwent another EKG on June 25, 2011, which came back normal and showed no significant changes since her June 24, 2011 EKG. (Exhibit 4, SJS00686).

16. St. John Medical Center physicians noted that Ms. Salgado had just been discharged from their facility the day prior, and that they were in the process of formally discharging her when she got angry that she would not be receiving any more narcotics and therefore left against medical advice. (Exhibit 4, SJS00700).

17. St. John Medical Center physicians again determined that Ms. Salgado was stable and that her chest pain was non-cardiac in nature. (Exhibit 4, SJS00704; Exhibit 7, *Deposition of Phillip Washburn, M.D. (Jan. 19, 2016)*, 283:1-10).

18. Physicians at St. John Medical Center gave Ms. Salgado medical clearance to be booked into the jail with glucose monitoring by medical staff. (Exhibit 4, SJS00704; Exhibit 5, LS00018; Exhibit 7, Washburn Dep., 280:1-9).

19. No prescriptions or treatment were ordered to be given at the jail, except for glucose monitoring. (Exhibit 4, SJS00704; Exhibit 5, LS00018).

20. A prescription form signed by the ER physician stated that Ms. Salgado was

"medically stable" enough to go to jail. (Exhibit 5, LS00018).

21. On June 25, 2011, Ms. Salgado was booked into DLM. (Exhibit 2, *Jail Records from DLM,* GLANZ-Revilla05409; Exhibit 6, GLANZ-Revilla05298; Exhibit 5, LS00001).

22. At the time of booking, she went through two separate screening processes: one by a detention officer and one by a nurse. (Exhibit 5, LS00025, LS00035-38).

23. At the time Ms. Salgado was booked into the jail, she had no complaints of chest pain. (Exhibit 5, LS00036).

24. In her receiving screening performed by a jail nurse, Ms. Salgado reported that her medical problems included insulin-dependent Diabetes mellitus ("IDDM"), cardiac, neuropathy, cholesterol, and hypertension ("HTN"). (Exhibit 5, LS00035).

25. Ms. Salgado also reported in her receiving screening that she required a special diet due to her diabetes. (Exhibit 5, LS00036).

26. During her receiving screening, Ms. Salgado denied using any drugs, including opiates and benzodiazepines, and she indicated that she was having no signs or symptoms of substance withdrawal. (Exhibit 5, LS00038).

27. Ms. Salgado reported during her intake screening that she was not currently experiencing any symptoms. (Exhibit 5, LS00036).

28. The same day, June 25, 2011, Dr. Washburn entered orders to monitor Ms. Salgado's blood glucose by finger-stick blood sugar ("FSBS") in response to her self-reported medical condition of diabetes. (Exhibit 5, LS00030, line 12).

29. The nurses followed Dr. Washburn's orders for blood glucose monitoring. (Exhibit 5, LS00032, LS00031 lines 8-11, 18, 23 and 25, LS00028; Exhibit 8, *Sheriff's Office Incident Report*, GLANZ-Revilla05282; Exhibit 9, *Deposition of Karen Metcalf, LPN (Oct. 12,*

2015), 138:24-139:15, 144:19-146:1).

30. That day, Ms. Salgado was also placed on a special diet (2800 calorie ADA diet with bedtime snacks) in response to her self-reported medical condition of diabetes. (Exhibit 5, LS00043).

31. Ms. Salgado was referred to see Dr. Washburn for complaints of nausea, vomiting, diabetes, and alcohol abuse. (Exhibit 5, LS00043).

32. The evidence is undisputed that no healthcare provider ignored any of Ms. Salgado's signs or symptoms on June 25, 2011. (Exhibit 10, *Deposition of Plaintiff's Expert Scott Allen, M.D. (July 19, 2016),* 237:17-238:4).

33. Ms. Salgado's blood sugar was taken by nurses early in the morning of June 26, 2011. (Exhibit 5, LS00031, line 25, LS00032).

34. That afternoon, her blood sugar was taken again and came back elevated at 238. (Exhibit 5, LS00031, line 23, LS00032).

35. In response, she was administered insulin. (Exhibit 5, LS00031, ln. 22).

36. While in the Medical Unit in the afternoon of June 26, 2011, Ms. Salgado first began complaining of chest pain in the jail, which she reported had started suddenly at 4:15 p.m. that day. (Exhibit 5, LS00040-41).

37. Her description of chest pain was consistent with the pain she described in her recent visits to St. Francis and St. John's. (Exhibit 3, SFHS01105; Exhibit 4, SJS00700; Exhibit 11, *Deposition of Plaintiff's Expert Dipan Shah, M.D. (June 27, 2016),* 90:7-21).

38. She was assessed by a nurse at approximately 4:15 p.m. on June 26, 2011, who noted that Ms. Salgado's lungs were clear to auscultation ("cta") bilaterally in all lobes, her heart had no rubs, bruits or murmurs, with normal S1 and S2. (Exhibit 5, LS00041).

39. The nurse further noted that Ms. Salgado appeared to be hyperventilating and refused to follow instructions on pursed lip breathing. The nurse indicated that she gave Ms. Salgado a bag to breathe into, and Ms. Salgado reported that she could not hold up the bag due to weakness. At this time, Ms. Salgado did not have any diaphoresis, no cyanosis, and no dyspnea. (Exhibit 5, LS00042).

40. Although she reported nausea and vomiting, the nurse noted that she had no actual emesis while in the Medical Unit and that she was observed only spitting in a biohazard bag. (Exhibit 5, LS00041).

41. The nurse contacted Dr. Washburn. (Exhibit 5, LS00042-43).

42. Dr. Washburn prescribed Ms. Salgado Promethazine in response to her complaints of nausea and vomiting; Humulin in response to her self-reported Diabetes; and Nitrogylcerin, Maalox and Aspirin in response to her complaints of chest pain/pressure and reflux. (Exhibit 5, LS00030, lines 7-11, LS00042-43).

43. Dr. Washburn also ordered an EKG. (Exhibit 5, LS00042-43).

44. Her EKG was performed. (Exhibit 10, Dr. Allen Dep., 242:18-23; Exhibit 12, *Radiology Results*, GLANZ-Revilla05515-05516).

45. The EKG came back on two strips, one reading "abnormal" and the second "borderline." (Exhibit 10, Dr. Allen Dep., 244:21-24; Exhibit 12, GLANZ-Revilla05515-05516).

46. Dr. Washburn had the EKG results read over the phone to him. (Exhibit 7, Dr. Washburn Dep., 221:15-21).

47. At approximately 4:23 p.m., Ms. Salgado was administered Nitro, Maalox, and Aspirin in response to her complaints of chest pressure/pain and reflux. (Exhibit 5, LS00031, lines 19-21).

48. In total, Ms. Salgado was given four doses of Nitro: at 4:23 p.m., 4:30 p.m., 4:35 p.m., and 4:45 p.m. (Exhibit 5, LS00032).

49. Ms. Salgado's vital signs were also taken five separate times during this encounter and were stable. (Exhibit 5, LS00041-42, LS00032).

50. Ms. Salgado reported to jail healthcare providers that her chest pain stopped at approximately 5:30 p.m. (Exhibit 5, LS00041).

51. Further, chest pain/indigestion protocol was initiated on Ms. Salgado on June 26, 2011 by Mary Hudson, LPN in response to her complaints of chest pressure/pain. (Exhibit 5, LS00040-41, LS00035).

52. On the morning of June 27, 2011, Ms. Salgado complained of nausea and vomiting, abdominal pain, and general chest pain. (Exhibit 5, LS00035; Exhibit 9, Nurse Metcalf Dep., 135:21-136:3).

53. Nurse Metcalf did not witness Ms. Salgado vomiting, but she notified Dr. Washburn of Ms. Salgado's condition. (Exhibit 5, LS00035; Exhibit 9, Nurse Metcalf Dep., 135:21-136:3).

54. Ms. Salgado's blood sugar was taken that morning as well. (Exhibit 5, LS00032).

55. Ms. Salgado's vital signs taken at this time were stable. (Exhibit 5, LS00035; Exhibit 9, Nurse Metcalf Dep., 135:21-136:3).

56. Dr. Washburn personally assessed Ms. Salgado on the morning of June 27, 2011. (Exhibit 13, *Washburn Chart Entry,* GLANZ-Revilla05491; Exhibit 5, LS00035; Exhibit 9, Nurse Metcalf Dep. 135:21-136:19; Exhibit 11, Dr. Shah Dep., 207:19-24).

57. Dr. Washburn ordered a chest x-ray in response to Ms. Salgado's complaints of general chest and abdominal pain, and he prescribed Vistaril in response to Ms. Salgado's

complaints of nausea. (Exhibit 5, LS00035; Exhibit 9, Nurse Metcalf Dep., 135:21-136:3).

58. Ms. Salgado's chest x-ray revealed possible infiltrates. (Exhibit 13).

59. Chest infiltrates are suggestive for pneumonia (Exhibit 11, Dr. Shah Dep., 208:17-209:13; Exhibit 10, Dr. Allen Dep., 250:17-252:1)

60. Pneumonia is a known cause of chest pain. (Exhibit 11, Dr. Shah Dep., 209:14-17; Exhibit 10, Dr. Allen Dep., 200:19-201:9).

61. On June 27, 2011, Dr. Washburn prescribed Ms. Salgado Hydroxyzine for nausea and Doxycycline for his differential diagnosis of infiltrate or questionable pancreatitis. (Exhibit 5, LS00030, lines 1-2, 6).

62. Pursuant to Dr. Washburn's verbal orders, Ms. Salgado was admitted to the Infirmary on June 27, 2011 with an admission diagnosis of possible infiltrates. (Exhibit 5, LS00026-27).

63. Her vital signs were taken after her admission to the Infirmary, which remained stable (Exhibit 5, LS00027).

64. Her vital signs were taken again at approximately 10:00 p.m. with no significant change. (Exhibit 5, LS00028).

65. The next morning, at approximately 4:20 a.m. on June 28, 2011, Ms. Salgado's blood sugar was taken again and was high at 410. (Exhibit 5, LS00028, LS00032).

66. She was given Maalox in response to her complaints of reflux, another dose of Doxycycline for her suspected infiltrates or questionable pancreatitis, and insulin. (Exhibit 5, LS00030-32).

67. Approximately one hour later, her blood sugar was taken again and had decreased to 372 in response to the insulin. (Exhibit 5, LS00028).

68. Ms. Salgado's vital signs were taken again sometime after 5:10 a.m. on June 28, 2011, although it is not clear from the medical record what time this occurred. (Exhibit 5, LS00028; Exhibit 14, *Deposition of Plaintiff's Nurse Expert Jacqueline Moore, RN (May 5, 2016),* 289:6-19).

69. On the morning of June 28, 2011, Dr. Washburn again assessed her during his a.m. rounds. (Exhibit 13).

70. Dr. Washburn observed Ms. Salgado to be lying quietly and not in distress. (Exhibit 13).

71. When Dr. Washburn asked her about her pain from the day before, Ms. Salgado reported that her pain was abdominal and was better. She reported no further vomiting or chest pain. (Exhibit 13).

72. Dr. Washburn noted that Ms. Salgado had just mild abdominal pain. He listened to her chest, charting that her heart and lungs were clear, though he acknowledged the infiltrate seen on her x-ray the day before. (Exhibit 13).

73. Dr. Washburn noted that she was alert and answered questions appropriately at the time of his assessment. (Exhibit 13).

74. On his assessment, Dr. Washburn charted Ms. Salgado's diagnoses as insulin-dependent Diabetes mellitus ("IDDM"); history of alcohol abuse; abdominal pain, cause unknown, improving; and hirsutism (abnormally hairy). (Exhibit 13). Dr. Washburn's plan was to order another chest x-ray and to administer IV fluids. However, Ms. Salgado advised him that she had no peripheral veins, which was confirmed on examination. (Exhibit 13).

75. Dr. Washburn prescribed more Promethazine in response to her complaints of nausea and vomiting. (Exhibit 5, LS00030, line 3).

76. At approximately 3:00 p.m. on June 28, 2011, Nurse Metcalf again assessed Ms. Salgado. At that time, Ms. Salgado's blood sugar was 210, so she was given two units of regular insulin plus 17 units of Humulin. At this time, Ms. Salgado was awake, and her breathing was even and unlabored. (Exhibit 8, GLANZ-Revilla05282; Exhibit 9, Metcalf Dep. 138:24-139:15; Exhibit 5, LS00031, lines 17-18, LS00032).

77. Nurse Metcalf saw Ms. Salgado again at approximately 5:10 p.m., at which time Ms. Salgado was administered Aspirin in response to her chest pressure/pain, another dose of Doxycycline, Promethazine for nausea/vomiting, and Maalox for reflux. (Exhibit 5, LS00031; Exhibit 8, GLANZ-Revilla05282; Exhibit 9, Metcalf Dep. 144:19-146:1, 146:2-147:5, 148:2-25).

78. At this time, Nurse Metcalf assisted Ms. Salgado to sit up to take her medications, and Ms. Salgado reported that she was feeling a little better. Ms. Salgado took her medication without difficulty, and Nurse Metcalf assisted her to lie back down. (Exhibit 8, GLANZ-Revilla05282; Exhibit 9, Metcalf Dep. 144:19-146:1, 148:2-25).

79. At approximately 5:30 p.m. on June 28, 2011, Nurse Metcalf made rounds and saw that Ms. Salgado was resting with her eyes closed and observed her breathing but did not disturb her. (Exhibit 8, GLANZ-Revilla05282; Exhibit 9, Metcalf Dep. 146:2-147:5).

80. At approximately 7:00 p.m., Nurse Metcalf and Nurse Paul Wallace discovered Ms. Salgado non-responsive in her cell while making rounds. (Exhibit 9, Metcalf Dep. 147:8-17).

81. Each of Ms. Salgado's diagnosed medical conditions was being treated appropriately and reasonably. (Exhibit 10, Dr. Allen Dep., 258:21-259:1, 261:4-9).

82. Ms. Salgado was receiving treatment for all of her complained-of medical symptoms: infiltrates, chest pressure, reflux, chest pressure, nausea and vomiting, diabetes, and questionable pancreatitis. (Exhibit 10, Dr. Allen Dep., 261:4-9; Exhibit 11, Dr. Shah Dep.,

232:7-20).

83. There is no sign or symptom that went unassessed or untreated by the jail healthcare providers. (Exhibit 11, Dr. Shah Dep., 232:7-20; Exhibit 10, Dr. Allen Dep., 258:21-259:1, 261:4-9).

84. The nurses monitored Ms. Salgado's vital signs throughout her incarceration. (Exhibit 5, LS00032, LS00041-42, LS00035, LS00027, LS00028).

85. Ms. Salgado's diagnosis of diabetes was recognized, monitored and treated during her three-day incarceration. (Exhibit 10, Dr. Allen Dep., 237:13-16; Exhibit 5, LS00028, 31-32, 43; Exhibit 8, GLANZ-Revilla05282; Exhibit 9, Metcalf Dep. , 138:24-139:15, 144:19-146:1)

86. There are numerous non-cardiac causes of chest pain. (Exhibit 11, Dr. Shah Dep., 66:2-68:3; Exhibit 10, Dr. Allen Dep., 199:21-200:15).

87. Ms. Salgado was never diagnosed with acute coronary syndrome. (Exhibit 11, Dr. Shah Dep., 249:15-250:25).

88. Chronic pancreatitis can cause chest pain similar to that complained of by Ms. Salgado. (Exhibit 11, Dr. Shah Dep., 68:4-18; Exhibit 10, Dr. Allen Dep., 199:21-200:25).

89. Ms. Salgado's chest pain/indigestion complaints were assessed by nursing staff. (Exhibit 5, LS00035, 41-42; Exhibit 11, Shah Dep., 235:8-9).

90. Ms. Salgado received medications from jail staff in response to her complaints of chest pain/indigestion. (Exhibit 5, LS00030-31; Exhibit 11, Dr. Shah Dep., 189:2-14, 215:4-7; Exhibit 10, Dr. Allen Dep., 247:2-7, 261:4-9).

91. Ms. Salgado's nausea and vomiting complaints were assessed by nursing staff. (Exhibit 5, LS00027, 41).

92. Ms. Salgado received medications from jail staff in response to her complaints of

nausea and vomiting. (Exhibit 5, LS00030-31, 35; Exhibit 13).

93. No autopsy was performed on Ms. Salgado. (Exhibit 1, *Death Certificate*).

94. Dr. Washburn was not deliberately indifferent to Ms. Salgado's medical needs. (Exhibit 11, Dr. Shah Dep., 44:1-13).

95. Ms. Salgado was assessed by both a physician and by nurses. (Exhibit 11, Dr. Shah Dep., 234:22-235:9).

96. Dr. Washburn was the sole physician providing care to Ms. Salgado. (Exhibit 10, Dr. Allen Dep., 265:14-17).

97. Dr. Washburn did not ignore Ms. Salgado's medical condition. (Exhibit 10, Dr. Allen Dep., 257:21-258:9, 261:4-9; Exhibit 11, Dr. Shah Dep., 232:7-20, 235:21-236:25).

98. Ms. Salgado's cause of death remains unknown. (Exhibit 10, Dr. Allen Dep., 260:24-261:3; Exhibit 11, Dr. Shah Dep., 238:12-23).

99. Plaintiff's experts cannot rule out chronic pancreatitis as the cause of Ms. Salgado's death. (Exhibit 11, Dr. Shah Dep., 73:7-15; Exhibit 10, Dr. Allen Dep., 260:24-261:3).

100. CHC Defendants did not control the medical decisions of its physicians or medical staff.

101. CHC Defendants did not employ Dr. Washburn. (Exhibit 15, *Employment Agreement of Washburn*).

102. Plaintiff has not identified any policy or custom which encouraged or required physicians or nurses to deny medical care.

103. The CHC Defendants' policies and procedures complied with NCCHC guidelines. (Exhibit 14, Nurse Moore Dep., 84:6-9).

104. Plaintiff has not put forth any expert testimony that any of CHC Defendants'

policies or procedures caused Ms. Salgado's death.

105. Plaintiff has failed to put forth any evidence that CHC Defendants possess final authority to establish municipal policy.

106. The Tulsa County Sheriff is has final decision-making authority regarding the provision of medical care in the Tulsa County Jail. OKLA. STAT. TIT. 57, § 52; *Estate of Crowell ex rel. Boen v. Board of County Comm'rs of Bryan County*, 237 P.3d 134 (Okla. 2010); (Exhibit 17, *Deposition of Sheriff Glanz (June 10, 2015)*, 18:24-19:14).

ARGUMENTS AND AUTHORITY

Pursuant to Rule 56 of the Federal Rules of Civil Procedure, summary judgment may be granted where there is no genuine issue of material fact and one party is entitled to judgment as a matter of law. FED. R. CIV. P. 56(c); *Celotex Corp. v. Catrett*, 477 U.S. 317, 323 (1986). Only disputes over facts which are material will preclude summary judgment. That is, a material fact is one which might affect the outcome of the suit under the governing law, and such facts are genuinely disputed "if the evidence is such that a reasonable jury could return a verdict for the nonmoving party." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 272, 248 (1986). Also, summary judgment is properly entered against a party who fails to make a showing sufficient to establish the existence of an element essential to that party's case, and on which that party will bear the burden of proof at trial. *Celotex Corp.*, at 322.

Plaintiff alleges CHC Defendants violated the civil rights of Ms. Salgado by failing to provide her with adequate medical care, and for failing to maintain adequate policies and customs within the jail. (*See* Doc. No. 4, Amended Complaint, ¶¶ 172-178, 184-192, 193-200, 201-207). A municipality can be found liable under 42 U.S.C. § 1983 only where the municipality itself was at fault and caused the constitutional violation at issue. *City of Canton*,

Ohio v. Harris, 489 U.S. 378,387 (1989). A municipality cannot be held liable under a *respondeat superior* theory solely because its employees inflicted injury on the plaintiff. *Monnell v. Dept. of Soc. Serv. Of New York*, 736 U.S. 658, 691(1978); *Hinton v. City of Elwood*, 997 F.2d 774, 782 (10th cir. 1993). It is only when execution of a government's policy or custom, whether made by its lawmakers or by those whose edicts or acts may fairly be said to represent official policy, inflicts the injury that the government as an entity is responsible under 42 U.S.C. § 1983. *Monnell v. Dept. of Soc. Serv. Of New York*, 736 U.S. 658, 694(1978).

A municipality may violate a person's civil rights "directly" through a designated decisionmaker who caused a deprivation of rights, such as when a city prosecutor directs an unlawful entry and search. *Pembaur v. City of Cincinnati*, 475 U.S. 469(1986). In a case based upon the direct action of a decisionmaker, municipal liability attaches only where the decisionmaker possesses *final authority to establish municipal policy* with respect to the action ordered. *Id.* at 481. The official must be *responsible for establishing final government policy* respecting such activity before the municipality can be held liable. *Id.* at 483. A municipality may "directly" violate the constitution when its final policymakers implement a written policy that is facially unconstitutional. In *Monnell, supra*, the municipality enacted an unconstitutional policy requiring early pregnancy leave. Because the municipal fathers had approved this facially unconstitutional policy, the municipality was liable. *Monnell v. Dept. of Soc. Serv. Of New York*, 736 U.S. 658(1978). When a plaintiff claims that a particular municipal action *itself* violates federal law, or directs an employee to do so, resolving issues of fault and causation is straightforward. *Board of County Com'rs of Bryan County, Okl. v. Brown*, 520 U.S. 397, 404 (1997). All that is required is to prove that the final decisionmaker intentionally deprived a plaintiff of a constitutional right, and that acts of the decisionmaker are the acts of the

municipality. *Id.* at 405.

In this case, we are not dealing with an allegation that CHC Defendants ordered a constitutional violation; therefore, the burden of proof is much higher. Plaintiff in this case seeks to establish corporate liability by proving an employee of the corporation acted to violate the constitutional rights of the deceased, and the unwritten "policies or customs" of the municipality caused the employee to act unconstitutionally. In establishing this type of liability, one must first look to determine whether plaintiff has proved a constitutional violation by an employee of the municipality. A municipality will not be liable for a constitutional violation based upon a "policy" argument when there was no underlying constitutional violation by any of its employees. *Olsen v. Layton Hills Mall*, 312 F.3d 1304, 1317-18(10th cir. 2002). Collective allegations against the state are not sufficient to create a civil rights claim; a plaintiff must identify who exactly injured him and then join that party as a defendant. *Robbins v. Okla. ex rel. Dep't of Human Servs.*, 519 F.3d 1242 (10th Cir. 2008); *Stone v. Albert*, 338 Fed. Appx. 757, 759 (10th cir. 2009); *Gray v. Weber*, 244 Fed Appx. 753 (8th cir. 2007). Therefore, if Plaintiff is unable to prove a constitutional violation by an employee of the CHC Defendants, then she loses her civil rights claim against the corporations.

In this case, the written policies were constitutional, and no corporate decisionmaker ordered the violation of anyone's rights. Plaintiff seeks to establish liability by showing an unwritten policy or custom at the jail caused the employees to violate decedent's rights. Under these facts, the courts look closely at the intent and acts of the municipality itself, rather than at the acts of the employees. Did the municipal policymakers establish an unwritten policy or custom that caused the constitutional violation? Rigorous standards of culpability and causation must be applied to ensure that the municipality is not held liable solely for the actions of its

employees. *Board of County Com'rs of Bryan County, Okl. v. Brown,* 520 U.S. 397, 405 (1997). Plaintiff must prove *deliberate action* by the municipality which was the moving force behind the plaintiff's deprivation of federal rights. Id. at 400. Plaintiff must demonstrate that municipal action was taken with "deliberate indifference" as to its known or obvious consequences. A showing of simple or even heightened *negligence by the municipality will not suffice*. *Id*. at 407.

In a policy or custom case, both fault and causation as to the acts or omission of the corporation itself must be proved. *City of Canton, Ohio v. Harris,* 489 U.S. 378,394 (1989). Municipal liability only attaches where the municipal decisionmaker possesses final authority to establish municipal policy with respect to the action ordered. *Id*. at 481. The official must be responsible for establishing final government policy respecting such activity before the municipality can be held liable. *Id*. at 483; *Lankford v. Hobart,* 73 F.3d 283,286(10th Cir. 1996). Whether the governmental official had final decision-making power is a question of state law. *Id*. Oklahoma state law establishes that the Sheriff has final decision-making authority regarding the provision of medical care in a jail. Okla. Stat., tit. 57, § 52.

Where plaintiff bases her claim on the municipality establishing a policy which caused the constitutional violation, the policy must be one which the municipality officially sanctioned or ordered. *Pembaur v. City of Cincinnati,* 475 U.S. 469,480(1986). The policy must be the "official policy" adopted by the municipality. *Id.* at 479. The policy must have been made by an official whose acts may fairly be said to represent official policy. *Id.* at 480. A municipality is held liable only for the decisions of its duly constituted legislative body or of those officials whose acts may fairy be said to be those of the municipality. *Brd of County Com'rs of Bryan County, Okl. v. Brown,* 520 U.S. 397, 403-4(1997). A custom must have been formally approved by an appropriate decisionmaker. *Id*. at 404.

The *Brown* case involved a fact situation similar to ours, wherein plaintiff alleged the municipality was liable for a constitutional violation, even though the written municipal policies were constitutional. The court applied a stringent burden of proof, holding that inadequate pre-employment screening of an employee by the hiring supervisor was not enough to show a policy of deliberate indifference by the municipality. *Board of County Com'rs of Bryan County, Okl. v. Brown,* 520 U.S. 397, 411 (1997). The *Brown* court explained that even though the supervisor was indifferent to the employee's qualifications during the hiring process, this did not mean the municipality was indifferent. Rather, the court looked to the intent of the municipality itself. The plaintiff must demonstrate that a municipal decision reflects *deliberate indifference* to the risk that a violation of a particular constitutional or statutory right will follow the decision. *Id.* at 411. The jury must find the action of the municipality was *highly likely to inflict the particular injury* suffered by the plaintiff. *Id.* at 412. The constitutional violation must be a *plainly obvious consequence* of the municipal decision. *Id.* at 414. Municipalities are not liable unless *deliberate action attributable to the municipality directly caused* a deprivation of federal rights. *Id.* at 415. The municipality must consciously, knowingly disregard an obvious risk that a constitutional violation will occur. *Id.* at 415. The court went on to hold that the evidence did not show a conscious disregard by the municipality for a high risk that the "bad employee" would violate plaintiff's constitutional rights. *Id.* at 416

PROPOSITION I: PLAINTIFF CANNOT ESTABLISH ANY CHC DEFENDANTS VIOLATED MS. SALGADO'S CONSTITUTIONAL RIGHTS.

Plaintiff has generally alleged that the CHC Defendants violated Ms. Salgado's federally protected rights by being deliberately indifferent to her serious medical needs. (Doc. No. 4, ¶¶ 173 and 175). Moreover, Plaintiff alleges that the CHC Defendants are liable under 42 U.S.C. §

1983 under a municipal liability theory. (Doc. No. 4, ¶¶ 184-192). 42 U.S.C. § 1983 provides:

> **Every person** who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, **subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress**…

42 U.S.C.A. § 1983 (emphasis added).

A. CHC DEFENDANTS WERE CORPORATE ENTITIES AND NOT "PERSONS" AS THE PLAIN LANGUAGE OF 42 U.S.C. § 1983 REQUIRES.

The CHC Defendants were private corporations, not "persons". As a result, the Court must grant summary judgment in favor of the CHC Defendants on all of Plaintiff's claims against the CHC Defendants under 42 U.S.C. § 1983 because the plain language of the statute does not provide the Plaintiff a right of action against private corporate entities such as the CHC Defendants.

B. NO EMPLOYEE OF CHC DEFENDANTS VIOLATED THE CONSTITUTIONAL RIGHTS OF DECEDENT.

A municipality will not be liable for a constitutional violation based upon a "policy" argument when there was no underlying constitutional violation by any of its employees. *Olsen v. Layton Hills Mall*, 312 F.3d 1304, 1317-18 (10th Cir. 2002). Collective allegations against the state are not sufficient to create a civil rights claim; a plaintiff must identify who exactly injured him and then join that party as a defendant. *Robbins v. Oklahoma*, 519 F.3d 1242 (10th Cir. 2008); *Stone v. Albert*, 338 Fed. Appx. 757, 759 (10th Cir. 2009); *Gray v. Weber*, 244 Fed Appx. 753 (8th Cir. 2007). With regard to the claims related to Lisa Salgado, Dr. Phillip Washburn and Nurse Rogers are the only named defendants who are alleged employees of CHC Defendants[2].

[2] Plaintiff Christine Wright has not pled any allegations or claims against Dr. Andrew Adusei.

(*See* Doc. No. 4, Amended Complaint). Defendants' Rogers and Washburn's briefs for their respective Motions for Summary Judgment are adopted by reference to further establish that there is no evidence that an employee of CHC Defendants violated the Constitution. (*See* Motions for Summary Judgment of Dr. Phillip Washburn and Chris Rogers on Plaintiff's Claims). Plaintiff did not sue any of CHC Defendants' other nurses, nurse practitioners or physicians. (*See* Doc. No. 4). Because Plaintiff has made no claim that such unnamed nurses, nurse practitioners or doctors violated the constitution, there can be no claim that a CHC policy caused such a violation by these doctors or nurses. *Olsen v. Layton Hills Mall*, 312 F.3d 1304, 1317-18(10th Cir. 2002).

Additionally, Dr. Washburn was not an employee of CHC Defendants. Dr. Washburn was an employee of Correctional Healthcare Physicians II, PC. (Exhibit 15, *Employment Agreement*). There is no claim in this case that CHC Defendants controlled the actions of Dr. Washburn through a policy or custom. (*See* Doc. No. 4, Amended Complaint). Further, Plaintiff has put forth no evidence that any CHC policy or custom encouraged or required Dr. Washburn to deny care to patients. To the contrary, CHC policy encouraged access to medical care for all inmates. (Exhibit 16, *Healthcare Policies and Procedures*). The evidence is uncontroverted that the medical decisions of Dr. Washburn regarding when to see a patient, whether to examine a patient, what type of examination was to be performed, what diagnosis was made, and whether to render treatment was not controlled by CHC Defendants. In fact, CHC's policies explicitly state that such policy manual "does not constitute, and is not a substitute for, professional medical advice. Professional medical staff should be consulted to structure and implement individualized medical treatment based upon an individual's specific health needs." (Exhibit 16, *Healthcare*

(*See* Doc. No. 4; *also,* Motion for Summary Judgment of Dr. Adusei on Plaintiff's Claims.)

Policies and Procedures, p. 2). Plaintiff has failed to put forth any evidence to the contrary. Because CHC did not control the decisions of the doctors, did not employ them and did not direct their acts, Plaintiff cannot show that CHC policy or custom caused Dr. Washburn to violate the constitution.

Plaintiff's allegations in this action are insufficient to establish a 42 U.S.C. § 1983 action against the CHC Defendants. In order to prevail in a § 1983 action for deliberate indifference, Plaintiff must prove that the Ms. Salgado was at a substantial and imminent risk of harm; that CHC Defendants were aware of facts from which the inference could be drawn that Ms. Salgado was a substantial and imminent risk of harm; and, further, that the CHC Defendants drew upon that inference that Ms. Salgado was a substantial and imminent risk of harm. Plaintiff has failed to meet this burden and, as a result, summary judgment in favor of the CHC Defendants is proper at this time. Because no CHC employee violated decedent's constitutional rights, CHC Defendants cannot be sued for a violation of the same. There can be no "policy or custom" which caused a deprivation of rights when no employee deprived him of his rights. Summary judgment is appropriate because there was no constitutional deprivation by a CHC employee.

C. CHC'S POLICIES DID NOT CAUSE A CONSTITUTIONAL DEPRIVATION.

The infirmary policies encouraged good medical care for inmates at the Tulsa County jail. Plaintiff has put forth no evidence that the infirmary policies failed to comply with NCCHC guidelines, or that the written policies direct jail employees to deny medical care or violate inmate constitutional rights. To the contrary, the evidence is uncontroverted that CHC's policies complied with NCCHC guidelines. (Exhibit 14, Nurse Moore Dep., 84:6-9). Neither of Plaintiff's physician experts relied on or offered opinions about CHC policies. Furthermore, the evidence is uncontroverted that these policies provide that inmates *shall* be provided with access

to medical care: "Inmates shall have timely access to care to meet their serious health care needs, including medical, dental and mental health needs. No barriers shall prevent inmates from receiving health care; being seen by a clinician; being given a professional clinical judgment; and receiving care that is ordered" (Exhibit 16, *J-A-01*, subsection E); "All inmates will have a receiving screening performed by qualified health care staff or health care trained security staff upon arrival at the facility in order to prevent those inmates who pose a threat to their own or others' health or safety from being admitted to the facility's general population." (Exhibit 16, *J-E-02*, sec. B). Plaintiff has failed to put forth any actual evidence that the policies of CHC violated the constitutional rights of decedent. There is no evidence in this case that CHC Defendants directed a constitutional violation through a policy in this case. To the contrary, the policies show that policymakers at CHC encouraged good care and did not violate the constitution. Therefore, summary judgment is appropriate.

D. CHC DEFENDANTS DO NOT HAVE THE FINAL DECISION MAKING AUTHORITY FOR A MUNICIPALITY.

Plaintiff presents no evidence that either a policymaker or a written corporate policy ordered a constitutional violation in this case. Therefore, Plaintiff may only argue the custom or unwritten policy of the municipality encouraged or allowed a constitutional violation. It bears repeating that Plaintiff cannot sustain this argument unless she can first prove a specific employee violated the constitution. A municipality will not be liable for a constitutional violation based upon a "policy" argument when there was no underlying constitutional violation by any of its employees. *Olsen v. Layton Hills Mall*, 312 F.3d 1304, 1317-18 (10th Cir. 2002). CHC Defendants assert that the care provided by CHC employees did not rise to the level of a constitutional violation; thus, the policy/custom argument cannot be reached. Even if this court

believes the evidence is sufficient to show a fact controversy regarding whether a CHC employee violated the constitution, there are still several hurdles that the Plaintiff cannot jump through.

First, rigorous standards of culpability and causation must be applied to ensure that the municipality is not held liable solely for the actions of its employees. *Board of County Com'rs of Bryan County, Okl. v. Brown*, 520 U.S. 397, 405 (1997). Plaintiff must prove *deliberate action* by the municipality which was the moving force behind the Plaintiff's deprivation of federal rights. *Id.* at 400. Plaintiff must demonstrate that municipal action was taken with "deliberate indifference" as to its known or obvious consequences. A showing of simple or even heightened *negligence by the municipality will not suffice*. *Id.* at 407. The proof must show action of the municipality was *highly likely to inflict the particular injury* suffered by the plaintiff. *Id.* at 412. The constitutional violation must be a *plainly obvious consequence* of the municipal decision. *Id.* at 414. Municipalities are not liable unless *deliberate action attributable to the municipality directly caused* a deprivation of federal rights. *Id.* at 415.

Second, the Plaintiff must prove that CHC was a final decisionmaker for the municipality who could establish jail policy. Municipal liability only attaches where the municipal decisionmaker possesses final authority to establish municipal policy with respect to the action ordered. *Id.* at 481. The official must be responsible for establishing final government policy respecting such activity before the municipality can be held liable. *Id.* at 483; *Lankford v. Hobart*, 73 F.3d 283,286 (10th Cir. 1996). Whether the governmental official had final decision-making power is a question of state law. *Id.*

In this case, Oklahoma law establishes that Sheriff Glanz had final decision-making authority regarding the provision of medical care in the jail. OKLA. STAT. TIT. 57, § 52; *Estate of Crowell ex rel. Boen v. Board of County Comm'rs of Bryan County*, 237 P.3d 134 (Okla.

2010)(holding that in "Oklahoma, […] a sheriff has a statutory duty to provide medical care to prisoners and is responsible for the proper management of the jail and the proper conduct of the jail personnel."). Sheriff Glanz testified that he was the final decisionmaker with regard to jail policy and the provision of medical care, as he is responsible for the management of all operations, planning, budgeting, and discipline within the jail. (Exhibit 17, *Deposition of Sheriff Glanz (June 10, 2015)*, 18:24-19:14). The evidence is undisputed that CHC Defendants did not make final decisions with regard to jail policy.

Finally, the relationship between the CHC Defendants and the Tulsa County jail is based entirely upon a contractual agreement, the terms of which state that the Tulsa County Sheriff's Office "is charged with the responsibility of administering, managing and supervising the health care delivery system of the David L. Moss Criminal Justice Center". (Exhibit 18, *Health Services Agreement*, CHM000153). The Health Services Agreement further dictates that "CHMO agrees to maintain State of Oklahoma minimum jail standards, NCCHC standards, ACA standards and all applicable State laws." (Exhibit 18, CHM000153). Thus, according to the terms of the Health Services Agreement, which controls all of Defendant's obligations, duties, responsibilities, and authority as it relates to DLM, CHC Defendants did not have any final decision making authority as to municipal policies at the jail. Under the terms of the Health Services Agreement, the CHC Defendants were obligated to follow the policies of the State of Oklahoma, the NCCHC, and ACA, as well as all applicable state laws. Moreover, if CHC Defendants had failed to comply with the policies of those other decision-makers, who are not parties to this suit, the Tulsa County Sheriff's Office had the express authority to terminate the agreement. (Exhibit 18, CHM000159). The requirement that a private corporation contracting with a governmental entity comply with policies promulgated by the state and other policy making entities, by its very

nature, shows that the CHC Defendants were not the final official policy making body at the Tulsa County Jail at all times relevant hereto. Therefore, a municipal liability theory of liability (which as explained below is the only possible theory of liability which the Plaintiff could assert against a non-person) cannot be established against the CHC Defendants because they do not, and did not, possess final authority to establish municipal policy at the Tulsa County Jail.

E. PLAINTIFF CANNOT ESTABLISH A CLAIM UNDER THE MUNICIPAL LIABILITY THEORY.

CHC Defendants cannot be held liable under a municipal liability theory under 42 U.S.C. § 1983 because the CHC Defendants did not possess the final decision-making authority for a municipality or government body. Assuming, *arguendo*, that CHC Defendants played a part in jail policies, that fact alone is insufficient to prove CHC Defendant liability; Plaintiff must prove the bad intent of CHC Defendants—that policymakers for CHC Defendants knowingly established a policy or custom that caused an employee to violate the constitution. Plaintiff must prove who the policymakers were for CHC and what they knew. The law is settled that CHC Defendants cannot be liable for a constitutional violation through the application of *respondeat superior*. *Monnell v. Dept. of Soc. Serv. Of New York*, 736 U.S. 658 (1978). There is no such evidence here. Plaintiff has not and cannot identify any unconstitutional policy or custom of the municipality that was the moving force behind Ms. Salgado's death, nor can she establish that any such policy actually directly caused Ms. Salgado's death in this case.

"To establish municipal liability, a plaintiff must show (1) the existence of a municipal custom or policy and (2) a direct causal link between the custom or policy and the violation alleged." *Jenkins v. Wood*, 81 F.3d 988, 993-994 (10th Cir. 1996)(citing *City of Canton v. Harris*, 489 U.S. 378, 385 (1989); *Hinton v. City of Elwood*, 997 F.2d 774, 782 (10th Cir. 1993)).

The U.S. Supreme Court has held that, where a plaintiff is making a claim under 42 U.S.C. § 1983 based on a municipal liability theory, "it is not enough for a plaintiff merely to identify conduct properly attributable to the municipality. The plaintiff must also demonstrate that, through its *deliberate* conduct, the municipality was the 'moving force' behind the injury alleged." *Bd. of County Comm'rs of Bryan County v. Brown*, 520 U.S. 397, 404 (1997). Furthermore, the Supreme Court also held that "a plaintiff must show that the municipal action was taken with the requisite degree of culpability and must demonstrate a direct causal link between the municipal action and the deprivation of federal rights." *Id.* "A showing of simple or even heightened negligence will not suffice." *Id.* at 407.

Plaintiff has not identified any specific policy or custom of any of the CHC Defendants which was the "moving force" behind Ms. Salgado's death. Despite her vague claims in her Amended Complaint, Plaintiff lacks any actual evidence to show that the CHC Defendants acted with any degree of culpability toward Ms. Salgado which would place her at substantial and imminent risk of death. The Plaintiff cannot, and has not, point to any specific policy or custom in effect at the Tulsa County Jail in June of 2011 which was the "moving force behind any constitutional violation", nor has, or can, the Plaintiff point to a policy or custom in effect at the jail in June of 2011 which "directly caused" Ms. Salgado's death. In fact, the evidence is undisputed in this case that the cause of Ms. Salgado's death is unknown. (Exhibit 11, Dr. Shah Dep., 238:12-23; Exhibit 10, Dr. Allen Dep., 260:24-261:3). Plaintiff has failed to put forth the requisite expert testimony to establish causation in order to withstand summary judgment on a negligence action against Defendants. Therefore, summary judgment in favor of the CHC Defendants on any claim asserted by the plaintiff under the municipal liability theory is appropriate at this time and must be granted as a matter of law.

F. CHC DEFENDANTS CANNOT BE HELD VICARIOUSLY LIABLE FOR ANY § 1983 CLAIMS AGAINST ITS EMPLOYEES OR AGENTS.

It is not clear from Plaintiff's Amended Complaint whether she is now trying to hold the CHC Defendants liable for any alleged constitutional violations by any of their employees or agents. As noted above, the Plaintiff has individually sued one employee of the CHC Defendants, Chris Rogers, and Dr. Washburn, a non-employee of CHC Defendants, and asserted that they have violated Ms. Salgado's constitutionally protected rights. While the merits of Plaintiff's claims have been more thoroughly addressed in each of those individual health care provider's motions for summary judgment, the fact remains that the CHC Defendants cannot be held vicariously liable under 42 U.S.C. § 1983 as a matter of law. Specifically, the U.S. Supreme Court has repeatedly stated that "A municipality or other local government may be liable under [42 U.S.C. § 1983] if the governmental body itself 'subjects' a person to a deprivation of rights or 'causes' a person 'to be subjected' to such deprivation." *Connick v. Thompson*, 131 S. Ct. 1350, 1359 (2011) (citing *Monell* at 692). Moreover, the Supreme Court has reiterated that "under § 1983, local governments are responsible only for 'their own illegal acts" and "[t]hey are not vicariously liable under § 1983 for their employees' actions." *Id.* (quoting *Pembaur* at 479). Therefore, the CHC Defendants must be granted summary judgment in their favor on any 42 U.S.C. § 1983 claims the Plaintiff may be asserting based on vicarious liability of the CHC Defendants' employees.

G. PLAINTIFF CANNOT ESTABLISH THE SUBJECTIVE COMPONENT NECESSARY TO MAINTAIN A DELIBERATE INDIFFERENCE CLAIM AGAINST ANY OF THE DEFENDANTS IN THIS CASE.

Even if the CHC Defendants were a municipal body with final policy making authority, or a "person" pursuant to 42 U.S.C. § 1983, the Plaintiff still lacks the requisite evidence to

prove that the CHC Defendants were deliberately indifferent to any substantial and imminent risk of death. In this case, the Plaintiff asserts the defendants violated Ms. Salgado's rights under the Eighth and Fourteenth Amendments to the Constitution of the United States.

The subjective component of the deliberate indifference test "requires a showing that the defendant acted with a culpable state of mind." *Gaston v. Ploeger*, 229 Fed.Appx. 702, 710 (10th Cir. 2007). A jail official "cannot be liable for a claim of deliberate indifference 'unless the official knows of and disregards an excessive risk to inmate health and safety; the official must both be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, and he must also draw the inference."" *Heidtke v. Corr. Corp. of Am.*, 489 Fed. Appx. 275, 279 – 280 (10th Cir. 2012)(quoting *Self v. Crum*, 439 F.3d 1227, 1231). "The subjective Component is akin to recklessness in the criminal law, where, to act recklessly, a person must consciously disregard a substantial risk of serious harm." *Id.* at 280. The Tenth Circuit has explained that "our case law firmly establishes that 'the subjective component is not satisfied, absent an extraordinary degree of neglect'". *Heidtke* at 280 (quoting *Self* at 1232). **The Tenth Circuit Court has said that "in this Circuit, the 'negligent failure to provide adequate medical care, even one constituting medical malpractice, does not give rise to a constitutional violation."** *Id.* (quoting *Self* at 1233). "Only when the symptoms obviously point to a substantial risk of harm can we draw an inference of the medical professional's conscious disregard of an inmate's medical emergency." *Id.* at 282.

Although the CHC Defendants are not "persons" under 42 U.S.C. § 1983, and the analysis above should only be applied to individuals personally involved in an inmate's incarceration, if the Plaintiff attempts to argue that the CHC Defendants should be subjected to this standard, or if she attempts to argue the CHC Defendants are vicariously liable for the acts of

their employees or agents, the Plaintiff still will be unable to demonstrate the CHC Defendants or its employees or agents knew Ms. Salgado was at substantial risk of serious harm while incarcerated at the Tulsa County Jail and that the CHC Defendants or their employees or agents consciously disregarded any such risk.[3]

In her Amended Complaint, Plaintiff very generally alleged that the CHC Defendants violated Ms. Salgado's federally protected rights by knowing "there was a strong likelihood that Ms. Salgado was in danger of serious injury and harm" and that the CHC Defendants were deliberately indifferent to her constitutionally protected rights by "fail[ing] to treat Ms. Salgado's serious medical condition properly; fail[ing] to conduct appropriate medical assessments; fail[ing] to create and implement appropriate medical treatment plants; fail[ing] to promptly evaluate Ms. Salgado's physical health; fail[ing] to properly monitor Ms. Salgado's physical health; fail[ing] to provide access to medical personnel capable of evaluating and treating her serious health needs; and fail[ing] to take precautions to prevent Ms. Salgado from further injury." (Doc. No. 4, ¶¶ 173 and 175). However, once the Plaintiff's experts were deposed, the specific criticisms against the jail healthcare providers in Ms. Salgado's case were limited to just six very general criticisms:

1. Nursing failure to acknowledge the seriousness of alcohol withdrawal.

Plaintiff's nurse expert, Jacqueline Moore, RN, testified that the nurses in Ms. Salgado's case failed to acknowledge the seriousness of Ms. Salgado's alcohol withdrawal. (Exhibit 14, Nurse Moore Dep., 242:25-243:8). After being shown additional records which Plaintiff's

[3] In addition to the following argument, CHC Defendants' incorporate and adopt by reference the arguments contained within the Motions for Summary Judgment of Defendant Phillip Washburn, M.D., Defendant Andrew Adusei, M.D., and Defendant Chris Rogers, RN, on the claims of Plaintiff Christine Wright.

counsel had not provided to Nurse Moore in her expert review, Nurse Moore agreed that there is just no evidentiary basis for such criticism:

Q: Is there anything in these records that would suggest to you that she is beginning to have withdrawal symptoms?
A: Not in these records.
Q: And I know we're beating a dead horse here, but this is the first time that you've seen these records from her second admission?
A: Yes.
Q: Do these records impact your opinions at all in this case?
A: The alcohol withdrawal, yes, because I didn't have them.
Q: And how does it impact your opinions on the alcohol withdrawal?
A: Because when she went to St. John's, when she first went to the first hospital, I thought that they hadn't – that they should have called St. John's just to find out because they knew she'd signed out AMA. And if they had they might have realized more information and may not have cleared her quite so fast. But now that I see these records, I don't have a problem.

(Exhibit 14, Nurse Moore Dep., 264:17-265:14).

Nurse Moore's testimony is that, despite Ms. Salgado having no signs or symptoms of alcohol withdrawal *at any point in time*, the jail healthcare providers should have gone ahead and initiated alcohol withdrawal protocols, not because the policy or Ms. Salgado's presentation actually required it, but because "it's just not that hard of a thing to do for three days" "only because there are so many deaths due to alcohol intoxication in the jails" (Exhibit 14, Nurse Moore Dep., 265:15-266:11). Ms. Salgado did not exhibit any symptoms of alcohol withdrawal at any time. Nurse Moore testified that the symptoms of alcohol withdrawal symptoms she would look for include nausea, vomiting, tremors, diaphoresis, agitation, lack of orientation, headaches, and perceptual orientation. (Exhibit 14, Nurse Moore Dep., 261:13-22). During her receiving screening, Ms. Salgado specifically indicated that she was having no signs or symptoms of substance withdrawal. (Exhibit 5, LS00037). The nurse charted that Ms. Salgado was not having shakes or seizures. (Exhibit 5, LS00037). Ms. Salgado reported to the healthcare provider that she was not currently experiencing *any* symptoms of any nature. (Exhibit 5, LS00036). In

addition, the medical provider who assessed Ms. Salgado immediately prior to her incarceration at St. John's also charted that she did not have any alcohol withdrawal symptoms. (Exhibit 4, SJS00700; Exhibit 14, Nurse Moore Dep., 260:3-10, 260:21-261:7). Plaintiff's nurse expert agrees that Ms. Salgado was never at risk for alcohol withdrawal:

> Q: Can you point to somewhere within the record that she begins to have symptoms of alcohol withdrawal?
> A: No
> […]
> Q: Are any of the other symptoms she had indicative of alcohol withdrawal?
> A: No.

(Exhibit 14, Nurse Moore Dep., 269:3-11);

> Q: And you can't say to a medical degree of probability that she did suffer from alcohol withdrawal, correct?
> A: Correct.

(Exhibit 14, Nurse Moore Dep., 269:23-271:1).

The evidence is uncontroverted that Ms. Salgado never suffered from alcohol withdrawal, that she never exhibited signs or symptoms of alcohol withdrawal, and therefore the jail healthcare providers were never put on notice of any risk of Ms. Salgado suffering from alcohol withdrawal, as that risk never existed. Finally, Plaintiff has offered no causation testimony to link any such alleged failure to initiate alcohol withdrawal protocol with Ms. Salgado's cause of death. As such, Plaintiff has failed to establish a constitutional claim against Defendants.

2. Nursing failure to refer Ms. Salgado to mental health.

Plaintiff's nurse expert also criticized CHC nurses for allegedly failing to refer Ms. Salgado to mental health. (Exhibit 14, Nurse Moore Dep., 244:12-15). However, Nurse Moore agreed that Ms. Salgado did not report to the nurses during her booking assessment that she was suicidal. (Exhibit 14, Nurse Moore Dep., 245:8-11). Nurse Moore also agreed that the nurse did not indicate that Ms. Salgado appeared to be suicidal. (Exhibit 14, Nurse Moore Dep.,

245:12-14). Moreover, Nurse Moore agreed that there was nothing in the chart to indicate that Ms. Salgado was, in fact, suicidal. (Exhibit 14, Nurse Moore Dep., 245:15-20). Thus, by Plaintiff's nurse expert's own testimony, there was absolutely no evidence to indicate that Ms. Salgado was even at a risk of suicide. Moreover, during the intake screening performed by a nurse, Ms. Salgado reported that she was *not* suicidal and that she did *not* have a suicide plan. (Exhibit 5, LS00036).

Notably, the CHC mental health policy in effect at the time of Ms. Salgado's care required that all inmates receive a mental health screening within 14 calendar days of admission to the facility. (Exhibit 16, *J-E-05*, POL000144 at I.B.). Further, the CHC Receiving Screening policy in effect in June 2011 did not require that inmates who report only a prior history of suicide attempts are to be referred to mental health. (Exhibit 16, *J-E-02*, POL000133-136.). Nurse Moore testified that Defendant CHC's policies complied with NCCHC guidelines and were appropriate. (Exhibit 14, Nurse Moore Dep., 84:6-9). It is also noteworthy that Ms. Salgado's receiving screening *was* reviewed by psychiatrist Stephen Harnish, M.D. on June 27, 2011 at 5:50 a.m. (Exhibit 5, LS00007). Most importantly, though, is the fact that Nurse Moore testified that the referral to mental health had no effect whatsoever on the outcome of the case. (Exhibit 14, Nurse Moore Dep., 144:12-22). Thus, Plaintiff has failed to establish that Ms. Salgado was at risk of suicide, and Plaintiff has failed to link any such alleged nursing failure to initiate suicide precautions to the cause of Ms. Salgado's death. Therefore, Plaintiff has failed to establish a constitutional claim against CHC Defendants.

3. Nursing failure to adequately assess Ms. Salgado for chest pain.

Plaintiff's nurse expert additionally criticized Ms. Salgado's nurses for allegedly failing to adequately assess Ms. Salgado for chest pain. (Exhibit 14, Nurse Moore Dep., 243:9-12).

Nurse Moore's criticism is limited to the nurse's alleged failure to chart Ms. Salgado's vital signs for a period of thirty-four (34) hours while Ms. Salgado was in the infirmary. (Exhibit 14, Nurse Moore Dep., 284:15-285:17). In Nurse Moore's defense, she was not familiar with the types of documents in the CHC chart, making it difficult to navigate. (Exhibit 14, Nurse Moore Dep., 242:17-21). However, Nurse Moore's criticism that there was no charting of Ms. Salgado's vital signs for 34 hours is completely erroneous. Nurse Moore agreed that Ms. Salgado's vital signs were taken at approximately 7:00 p.m. on June 27, 2011, at the time of her admission to the infirmary. (Exhibit 14, Nurse Moore Dep., 285:25-286:8). Nurse Moore agreed that Ms. Salgado's vital signs were normal at that time, except that she was hyperventilating. (Exhibit 14, Nurse Moore Dep., 285:25-287:8; Exhibit 5, LS00027). Although she claimed that she could not read the handwriting on the page, Nurse Moore agreed it appears that vital signs were again taken on June 27, 2011 at 10:00 p.m. (Exhibit 14, Nurse Moore Dep., 287:12-25; Exhibit 5, LS00028). Nurse Moore also agreed that another set of vital signs were taken sometime after 5:10 a.m. on June 28, 2011. (Exhibit 5, LS00028; Exhibit 14, Nurse Moore Dep. 289:6-19). Thus, Nurse Moore agreed that a nurse did chart Ms. Salgado's vital signs on the date of her death. The record is uncontroverted that Ms. Salgado was seen throughout June 28, 2011. At 3:00 p.m. on June 28, 2011, Nurse Metcalf again assessed Ms. Salgado. At that time, Ms. Salgado's blood sugar was 210, so she was given two units of regular insulin plus 17 units of Humulin. Nurse Metcalf reported that at this time, Ms. Salgado was awake, and her breathing was even and unlabored. (Exhibit 8, GLANZ-Revilla05282; Exhibit 9, Nurse Metcalf Dep., 138:24-139:15).

Nurse Metcalf saw Ms. Salgado again at 5:10 p.m. on June 28, 2011, at which time Ms. Salgado was given Aspirin, Doxycycline, and Promethazine. Nurse Metcalf assisted Ms. Salgado to sit up, and Ms. Salgado reported that she was feeling a little better. Nurse Metcalf testified that

Ms. Salgado took her medication without difficulty, and she assisted her to law back down. Nurse Metcalf further testified and charted that Ms. Salgado did not eat her supper. (Exhibit 8, GLANZ-Revilla05282; Exhibit 9, Nurse Metcalf Dep., 144:19-146:1, 148:2-25). The medical records indicate that at approximately 5:08 p.m. on June 28, 2011, Ms. Salgado's blood sugar was taken, which was 210. At that time, she received insulin, Maalox, Doxyclycline, Aspirin, and Promethazine. (Exhibit 5, LS00031, lines 1-7, LS00032; Exhibit 9, Nurse Metcalf Dep. 144:19-146:1). Nurse Metcalf also reported in her written statement and testified that at 5:30 p.m. on June 28, 2011, she made rounds and saw that Ms. Salgado was resting with her eyes closed and observed her breathing. (Exhibit 8, GLANZ-Revilla05282; Exhibit 9, Nurse Metcalf Dep. 146:2-147:5). An hour and a half later, at approximately 7:00 p.m., Nurse Metcalf and Nurse Paul Wallace discovered Ms. Salgado non-responsive in her cell while making their evening rounds. (Exhibit 8, GLANZ-Revilla05282; Exhibit 9, Nurse Metcalf Dep. 147:8-17).

Despite her criticism of Nurse Metcalf's alleged failure to chart vital signs, Nurse Moore could not point to any actual standard or basis for this criticism. Nurse Moore testified that the national standard of care does not require vital signs be taken every day. (Exhibit 14, Nurse Moore Dep., 328:17-25). Nurse Moore further testified that the NCCHC standards do not require vital signs to be taken every day. (Exhibit 14, Nurse Moore Dep., 327:17-22). Furthermore, Nurse Moore testified that the CHC policy in effect at the time of Ms. Salgado's care did not require vital signs to be recorded daily. (Exhibit 14, Nurse Moore Dep., 329:1-5). Significantly, even if the nurses at the jail performed inadequate assessments on Ms. Salgado, which Defendant denies, this allegedly deficient care is insufficient to establish a constitutional violation. Performance of a cursory examination does not rise to the level of a civil rights violation. *Duffield v. Jackson*, 545 F.3d 1234, 1239 (10th Cir. 2008).

Notwithstanding Nurse Moore's unfounded charting criticism, the evidence is undisputed that each of Ms. Salgado's diagnosed medical conditions was being treated appropriately and reasonably. (Exhibit 10, Dr. Allen Dep., 258:21-259:1, 261:4-9). The evidence is also undisputed that Ms. Salgado was receiving treatment for all of her complained-of medical symptoms: infiltrates, chest pressure, reflux, chest pressure, nausea and vomiting, diabetes, and questionable pancreatitis. (Exhibit 10, Dr. Allen Dep., 261:4-9; Exhibit 11, Dr. Shah Dep., 232:7-20). Additionally, the evidence is undisputed that there is *no* sign or symptom that went unassessed or untreated by the jail healthcare providers. (Exhibit 11, Dr. Shah Dep., 232:7-20). Further, the evidence is undisputed that Ms. Salgado was assessed by both a physician and by nurses. (Exhibit 11, Dr. Shah Dep., 234:22-235:9).

It is also noteworthy that Plaintiff did not name and serve Nurse Metcalf as a Defendant in this matter. Collective allegations against the state are not sufficient to create a civil rights claim; a plaintiff must identify who exactly injured him and then join that party as a defendant. *Robbins v. Oklahoma*, 519 F.3d 1242 (10th Cir. 2008); *Stone v. Albert*, 338 Fed. Appx. 757, 759 (10th Cir. 2009); *Gray v. Weber*, 244 Fed Appx. 753 (8th Cir. 2007). Furthermore, there is no expert testimony to link Nurse Moore's criticisms with Ms. Salgado's cause of death. Plaintiff must also show a causal link between the acts of the individual and the alleged constitutional deprivation. *Duffield v. Jackson*, 545 F.3d 1234 (10th Cir. 2008). Plaintiff has not and cannot produce any evidence to link Nurse Metcalf's alleged charting deficiencies with the cause of Ms. Salgado's death. Plaintiff has failed to establish a *prima facie* case of deliberate indifference on the part of the CHC nurses.

4. Dr. Washburn's failure to adequately chart his clinical reasoning.

Plaintiff's physician internist expert criticizes Dr. Washburn for allegedly inadequately

charting on Ms. Salgado's care. (Exhibit 10, Dr. Allen Dep., 250:8-16, 251:4-252:11, 256:15-257:4, 262:3-16). Plaintiff's internist expert, Scott Allen, M.D. offered *just one* criticism of Dr. Washburn: for not documenting that he saw Ms. Salgado on June 27, 2011 in real time and for not providing his reasoning for his medical decisions. (Exhibit 10, Dr. Allen Dep., 250:8-16). Thus, Dr. Allen's criticisms against Dr. Washburn do not even relate to his *care* but instead to his documentation of his reasoning for providing care.

Dr. Allen testified that he could not offer a standard of care opinion of whether it was appropriate for Dr. Washburn to admit Ms. Salgado to the medical unit for observation on June 27, 2011 (as opposed to transferring her to the hospital) because Dr. Washburn's charting did not document his thought process in making that decision. (Exhibit 10, Dr. Allen Dep., 251:4-252:11). In fact, the extent of Dr. Allen's criticisms in this case relate to Dr. Washburn's failure to chart when he saw Ms. Salgado on June 27, 2011, and not the actual care provided:

> Q: Based off of the evidence that you have reviewed relating to this jail admission, is it your testimony that you are uncertain as to why Dr. Washburn had admitted this patient to the infirmary on June 27, 2011?
>
> A: I'm unclear on his clinical reasoning because he did not leave a note explaining what he was thinking. We're talking about clues, and the clues provide some suggestion that the patient was admitted because of ongoing symptoms, there was an admission diagnosis as recorded by a nurse, the infiltrate, and there's an antibiotic ordered and there's also notation that these are the medical conditions. I agree those are there and I agree that those are problems that needed to be addressed and appeared to have been addressed.

(Exhibit 10, Dr. Allen Dep., 256:15-257:4).

Dr. Allen further testified that Dr. Washburn was not ignoring Ms. Salgado's medical condition, as he was providing treatment, and again that his criticisms of Dr. Washburn are limited to Dr. Washburn's failure to document, one way or the other, with regard to coronary artery syndrome:

> Q: You'll agree that the act of admitting a patient from general population into the

medical unit was not a breach of a standard of care by Dr. Washburn, was it?

A: Well, again, he's done something. He's exceeded doing the threshold of doing nothing, but the active issue here on this case, we've talked about other disease processes, but we really haven't talked about the question of acute coronary syndrome, and whether that was addressed. And if the consideration was given to acute coronary syndrome, whether it was either ruled out or moved lower on the differential diagnosis, or why it was not evaluated more aggressively.

(Exhibit 10, Dr Allen Dep., 257:21-258:9).

Dr. Allen again and again limited his standard of care opinions to Dr. Washburn's documentation, not his care:

Q: You're not critical of Dr. Washburn for on June 29th documenting what he documented, are you?

A: Well, I'm critical of the fact, as we've already established, that he did not document it in real time, but having not documented it in real time, it was good that he made an effort to enter a note on a medical record.

Q: Are you of the opinion that it was below the standard of care for Dr. Washburn to have not documented this note on June 28, 2011, versus June 29th, 2011?

A: I think it is, and simply because of the reason that it was a chest pain complaint and a history with known coronary disease.

(Exhibit 10, Dr. Allen Dep., 262:3-16).

However, Dr. Allen's reasoning for Dr. Washburn's only alleged breach in the standard of care is nonsensical, as Dr. Allen could not even say that it had any actual impact on Ms. Salgado's care or outcome. Dr. Allen testified that Dr. Washburn breached the standard of care with failing to chart in real time because charting is important "for recordkeeping, memorializing, and eventually to be passed on to typically the primary care provider for ongoing conditions and care." (Exhibit 10, Dr. Allen Dep., 264:17-25). However, Dr. Allen agrees that in this case Dr. Washburn was the primary care provider, and that Dr. Washburn knew that he had seen Ms. Salgado on June 28, 2011 when he examined her again the next day, on June 29, 2011. (Exhibit 10, Dr. Allen Dep., 265:1-13). Further, Dr. Allen agreed that Dr. Washburn was the sole physician providing care to Ms. Salgado. (Exhibit 10, Dr. Allen Dep., 265:14-17). Dr. Allen still testified that Dr. Washburn's failure to chart in real time was a breach in the standard of care

because he "left no written documentation for the nurses as shifts change, as to what he's thinking about this chest pain." (Exhibit 10, Dr. Allen Dep., 265:18-22). However, Dr. Allen conceded that this argument is flawed because the nurses did not seem to have any problems communicating with Dr. Washburn when they had questions or concerns related to Ms. Salgado. (Exhibit 10, Dr. Allen Dep., 266:4-11). Thus, the very basis for Dr. Allen's criticism against Dr. Washburn is groundless when applied to the facts of this case.

At the end of the day, Dr. Allen's only standard of care criticism in this matter is that Dr. Washburn did not document his thought process for his treatment:

> Q: Of course in the very next line, Dr. Nguyen says her symptoms may or may not be cardiac related based on her risk factors.
> A: Correct.
> Q: And yet you have a belief that Dr. Washburn should have discovered this?
> A: **I have a belief that Dr. Washburn fell below the standard of care by not documenting his clinical thinking.**
> Q: That's it. Right?
> […]
> A: So I have a belief that Dr. Washburn could have discovered this, but we don't know what he was thinking.
> Q: And that is what you considered to be a breach in the standard of care?
> A: The absence of a note in an acute situation like this in a patient with coronary disease and chest pain, yes, that's a breach in the standard of care.
> Q: And you stated earlier, we really don't know what caused her death. Correct?
> A: Correct.

(Exhibit 10, Dr. Allen Dep., 286:6-287:25).

Dr. Allen criticizes Dr. Washburn for not expressly charting his mental processes behind his clinical judgment. Dr. Allen does not criticize Dr. Washburn's actual care—just that he can't extrapolate Dr. Washburn's reasoning for providing such care from the face of the medical chart. Significantly, Dr. Allen agrees that Dr. Washburn *was* providing care to Ms. Salgado. Dr. Allen agreed that Ms. Salgado's diabetes was not being ignored, that there were orders in place, and that her blood sugar levels were being tested. (Exhibit 10, Dr. Allen Dep., 237:13-16). Moreover,

the evidence is undisputed that each of Ms. Salgado's diagnosed medical conditions was being treated appropriately and reasonably. (Exhibit 10, Dr. Allen Dep., 258:21-259:1, 261:4-9). The evidence is undisputed that Ms. Salgado was receiving treatment for all of her complained-of medical symptoms: infiltrates, chest pressure, reflux, chest pressure, nausea and vomiting, diabetes, and questionable pancreatitis. (Exhibit 10, Dr. Allen Dep., 261:4-9). The evidence is undisputed that there is *no* sign or symptom that went unassessed or untreated by the jail healthcare providers. (Exhibit 11, Dr. Shah Dep., 232:7-20). Further, the evidence is undisputed that Ms. Salgado was assessed by both a physician and by nurses. Exhibit 11, Plaintiff Expert Shah Dep., 234:22-235:9

Thus, there is no allegation of a denial of care. Where there is no allegation of a total denial of care, but rather plaintiff disagrees with the care provided, the civil rights claim fails. *Kermicle v. Day,* 428 F.Supp.16 (10th. Cir. 1976). As such, Plaintiff has failed to meet her *prima facie* burden of establishing a constitutional claim against Defendant under 42 U.S.C. § 1983. Where there is no allegation of a total denial of care, but rather plaintiff disagrees with the care provided, the civil rights claim fails. *Kermicle v. Day,* 428 F.Supp.16 (10th. Cir. 1976). Therefore, summary judgment against all claims of Plaintiff in favor of Defendant is proper at this time.

5. Dr. Washburn made an incorrect judgment call and/or provided inadequate treatment for Ms. Salgado's complaints of chest pain.

Plaintiff's physician cardiologist expert criticizes Dr. Washburn for making an incorrect judgment call by not transferring Ms. Salgado to an emergency room on June 26, 2011 and for providing allegedly inadequate treatment for Ms. Salgado's complaints of chest pain. (Exhibit 11, Shah Dep., 190:24-191:16, 203:11-18, 205:9-206:4).

At the time Ms. Salgado was booked into the jail, the evidence is undisputed that she was not complaining of chest pain. (Exhibit 5, LS00036). The evidence is further undisputed that Ms. Salgado first complained of chest pain in the jail in the afternoon of June 26, 2011. (Exhibit 5, LS00040-41). While sitting in the Medical Unit waiting to return to her pod, Ms. Salgado began complaining of burning chest pain in her epigastric region which she reported had started suddenly. She further complained of nausea, shortness of breath, and chest wall tenderness. (Exhibit 5, LS00040-41). Specifically, she reported that her chest pain had suddenly started at 4:15 p.m. on June 26, 2011. (Exhibit 5, LS00041). Her description of chest pain was consistent with the chest pain she described in her prior visit to St. Francis and St. John Medical Center. (Exhibit 4, SJS00598, 700; Exhibit 11, Dr. Shah Dep., 90:7-21). Although she reported nausea and vomiting, the nurse noted that Ms. Salgado had no actual emesis while in the Medical Unit, and that she was observed only spitting in a biohazard bag. (Exhibit 5, LS00041). Additionally, Ms. Salgado's lungs and heart had no abnormal findings upon physical examination. Her lungs were clear to auscultation ("cta") bilaterally in all lobes, her heart had no rubs, bruits or murmurs, with normal S1 and S2. (Exhibit 5, LS00041).

Ms. Salgado was referred to see Dr. Washburn for complaints of nausea, vomiting, diabetes, and alcohol abuse. (Exhibit 5, LS00043). Dr. Washburn immediately ordered Promethazine in response to her complaints of nausea and vomiting; Humulin in response to her self-reported Diabetes; and Nitroglycerin ("Nitro"), Maalox and Aspirin in response to her complaint of chest pain/pressure and reflux. (Exhibit 5, LS00030, lines 7-11, LS00042-43). Thereafter, Dr. Washburn began to attempt to determine the precise cause of Ms. Salgado's abdominal and chest pain.

This is not the straight-forward heart attack case that Plaintiff would like this court to

believe. To the contrary, the evidence is undisputed that nobody can prove Ms. Salgado died of a heart attack. The evidence is also undisputed that chest pain can have numerous causes, most of which are non-cardiac in nature. Both of Plaintiff's experts testified that there is a huge list of causes of non-cardiac chest pain, including gastrointestinal disorders, reflux (heartburn), disorders of the esophagus including spasms, stomach disorders, peptic ulcer disease, pneumonia or other diseases of the lung, gallbladder disease, cervical disk disease, pneumonia, musculoskeletal trauma or strain, herpes zoster, emotional psychiatric conditions, anxiety, liver disorders, and chronic pancreatitis (Exhibit 11, Dr. Shah Dep., 66:2-68:3; Exhibit 10, Dr. Allen Dep., 199:21-200:15). Dr. Washburn, the provider who actually treated Ms. Salgado, also explained that there are many causes of chest pain, such as hiatal hernia or alcohol gastritis, and because of that "sometimes it's extremely hard to diagnose." (Exhibit 7, Washburn Dep., 250:15-23).

Ms. Salgado described her chest pain as burning pain in her epigastric region which radiated into her neck. (Exhibit 5, LS00041). The epigastric region means the upper abdominal area, up around the stomach. (Exhibit 11, Dr. Shah Dep., 175:16-176:6). Pain in the epigastric region (in the upper abdomen just below the ribs) is a common symptom of reflux or chronic pancreatitis. (Exhibit 11, Dr. Shah Dep., 68:4-18; Exhibit 10, Dr. Allen Dep., 199:21-200:25).

Nonetheless, because these were complaints of chest pain, Dr. Washburn ruled out acute coronary syndrome on his differential diagnosis. Dr. Washburn ordered an EKG. (Exhibit 5, LS00030, lines 7-11, LS00042-43). Plaintiff's cardiology expert agreed that it was appropriate and reasonable for Dr. Washburn to obtain an EKG on Ms. Salgado. (Exhibit 11, Dr. Shah Dep., 181:4-9). Ms. Salgado's EKG was performed. (Exhibit 10, Dr. Allen Dep., 242:18-23; Exhibit 12, GLANZ-Revilla05515-05516). The EKGs came back on two strips, one reading "abnormal"

and the second "borderline." (Exhibit 10, Dr. Allen Dep., 244:21-24; Exhibit 12, GLANZ-Revilla05515-05516). Dr. Washburn had the EKG results read over the phone to him. (Exhibit 7, Dr. Washburn Dep., 221:15-21). Dr. Washburn testified that, although he has no specific memory to this day of reviewing Ms. Salgado's EKG, he's certain that he did review it by having a nurse read the results to him because his pattern and practice as a clinical healthcare provider is to always review such results. (Exhibit 7, Dr. Washburn Dep., 161:4-162:1, 163:7-25).

Dr. Washburn further explained that, although Ms. Salgado's EKG results read abnormal on their face, his impression was that her EKGs did not indicate a serious condition. Rather, the first strip revealed normal sinus rhythm, right atrial enlargement and ST abnormality. (Exhibit 12, GLANZ-Revilla05515; Exhibit 7, Dr. Washburn Dep., 158:20-159:1). However, Dr. Washburn explained his clinical opinion that although the ST wave is a little bit abnormal, this could be explained by non-cardiac causes. (Exhibit 7, Dr. Washburn Dep., 159:2-6). The second strip showed normal sinus rhythm and atrial enlargement. Although it read "borderline EKG" on the printout, Dr. Washburn explained his clinical opinion that this was an essentially normal EKG, as atrial enlargement is not a serious condition. (Exhibit 7, Dr. Washburn Dep., 158:14-17, 162:17-24).

It is undisputed that EKG ST-segment and T-wave segment abnormalities can have a number of non-cardiac causes, including anxiety, certain drugs, pulmonary embolisms, electrolyte imbalances, and esophageal diseases. In fact, according to Plaintiff's cardiology expert, the possible causes of ST- and T-wave abnormalities on an EKG is "exhaustive". (Exhibit 11, Dr. Shah Dep., 73:18-79:25). Also, Plaintiff's expert testified that EKGs can be nonspecific and are non-diagnostic by themselves, and because of this it's important to look at the entire

clinical picture when making a medical diagnosis and judgment call related to a patient's care who has an abnormal EKG. (Exhibit 10, Dr. Allen Dep., 204:10-205:3). Plaintiffs' experts agreed that because of the dubious nature of EKG abnormalities, the ability to compare an EKG with prior EKGs, if available, improves diagnostic accuracy. (Exhibit 11, Dr. Shah Dep., 80:1-18; Exhibit 10, Dr. Allen Dep., 202:21-203:2). Dr. Allen explained the reason why it is helpful to compare abnormal EKGs with prior EKGs:

> Q: Do you agree that the availability of prior EKG tracings improves diagnostic accuracy and reduces the rate of admissions with patients with abnormal baseline EKGs?
> A: Yes.
> Q: And the reason for that is, if you have patients who always – I don't know how else to put it – always have a bad or abnormal EKG reading, the presence of an abnormal EKG reading does not tell you that there is a new significant medical problem going on with that patient at that point in time?
> […]
> A: Is an old EKG helpful? In interpreting an abnormal EKG, absolutely. An abnormality, certain ones, and many common ones, that are found to be consistent across previous EKGs and a new one, would be helpful.
> Q: There are just some patients who have borderline or abnormal EKGs regularly?
> A: Yes.

(Exhibit 10, Dr. Allen Dep., 202:23-203:21).

Despite agreeing to the importance of comparing abnormal EKGs with prior EKGs to get an accurate diagnosis, Plaintiff's expert cardiologist Dr. Shah admitted that he had not taken the time to review Ms. Salgado's prior EKGs, and that he could not testify one way or the other as to whether Ms. Salgado's tracings had changed significantly. (Exhibit 11, Dr. Shah Dep., 182:8-17). However, Dr. Allen agreed that Ms. Salgado had a history of having abnormal EKGs. (Exhibit 10, Dr. Allen Dep., 203:22-204:3). Thus, the evidence is undisputed that Ms. Salgado had an established history of having abnormal EKGs prior to coming to the jail. And, in fact, the evidence is undisputed that there was no significant difference in Ms. Salgado's EKG results from her prior EKGs.

Dr. Washburn took Ms. Salgado's clinical presentation into consideration when reviewing her EKG and complaints of chest pain. In fact, at the time her EKG was performed, Ms. Salgado was refusing to stop rubbing her chest and refusing to slow down her breathing. (Exhibit 5, LS00042). Plaintiff's cardiology expert agreed that Ms. Salgado's noncompliance with nursing instructions (e.g., rubbing her chest and breathing heavily) could have caused her abnormalities on an EKG:

> Q: A patient who is rubbing her chest and refusing to slow down her breathing could have an impact on the EKG tracing being performed at that time, correct?
> A: Yes, it's possible. If they are moving or breathing rapidly, it could cause you to get a poor baseline. So, it could cause you to get a suboptimal EKG.

(Exhibit 11, Dr. Shah Dep., 180:18-24, *see also* 179:1-12 (where Dr. Shah testified that hyperventilation can cause abnormalities on EKGs).

Dr. Washburn also took Ms. Salgado's medical history into consideration, including her recent EKG results. When Ms. Salgado first presented to Dr. Washburn for care, Dr. Washburn was aware that Ms. Salgado had been very recently released from St. John's with medical clearance to be admitted to the jail, specifically with cardiac clearance. (Exhibit 7, Dr. Washburn Dep., 280:13-17; Exhibit 4, SJS00704; Exhibit 5, LS00018).

Dr. Washburn also ordered Nitro to treat Ms. Salgado's chest pain. (Exhibit 5, LS00030, lines 7-11, LS00042-43). Plaintiff's experts both testified that Dr. Washburn's orders for Nitro were appropriate and reasonable. (Exhibit 11, Dr. Shah Dep., 189:2-14; Exhibit 10, Dr. Allen Dep., 247:2-7). In fact, Ms. Salgado reported that her chest pain had resolved at 5:30 p.m., after she had received four doses of Nitro. (Exhibit 5, LS00041). Plaintiff's expert criticizes Dr. Washburn for failing to transfer Ms. Salgado to a hospital at this point in time, despite the fact that Ms. Salgado no longer had any complaints of chest pain. (Exhibit 11, Dr. Shah Dep.,

190:24-191:9). However, notwithstanding his criticism, Dr. Shah specifically testified that Dr. Washburn was not deliberately indifferent to Ms. Salgado's medical condition:

> Q: I just want to make sure that you're not going to come into Tulsa County – or actually Tulsa Federal Court and tell the jurors that the Tulsa County Jail was negligent and deliberately indifferent to Lisa Salgado because the jail lacked the resources that you have at Methodist Hospital in Houston, Texas?
>
> A: Yeah, I think simply on the resources alone, no. I think it's a matter of employing the resources that you have and recognizing when you have a resource limitation and you need to send the patient on to an area that has more resources.

(Exhibit 11, Dr. Shah Dep., 44:1-13).

Thus, Dr. Shah's criticism as it relates to Dr. Washburn is not for being deliberately indifferent, but for allegedly failing to recognize that he did not have the resources to care for Ms. Salgado's condition and transferring her out at that time for further evaluation of acute coronary syndromes. However, failure to provide a test or failure to transfer to an outside facility does not rise to the level of a civil rights violation. *Smart v. Villar*, 547 F.2d 112 (10th Cir. 1976). Moreover, delay in transfer to another facility does not constitute a violation. *Redding v. Marsh*, 750 F.Supp.473, 479 (E.D.Okl.1990).

Moreover, regardless of whether Plaintiff believes the treatment provided to Ms. Salgado was inappropriate, the evidence is undisputed that Dr. Washburn was not ignoring her complaints of chest pain but instead was actively treating them. Plaintiff's disagreement with Dr. Washburn's method of treatment is insufficient to establish a constitutional violation. Furthermore, Dr. Washburn did not believe that the cause of Ms. Salgado's chest pain was cardiac in nature. This is consistent with her presentation of symptoms and her *three* hospitalizations in the week immediately preceding her booking into the jail. Based on the results of Ms. Salgado's EKG, her symptoms, clinical presentation, and medical history, Dr. Washburn ruled out acute coronary syndrome in his differential diagnosis. Dr. Washburn testified that,

based off of Ms. Salgado's history, he did not believe Ms. Salgado had acute coronary syndrome and did not feel, in his clinical judgment, that her condition necessitated emergent transfer to the hospital as opposed to continuous observation in the jail's infirmary:

Q: So it's fair to say that you at this point in time had not made a definitive diagnosis?
A: No, I had not.
Q: Why not?
A: Well, things aren't always as they appear in medicine.
Q: Okay. Explain that to me.
A: She was vomiting and had chest pain, and she'd been cleared at Saint Francis Hospital for cardiac disease, or at least critical cardiac disease. **And I could make a case for her not having it, having heart trouble. And didn't think it was necessary to go to the hospital because of her history.**
Q: What history?
A: Of drinking a fifth of vodka and throwing it up, and that'll burn a hole in your stomach. And apparently she had some **pancreatitis**, somebody along the line said. And that was another problem that I'm sure they could do anything for her in the hospital for that, except relieve the pain, maybe. And they were doing that and she didn't want to go home. She wanted more morphine. So maybe they were helping her. I don't know. I don't know.
Q: But those are the reasons that you chose not to send her back to the hospital; yes?
A: Yeah, but I got a non-threatening report from them.
[…]
Q: No, I asked you why you didn't send her to the hospital.
A: Okay. And I gave you some reasons.
Q: And you gave me the reasons of what?
A: Okay, I agree that the drinking whiskey and whatever else had gone on –
Q: The drug-seeking?
A: Yeah, the drug-seeking behavior, and I don't know what else, but…I didn't hold her in contempt for drinking, but I knew she'd probably burned her stomach and had some chest pain and stomach, esophageal pain. And I thought we'd handle it all right here. We didn't.
Q: You know that in hindsight now?
A: Yeah, **it's a judgment call**. Yeah.

(Exhibit 7, Dr. Washburn Dep., 224:18-228:4).

Dr. Washburn did not see anything from the results of Ms. Salgado's EKG which, in his professional opinion as the physician providing hands-on care to Ms. Salgado, could have explained her reports of chest pain. (Exhibit 7, Dr. Washburn Dep., 159:7-13, 212:16-213:5). As

a result, Dr. Washburn looked to other possible explanations for the cause of Ms. Salgado's chest pain. This does not rise to the level of a constitutional violation. If a person did not know of the underlying facts indicating a danger, or knew the facts but believed the risk was insubstantial or nonexistent, there is no constitutional violation. *Farmer v. Brennan*, 511 U.S. 825, 845 (1994).

It is undisputed that Dr. Washburn also considered other potential causes of Ms. Salgado's chest pain. Dr. Washburn ordered a chest x-ray. (Exhibit 5, LS00035). The chest x-ray revealed infiltrates. (Exhibit 12, *Chest X-Ray*, GLANZ-Revilla05519). Plaintiff's experts agree that Ms. Salgado's chest x-ray taken on June 27, 2011 at the jail appeared to show a slight infiltrate, which is suggestive for possible pneumonia. (Exhibit 11, Dr. Shah Dep., 208:17-209:13; Exhibit 10, Dr. Allen Dep., 250:17-252:1). Infiltrates are suggestive of possible pneumonia. (Exhibit 11, Dr. Shah Dep., 209:8-13). In fact, the evidence is undisputed that pneumonia is a known cause of chest pain. (Exhibit 11, Dr. Shah Dep., 67:12-13, 209:14-17; Exhibit 10, Dr. Allen Dep., 200:19-201:9).

Dr. Washburn was also aware that Ms. Salgado had recently been involved in a motor vehicle accident. (Exhibit 13; Exhibit 11, Dr. Shah Dep., 177:7-20). It is undisputed that motor vehicle accidents can cause musculoskeletal pain. (Exhibit 11, Dr. Shah Dep., 67:14-18). In fact, Ms. Salgado's health care providers prior to her incarceration had already diagnosed her chest pain as being musculoskeletal pain. (Exhibit 4, SJS00598).

Dr. Washburn also took into account Ms. Salgado's reported history of binge drinking alcohol. (Exhibit 13). It is further undisputed that alcoholic gastritis is a known cause of chest pain and nausea and vomiting. (Exhibit 11, Dr. Shah Dep., 66:11-21). Ms. Salgado reported a history of having drunk a fifth of vodka the day prior to her incarceration. (Exhibit 5, LS00036). In fact, Ms. Salgado was arrested for DUI. (Exhibit 6, GLANZ-Revilla05298). Plaintiff's expert

agreed that electrolyte imbalances can be caused by exhaustive alcohol intake, and that such electrolyte imbalances could cause EKG abnormalities. (Exhibit 11, Dr. Shah Dep., 74:6-15). It is undisputed that electrolyte imbalances can cause EKG abnormalities. (Exhibit 10, Dr. Allen Dep., 202:2-8; Exhibit 11, Dr. Shah Dep., 74:6-15).

Dr. Washburn also took into account Ms. Salgado's history of esophageal reflux (heartburn). It is also undisputed that esophageal reflux is another known non-cardiac cause of chest pain. (Exhibit 11, Dr. Shah Dep., 66:22-25; Exhibit 10, Dr. Allen Dep., 199:21-200:2). Ms. Salgado's prior medical history on June 23, 2011—just a week prior to Dr. Washburn assessing her—included a hospitalization for chest pain with a documented history of prior episodes of gastroesophageal reflux and alcoholism. (Exhibit 4, SJS00588; Exhibit 7, Dr. Washburn Dep., 127:6-4).

Ms. Salgado also reported a prior medical history of chronic pancreatitis, which Dr. Washburn took into consideration. **(**Exhibit 5, LS00030, lines 1-2, 6; Exhibit 7, Dr. Washburn Dep., 225:7-11). In fact, Plaintiff's experts agreed that Ms. Salgado's symptoms were consistent with the symptoms of pancreatitis. (Exhibit 11, Dr. Shah Dep., 68:4-8; Exhibit 10, Dr. Allen Dep., 200:19-201:9). Ms. Salgado complained of chest and abdominal pain. (Exhibit 5, LS000041); Exhibit 11, Dr. Shah Dep.,174:1-176:9; Exhibit 10, Dr. Allen Dep., 238:24-239:8). It is undisputed that pancreatitis is known cause of chest and abdominal pain such as that complained of by Ms. Salgado. (Exhibit 10, Dr. Allen Dep., 200:14-18; Exhibit 11, Dr. Shah Dep, 67:25-68:3).

It is undisputed that chronic pancreatitis can also cause elevated glucose. (Exhibit 10, Dr. Allen Dep., 201:10-20; Exhibit 11, Dr. Shah Dep., 71:1-9). Ms. Salgado had an elevated glucose number of times during the course of her treatment. (Exhibit 5, LS00028, 31-32). Ms. Salgado's

elevated glucose/blood sugar combined with her complaints of epigastric pain is suggestive of possible pancreatitis. Thus, there were numerous possible non-cardiac causes of Ms. Salgado's chest pain which Dr. Washburn was monitoring.

There is no evidence in this case to suggest that Dr. Washburn deliberately chose not to transfer Ms. Salgado to a hospital because he did not care about her medical complaints. In fact, the evidence is the opposite. Dr. Washburn testified that he cares about Ms. Salgado, as he cares about every one of his patients:

> Q: Did you not believe that Ms. Salgado was a person worth at least attempting to save?
> A: Every person is worth saving. If you can.

(Exhibit 7, Dr. Washburn Dep., 226:5-12).

Moreover, Dr. Washburn explicitly testified that at no point in time did he make the determination that he did not want to send Ms. Salgado to a hospital. To the contrary, Dr. Washburn testified that his thought process was to observe Ms. Salgado further to gather additional evidence to make a definitive diagnosis.

> Q: And despite that happening, despite those medical professionals coming and getting you, you made a decision, a conscious decision, not to send Ms. Salgado to the hospital, correct?
> A: I don't know if I did that or not. **I didn't say – I didn't say in my mind, "Don't send her." It's just I was needing some evidence.**

(Exhibit 7, Dr. Washburn Dep., 231:8-15).

Dr. Washburn wanted to continue to monitor Ms. Salgado to be able to make a more definitive diagnosis of her elusive chest pain. Dr. Washburn's medical chart and orders indicate that he had a differential diagnosis which included reflux, alcoholism, musculoskeletal pain from her motor vehicle accident, infiltrates and questionable pancreatitis. (Exhibit 5, LS00030, lines 1-2, 6, LS00032; Exhibit 13; Exhibit 10, Dr. Allen Dep., 261:4-9). Based on this differential diagnosis, Dr. Washburn made the clinical judgment to admit Ms. Salgado to the infirmary for

further observation. When a medical diagnosis is made, a person may rely on that diagnosis to deny further care; and such facts do not support a constitutional violation. *McCracken v. Jones*, 562 F.2d 22 (10th Cir. 1977). "[W]here a doctor orders treatment consistent with the symptoms presented and then continues to monitor the patient's condition, and inference of deliberate indifference is unwarranted under our case law." *Self v. Crum*, 439 F.3d 1227, 1232-33 (10th Cir. 2006).

Dr. Washburn was not deliberately indifferent to Ms. Salgado's medical needs. The evidence is undisputed that Dr. Washburn never ignored any of Ms. Salgado's complained-of symptoms. Plaintiffs' experts agree that Dr. Washburn was not ignoring Ms. Salgado's complaints of chest pain. (Exhibit 11, Dr. Shah Dep., 232:7-20, 235:21-236:25; Exhibit 10, Dr. Allen Dep., 261:4-9). If medical care was provided, and there is only a disagreement as to whether the proper care was provided, the case sounds in tort and does not rise to the level of a civil rights claim. *Smart v. Villar*, 547 F.2d 112 (10th Cir.1976); and *Debrow v. Kaiser*, 42 F. App'x 269, 269 (10th Cir. 2002). Dr. Washburn ordered treatment for infiltrates or questionable pancreatitis, which he believed to be the more likely causes of her chest pain. He prescribed Ms. Salgado an antibiotic to treat the infiltrates and questionable pancreatitis**.** (Exhibit 5, LS00030, lines 1-2 and 6). Plaintiffs' experts agreed that Ms. Salgado was receiving treatment for infiltrates. (Exhibit 11, Dr. Shah Dep., 215:4-7; Exhibit 10, Dr. Allen Dep., 261:4-9). Plaintiff's experts agreed that Dr. Washburn was treating Ms. Salgado for pancreatitis. (Exhibit 11, Dr. Shah Dep., 215:4-7; Exhibit 10, Dr. Allen Dep., 252:16-253:3). Dr. Washburn also prescribed Ms. Salgado Promethazine in response to her complaints of nausea of vomiting, Maalox for potential reflux, and Aspirin for chest pain. (Exhibit 5, LS00030, lines 7-11, LS00042-43). In fact, the evidence is undisputed that Dr. Washburn provided treatment for every single one of

Ms. Salgado's medical complaints. (Exhibit 10, Dr. Allen Dep., 258:21-259:1, 261:4-9).

Dr. Washburn never believed Ms. Salgado had acute coronary syndrome. In fact, when he last saw Ms. Salgado, all she complained of was abdominal pain; she advised that she was feeling better, her chest pain was gone, and she was no longer vomiting. (Exhibit 13). Dr. Washburn made a clinical judgment. (Exhibit 7, Dr. Washburn Dep., 224:18-228:4). Though Plaintiff's experts disagree with his clinical decision, Plaintiff's experts agree that Dr. Washburn made a clinical judgment call:

Q: So, this is what we call a judgment call, correct?
A: Correct.
Q: This is a judgment call that Dr. Washburn made at the time of the care and treatment of Ms. Salgado, correct?
A: Correct.
Q: It's a decision that different healthcare providers in different circumstances make every single day, correct, whether or not to admit a patient for further monitoring and observation or to continue treating them in their own facility?
A: Correct.
Q: And that's a judgment call that Dr. Washburn made under the circumstances and the information he had available to him at that time, correct?
A: Correct.

(Exhibit 11, Dr. Shah Dep., 193:4-20).

There is just no evidence of deliberate indifference in this case or any kind of indifferent mentality toward Ms. Salgado. **A physician making a clinical judgment, even assuming *arguendo* that it was the wrong clinical judgment, does not rise to the level of a constitutional violation.** *Smart v. Villar*, 547 F.2d 112 (10th Cir.1976); and *Debrow v. Kaiser*, 42 F. App'x 269, 269 (10th Cir. 2002). While Dr. Shah may disagree with Dr. Washburn's clinical decisions, an inadvertent failure to provide adequate medical care does not rise to the level of "wanton infliction of pain" necessary to sustain plaintiff's burden of proof for denial of the right to medical care. *Estelle v. Gamble*, 429 U.S. 97, 105 (1976).

At the end of the day, Plaintiffs' experts could not even testify as to whether Ms. Salgado

died of an acute coronary event or from pancreatitis, as the cause of her death remains unknown. (Exhibit 11, Dr. Shah Dep., 238:12-23; Exhibit 10, Dr. Allen Dep., 260:24-261:3, 268:20-24). Plaintiffs' experts could not rule out that Ms. Salgado had pancreatitis as opposed to acute coronary syndrome. (Exhibit 11, Dr. Shah Dep., 73:7-15; Exhibit 10, Dr. Allen Dep., 260:24-261:3). Thus, Plaintiff's experts cannot even testify as to whether Dr. Washburn's allegedly incorrect clinical judgment and treatment had any impact one way or the other on her ultimate outcome. Plaintiff has produced no evidence to establish a causal link between any of the foregoing alleged acts of Dr. Washburn and Ms. Salgado's alleged constitutional deprivation and, therefore, she has failed to establish a constitutional violation under 42 U.S.C. § 1983. *Duffield v. Jackson*, 545 F.3d 1234 (10th Cir. 2008).

Plaintiff cannot establish the subjective component of her deliberate indifference claim against any of the Defendants in this case. All things considered, the Plaintiff cannot demonstrate the CHC Defendants acted with a culpable state of mind because she cannot establish the CHC Defendants, or any of the defendants for that matter, were aware of facts from which the inference could be drawn that Ms. Salgado was a substantial and imminent risk of harm. Likewise, the Plaintiff also cannot establish that the CHC Defendants or any of the other defendants drew upon any inference that Ms. Salgado was a substantial and imminent risk of harm. As a result, summary judgment must be granted at this time in favor of the CHC Defendants on all of Plaintiff's claims against them based on 42 U.S.C. § 1983.

PROPOSITION II: PLAINTIFF CANNOT ESTABLISH A PRIMA FACIE CASE OF NEGLIGENCE AGAINST THE CHC DEFENDANTS.

In this case, the Plaintiff cannot establish a prima facie case of negligence against the CHC Defendants because she lacks the requisite expert testimony regarding the standards of care

applicable to the CHC Defendants and causation. Further, the CHC Defendants are immune from liability for negligence under the Oklahoma Governmental Tort Claims Act. Lastly, Plaintiff's state law negligence claims must be dismissed for Plaintiff's failure to file her cause of action within the applicable one (1) year statute of limitations.

A. PLAINTIFF LACKS EXPERT TESTIMONY TO ESTABLISH A PRIMA FACIE CASE OF NEGLIGENCE AGAINST THE CHC DEFENDANTS.

In this case, the Plaintiff generally asserts that the CHC Defendants, Defendant Phillip Washburn, M.D. and Defendant Chris Rogers, RN, were negligent for "failing to provide Ms. Salgado with prompt and adequate medical treatment despite requests and obvious need." (*See* Doc. No. 4, Amended Complaint, ¶ 196). Specifically, Plaintiff alleges in her Amended Complaint that the CHC Defendants were negligent in their "failure to treat Ms. Salgado's serious medical condition properly; failure to conduct appropriate medical assessments; failure to create and implement appropriate medical treatment plans; failure to promptly evaluate Ms. Salgado's physical health; failure to properly monitor Ms. Salgado's physical health; failure to provide access to medical personnel capable of evaluating and treating her serious health needs; and a failure to take precautions to prevent Ms. Salgado from further injury." (*See* Doc. No. 4, ¶¶ 193-200).

Under Oklahoma law, three elements are essential for a plaintiff to establish a prima facie case of negligence: (1) a duty owed by the defendant to protect the plaintiff from injury; (2) a failure of the defendant to properly exercise or perform that duty; and (3) injury to the plaintiff directly caused by the defendant's failure. *Thompson v. Presbyterian Hospital*, 652 P.2d 260, 263 (Okla. 1982). The absence of proof of any of these three essential elements is fatal to a negligence claim. *Id.* at 263. Moreover, in all but extraordinary cases, medical negligence must

be established through expert medical testimony. *Reed v. Shaughnessy*, 570 F.2d 309, 313 (10th Cir. 1978); *Boxberger v. Martin*, 552 P.2d 370 (Okla. 1976); *Johnson v. Hillcrest Health Center, Inc.*, 70 P.3d 811, 817 (Okla. 2003); *Turney v. Anspaugh*, 581 P.2d 1301 (Okla. 1978); *Robertson v. Lacroix*, 1975 OK CIV APP 14, 534 P.2d 17. In this case, the negligent acts or omission the Plaintiff has asserted against the defendants are for failing to provide "adequate medical treatment." Therefore, Plaintiff's claims in this case must be considered medical negligence claims which require expert medical testimony.

In this case, the Plaintiff has listed three (3) expert witnesses: Dipan Shah, M.D., a cardiologist retained to provide standard of care and causation testimony; Scott Allen, M.D., a standard of care and causation expert; and Jacqueline Moore, RN, a nursing standard of care expert. As more thoroughly addressed in Defendant Phillip Washburn, M.D.'s and Defendant Chris Rogers, RN's Motions for Summary Judgment, Dr. Shah and Dr. Allen are not qualified to offer opinions regarding the standards of care in correctional health care nursing. In fact, Dr. Shah specifically testified that he cannot opine on nursing standard of care. (Exhibit 11, Dr. Shah Dep., 231:15-22). Moreover, Dr. Allen agreed that he has never been to nursing school, has no training as a nurse, is not qualified to practice as a nurse, and has never practiced as a nurse in his life. (Exhibit 10, Dr. Allen Dep., 110:5-111:9). Similarly, Plaintiff's expert nurse Jacqueline Moore, RN is not qualified to offer opinions regarding the standards of care for physicians or causation, as she is not a medical doctor, has never been to medical school, and has no education, training or experience as a medical doctor. (Exhibit 14, Nurse Moore Dep., 119:15-18; Exhibit 19, *Curriculum Vitae of Nurse Moore*).

There is no admissible expert testimony to establish that Dr. Washburn's care and treatment of Ms. Salgado was below the standard of care. In his deposition, Dr. Shah expressly

testified that he cannot offer standard of care opinions in a correctional healthcare setting *without speculating*, and that he would defer such standard of care opinions. (Exhibit 11, Dr. Shah Dep., 194:9-197:25). Furthermore, Dr. Allen testified that his *only* standard of care criticism against Dr. Washburn is for failure to chart his clinical reasoning. (Exhibit 10, Dr. Allen Dep., 286:6-287:22). However, there is no testimony or evidence that any alleged failure to chart his clinical reasoning caused Ms. Salgado any injury or harm. In fact, it is nonsensical for Plaintiff or her expert to argue that an alleged failure to document his clinical reasoning had any impact on Ms. Salgado's care and outcome, as Dr. Washburn would have been aware of his own clinical reasoning, and he was the sole physician at the jail involved in Ms. Salgado's care.

Plaintiff's nurse expert's only nursing criticisms related to the care of Lisa Salgado were that the nurses failed to acknowledge the seriousness of alcohol withdrawal, failed to adequately assess Ms. Salgado for chest pain, inadequately charted, and failed to refer Ms. Salgado to mental health. (Exhibit 14, Nurse Moore Dep., 242:22-244:15). However, Nurse Moore testified that the referral to mental health had no effect whatsoever on the outcome of the case. (Exhibit 14, Nurse Moore Dep., 144:12-22). Further, after being shown additional records which Plaintiff's counsel had not provided to Nurse Moore in her expert review, Nurse Moore withdrew her opinions related to alcohol withdrawal. (Exhibit 14, Nurse Moore Dep., 264:17-265:14). The only jail nurse Plaintiff's nurse expert offered criticisms of is Karen Metcalf, LPN. Most significantly, Nurse Moore testified that if Nurse Metcalf did everything that she testified and charted that she did with respect to Ms. Salgado's care, then Nurse Moore would have no criticisms of her nursing care. (Exhibit 14, Nurse Moore Dep., 340:3-341:10). Plaintiff has put forth no evidence that controvert the fact that Nurse Metcalf did do everything that she charted and did with respect to Ms. Salgado's care. Thus, Plaintiff has failed to establish a breach in the standard of care

necessary to survive summary judgment.

Summary judgment is also proper on the negligence claims because the Plaintiff cannot offer expert testimony regarding proximate cause. In particular, the causation element of a *prima facie* case of negligence requires a plaintiff to present evidence that the harm suffered was "more likely than not" caused by the defendants' negligence. *McKellips v. Saint Francis Hosp., Inc.*, 741 P.2d 467, 473 (Okla. 1987). The mere possibility that the defendant "may have" caused a harm is insufficient to establish the requirement of proximate cause. *Hardy v. Southwestern Bell Telephone Co.*, 910 P.2d 1024, 1027 (Okla. 1996). The question of proximate cause is one of law as to whether the required proof of a causal nexus between the alleged negligence and resulting injuries exists. *Elledge v. Staring*, 939 P.2d 1163, 1165 (Okla. Civ. App. 1996) (citing *Thompson* at 263). In *Cohenour v. Smart*, 1951 OK 339, 240 P.2d 91, the Court held that mere possibilities are insufficient to prove causation; instead, the Plaintiffs must show through competent expert testimony that the act or conduct complained of more likely than not caused the harm complained of:

> It was incumbent upon the plaintiff, under the facts in that case, to prove not only that the accident could have caused the injury, but that it probably did. It is our opinion that where the evidence of the plaintiff does not show by expert testimony and all the surrounding facts and circumstances that the injury could have been caused by and was the probable result of the accident, then the plaintiff has not established sufficient facts to make out a cause of action.

Id, at ¶ 7. Additionally, negligence and causation can never be presumed from a showing no more than the happening of the harmful event. *Harder v. F.C. Clinton, Inc.*, 948 P.2d 298, 304 (Okla. 2009).

In this case, there is absolutely no expert testimony that any care and treatment, or lack of care, provided by the jail healthcare providers caused Ms. Salgado any harm. Dr. Allen

specifically testified that although he believes Dr. Washburn "breached the standard of care" in failing to chart his thought process, it is irrefutable that the cause of Ms. Salgado's death is unknown:

Q: And you stated earlier, we really don't know what caused her death. Correct?
A: Correct.
(Exhibit 10, Dr. Allen Dep., 260:24-261:3).

Q: We don't actually know that she died of a myocardial infarction, do wel?
A: No autopsy was done.
Q: I'm correct?
A: Yes.
Q: We don't know that she died of a heart attack, do we?
A: No.
Q: We don't know that she died of any cardiac condition that became acute enough to cause her death, do we?
A: No.
(Exhibit 11, Dr. Shah Dep., 238:12-23);

Q: And as you sit here today, you can't tell me one way or the other, whether or not Ms. Salgado passed away as a result of pancreatitis or acute coronary syndrome, can you?
A: Correct.
(Exhibit 10, Dr. Allen Dep., 260:24-261:3).

Dr. Shah clearly testified that he could not opine as to the cause of Ms. Salgado's death *without speculating*. (Exhibit 11, Dr. Shah Dep., 244:10-13). Dr. Allen testified that he cannot say to a medical degree of certainty that Ms. Salgado did not die of pancreatitis as opposed to acute coronary syndrome. (Exhibit 10, Dr. Allen Dep., 260:24-261:3, 268:20-24). There is absolutely no testimony that any different care or treatment would have saved Ms. Salgado's life.

In this case, the Plaintiff has failed to provide any expert testimony or evidence concerning the cause of Ms. Salgado's death. As such, the Plaintiff cannot establish proximate cause, an essential element of all medical negligence claims in Oklahoma. In particular, Plaintiff's medical experts have made no affirmative statement that, more likely than not, Ms.

Salgado's death would not have occurred in the absence of the alleged negligent acts or omissions of the defendants. Considering the Plaintiff cannot prove through expert testimony that the CHC Defendants were the proximate cause of Ms. Salgado's death, the Plaintiff cannot establish a prima facie case of negligence against the CHC Defendants and summary judgment on all negligence claims against the CHC Defendants is appropriate at this time.

B. THE CHC DEFENDANTS ARE IMMUNE FROM LIABILITY FOR THE NEGLIGENCE CLAIMS ASSERTED BY THE PLAINTIFF UNDER THE OKLAHOMA GOVERNMENTAL TORT CLAIMS ACT.

Summary judgment must also be granted on Plaintiff's negligence claims against the CHC Defendants because the CHC Defendants are considered "employees" of the state and immune from liability under the Oklahoma Governmental Tort Claims Act. In particular, section 152.1 of title 51 of the Oklahoma Statutes Annotated states the following:

> The State of Oklahoma does hereby adopt the doctrine of sovereign immunity. The state, its political subdivisions, and all of their employees acting within the scope of their employment, whether performing governmental or proprietary functions, shall be immune from liability.

OKLA. STAT. TIT. 51, § 152.1(A).

The Oklahoma Governmental Tort Claims Act goes on to define "employee" and specifically provides that "the following are employees of this state" … "(7) licensed medical professionals under contract with the city, county, or state entities who provide medical care to inmates or detainees in the custody or control of law enforcement agencies". OKLA. STAT. TIT. 51, § 152(7)(b).

In this case, the CHC Defendants, Defendant Washburn, and Defendant Rogers were all medical professionals under contract with the Tulsa County Sheriff's Office to provide medical care to inmates at the Tulsa County Jail. The CHC Defendants entered into a contract with the Board of County Commissioners of the Tulsa County, Oklahoma, on behalf of the Tulsa County

Sheriff's Office, to provide medical services in DLM. (Exhibit 18, *Health Services Agreement*).

Defendant Dr. Washburn is a licensed medical professional, as he is a Medical Doctor. (Exhibit 20, *Oklahoma Board of Medical Licensure and Supervision Licensure Confirmation for Dr. Washburn*). At all times relevant hereto, Dr. Washburn contracted with Correctional Healthcare Physicians, II, to provide medical services as Medical Director at DLM. (Exhibit 15, *Dr. Washburn's Employment Contract*, p. 10). Defendant Nurse Rogers is a licensed medical professional, as she is a Registered Nurse. (Exhibit 21, *Nurse Rogers' Registered Nurse Card*). At all times relevant hereto, Nurse Rogers contracted with Defendant CHC to provide nursing services at DLM. (Exhibit 22, *Nurse Rogers' Employee Status Sheet* (redacted)).

Under 51 O.S. § 152(7)(b), CHC Defendants are by law considered "employees of the state", as they are licensed professionals under contract with the county who provide medical care to inmates or detainees in the custody or control of Tulsa County Sheriff's Office. As a result, the CHC Defendants, Defendant Washburn, and Defendant Rogers are immune from liability for Plaintiff's negligence claims. Therefore, summary judgment in favor of the CHC Defendants on Plaintiff's negligence claims is appropriate at this time and must be granted as a matter of law.

C. PLAINTIFF'S STATE LAW CLAIMS AGAINST THE CHC DEFENDANTS ARE BARRED BY THE OKLAHOMA STATUTE OF LIMITATIONS.

Ms. Salgado was booked into DLM on June 25, 2011 (Exhibit 6, GLANZ-Revilla05298; Exhibit 5, LS00001). Ms. Salgado died on June 28, 2011. (Exhibit 1, Death Certificate). The initial Complaint in this matter did not include Plaintiff Christine Wright as a plaintiff. (*See* Doc. No. 2). Plaintiff first asserted her cause of action on May 31, 2013 when the Amended Complaint in this matter was filed. (*See* Doc. No. 4). The basis of Plaintiff's cause of action is that Ms.

Salgado allegedly received substandard medical care while incarcerated in the Tulsa County Jail. (*See* Exhibit 23, *Deposition of Plaintiff Christine Wright (April 14, 2015),* 104:15-107:19). Plaintiff failed to file her causes of action against the CHC Defendants within the applicable statute of limitations.

Okla. Stat. Ann. tit. 12, § 95(A) provides the statute of limitations for all "[c]ivil actions other than for the recovery of real property."

Section 95(A)(11) specifically provides that:

> **All actions filed** by an inmate or **by a person based upon facts that occurred while the person was an inmate** in the custody of one of the following:
>
> a. the State of Oklahoma,
> b. a contractor of the State of Oklahoma, or
> c. a political subdivision of the State of Oklahoma,
>
> **to include**, but not be limited to, the revocation of earned credits and **claims for injury to the rights of another, shall be commenced within one (1) year after the cause of action shall have accrued**…

(Emphasis added).

Section 95(A)(11) applies to all actions filed by a person based upon facts that occurred while the person is an inmate and specifically includes claims for injury to the rights of another. This court has recently held that Section 95(A)(11) is applicable to claims such as this one. *See Fisher v. Glanz*, No. 14-CV-678-TCK-PJC, 2016 U.S. Dist. LEXIS 38466, at *27-28 (N.D. Okla. 2016). In *Fisher*, this court held "that § 95(A)(11) trumps the more general § 95(A)(3) when a state constitutional claim is brought by [28] an inmate or based upon facts that occurred while the person was an inmate in state custody." *Id.*, citing *Koch v. Juber*, No. CIV-13-0750-HE,2014 U.S. Dist. LEXIS 70857, 2014 WL 2171753, at *2 (W.D. Okla. May 23, 2014).

As Plaintiff's claims against CHC Defendants are solely founded upon alleged facts that occurred while Ms. Salgado was in custody of the Tulsa County Jail, Oklahoma law provides a

one (1) year statute of limitations for Plaintiff to bring her action. Based on Plaintiff's allegations, her cause of action would have accrued on or about June 28, 2011, and the statute of limitations for her claim would have expired on or about June 28, 2012. Plaintiff had a period of one (1) year beginning at the time the cause of action accrued to investigate her claim and bring suit against any parties she chose to name. Instead, Plaintiff failed to bring her claim prior to the expiration of the statute of limitations and as such, her action is barred and must be dismissed.

CONCLUSION

For all of the reasons set forth herein, Defendant, Correctional Healthcare Companies, Inc., , pray that their Motion for Summary Judgment be granted, and that judgment on all of the claims against it by Plaintiff Christine Wright, as Special Administrator of the Estate of Lisa Salgado, deceased, be entered in favor of the Defendant.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on November 15, 2016, I electronically transmitted the attached document to the Clerk of Court using the ECF System for filing and transmittal of a Notice of Electronic Filing to the following ECF registrants:

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