Smolen | Smolen | Roytman PLLC
ATTORNEYS AT LAW

December 4, 2017

All Via Federal Express

Muskogee County / Muskogee County Board of County Commissioners
c/o Muskogee County Clerk
4100 West Broadway
Muskogee, Oklahoma 74401

Muskogee County Council of Youth Services
c/o Jean C. Lewis
107 North 16th Street
Muskogee, Oklahoma 74401

State of Oklahoma *ex. rel.* Office of
Juvenile Affairs
3812 N. 36th St., Suite 400
Oklahoma City, OK 73118

Re: Oklahoma Governmental Tort Claims Act (51 Okla. Stat. §151 et seq.)
Notice of Claim, Estate of Billy Woods

To the Above Recipients:

Please take notice that we are submitting this Tort Claim, pursuant to 51 Okla. Stat. §151 *et seq*, on behalf of Robbie Burke ("Claimant"), Special Administrator for the Estate of Billy Woods, deceased ("Billy" or "Mr. Woods").

A. Claimant's Name and Mailing Address

Robbie Emery Burke
320 S Boston Ave # 1030
Tulsa, Oklahoma 74103

B. Name and Address to Which to Send Notices

Daniel Smolen
Smolen Smolen & Roytman, PLLC
701 South Cincinnati
Tulsa, Oklahoma 74119

C. Summary of Claim

1. Introductory Statement

As described herein, Billy Woods tragically and needlessly died on December 15, 2016. He was just 16-years-old. Billy died alone in his room at the Muskogee County Regional Juvenile Detention Center (hereinafter, "MJDC" or "the Facility") after hanging himself with a bed sheet. In truth, however, this child died as a proximate result of reckless neglect and deliberate indifference to his serious medical and mental health needs. The lack of supervision, competent care and compassion Billy encountered at MJDC is shocking and heartbreaking. During his short stay at MJDC, Billy came into contact with numerous detention workers, including Shift Supervisor Jerrod Lang ("Lang"). Each of these detention workers had an opportunity and duty to help Billy. Any one of these individuals could have -- easily -- saved Mr. Woods' life had they followed simple procedures or shown him even a modicum of human decency. Yet, none of them could be bothered to take the most minimal steps to address Billy's conspicuous medical and mental health needs.

Indeed, Lang enhanced the risks to this vulnerable boy by humiliating and belittling him, only to later refuse to check on him for hours. And in a horrendous display of inhumanity, after Billy was found unresponsive in his room with the make-shift noose tied around his neck, Lang left Billy to go take an extended cigarette break. As valuable time was wasting, no one at the Facility attempted CPR, no one removed the noose from Billy neck and no one called 911 (for 20 minutes). Rather, while an unconscious sixteen-year-old boy laid under a sink, Lang was puffing on a cigarette. A half an hour later, Billy was pronounced dead. This is gross negligence. This is inhumane mistreatment. This is deliberate indifference.

2. Statement of Facts

Billy Woods was just a 16-year-old boy when he was brought to the Muskogee County Regional Juvenile Detention Center (hereinafter, "MJDC" or "the Facility") on December 14, 2016. Billy was admitted to MJDC for a mere curfew violation. At the time, MJDC was operated by Muskogee County Council of Youth Services ("MCCOYS") under a subcontract with Muskogee County (the "County").[1] Shift Supervisor Jerrod Lang ("Lang"), a MCCOYS employee, arrived at MJDC at 3:00 pm on December 14 and began conducting the resident intake process for Billy. However, Lang asserts that Billy did not cooperate with the process. As such, Billy was initially placed alone in a room for four (4) hours, without having completed the intake process.

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1 Juveniles housed at MJDC were technically under the custody of Oklahoma Department of Juvenile Affairs ("OJA"). However, MJDC is a County facility that was staffed with MCCOYS employees and agents.

When Lang and Billy resumed the intake procedure, Billy told Lang that he ***"had tried to commit suicide 'a lot.'"*** (emphasis added). Billy specifically informed Lang that his most recent suicide attempt occurred ***just one month prior*** to being placed at MJDC, and that he had tried to hang himself on multiple occasions. Thus, the suicide risk presented was known, substantial and documented.

More generally, it is well established that detained youth are at heightened and excessive risk of self harm. As stated in peer-reviewed medical literature:

> Suicide is the third leading cause of death in young people aged 15 to 24 years, affecting 9.5 per 100,000 adolescents in 2003. Suicide among youth has nearly doubled since 1950, increasing at a faster rate than among groups 25 years and older. ***Suicide is an even greater risk in incarcerated youth; available national data suggest that prevalence rates of completed suicide are between 2 and 4 times higher among youth in custody than among youth in the community.*** Incarcerated youth have characteristics commonly associated with increased risk for suicide, such as high rates of psychiatric disorder and trauma. Conditions associated with confinement, such as separation from loved ones, crowding, locked sleeping rooms, and solitary confinement, may also increase risk for suicide.

Abram, K, "Suicidal Ideation and Behaviors Among Youth in Juvenile Detention", J Am Acad Child Adolesc Psychiatry. 2008 Mar; 47(3): 291–300 (emphasis added).

Nevertheless, the County and MCCOYS did little, if anything, to alleviate these known risks. On the contrary, as demonstrated by this case, through their acts and omissions, the County and MCCOYS exacerbated and aggravated the already excessive risks of self-harm.

Lang purportedly filled out a written "suicide assessment" form contemporaneously with the intake process. Oddly, Billy did not sign the suicide assessment form, though he did sign all of the other intake forms. Lang did not place Billy on suicide watch and did not seek to secure any mental health assessment or treatment for Billy. Rather, Billy was placed in Room 1 at the Facility. Because Billy was not placed on suicide precautions, he had access to a flat sheet, a fitted sheet, one or two blankets and a pillow case. In addition, Room 1 was the only room in the Facility equipped with a handicap accessible bar across the front of the sink. In other words, Room 1 was the ***most dangerous possible placement*** for a young man with a known, and recent, history of attempted suicide by hanging. Room 1 presented the perfect means and opportunity for suicide by hanging.

Despite being tasked with conducting the suicide assessment, Lang had no training or education in psychology or psychiatry. Moreover, Lang was never provided with any training by OJA, the County or MCCOYS in recognizing or identifying the signs and symptoms of suicidal ideation. The Facility relies on shift supervisors, like Lang, to conduct all such suicide assessments despite their clear lack of qualifications, education

or training. Simply put, in deliberate indifference to the known and obvious risks to the juvenile resident population, the Facility does not have any qualified mental health professional to administer suicide assessments for the youthful residents.

The obvious and excessive risks of placing Billy in Room 1 *could* have been lessened by compliance with Oklahoma's Juvenile Detention Standards. For instance, the Juvenile Detention Standards require that "[a]ny juvenile shall be visibly observed by a staff member every 15 minutes, and this must be documented." OAC 377:3-13-44 at (15)(B). However, in clear violation of this requirement, Billy was not observed by MJDC staff every 15 minutes. On the contrary, there was a period of time, on December 15, 2016, when Woods was not checked on by staff for ***over two (2) hours.*** Making matters worse, MJDC staff, including Lang, falsely reported, on the daily notes form, that they had checked on Billy every 15 minutes, when video evidence proves they did not. In fact, the December 15 daily notes form was "pre-emptively filled out for the entire 3:00 pm to 11:00 pm shift ...."

Adding insult to injury, there is evidence that Lang ***"made fun of*** the way Woods talked", ***belittled*** Billy and ***ridiculed*** him about his middle name, Duane. This mistreatment caused Billy to be withdrawn from the other residents and to stay in his room. It is unconscionable that Lang would ridicule and belittle a troubled 16-year-old boy with a known history of suicide attempts. In this regard, such mistreatment constitutes a clear violation of the Juvenile Detention Standards' prohibition against punishment by "humiliation [or] mental abuse..." OAC 377:3-13-42(7). Moreover, by belittling and humiliating this highly vulnerable young man, Lang greatly enhanced the already significant risk that Billy would harm himself. Indeed, Lang created this enhanced danger in deliberate indifference to Woods' serious mental health needs. *See, e.g., Conradt v. NBC Universal, Inc.,* 536 F. Supp. 2d 380, 394–95 (S.D.N.Y. 2008) ("[A] reasonable jury could find that NBC persuaded the police officers to engage in tactics ... in a manner that they knew would publicly ***humiliate*** a public servant ..., thereby ***creating or enhancing the risk of suicide or other danger,*** without taking any steps to prevent a foreseeable injury.") (emphasis added).

As noted above, Billy was infrequently monitored during the 3:00 pm to 11:00 pm shift of December 15, 2016. The daily notes form indicates that detention worker Brandon Miller ("Miller") and Lang checked on Billy at 6:45 pm, 7:00 pm, 7:15 pm, 7:30 pm, 7:45 pm, 8:00 pm, 8: 15 pm, and 8:30 pm. However, video evidence proves that ***none of these purported welfare checks actually occurred.*** As one particularly stunning example of neglect, at approximately 7:32 pm, Miller placed his hand on the door to Billy's room, but did not bother to check on him. Then, at around 7:37 pm, Miller was standing right beside the door to Room 1, but failed to look in on him.

When Lang finally got around to actually checking on Billy, at 8:36pm, which was ***over two (2) hours after the last observation***, he discovered Woods unconscious and unresponsive in Room 1. Billy's skin appeared to be "purple" or grey in color and he had spittle hanging from his lip. There was a sheet tied around Billy's neck. The other end of the sheet was tied to the handicap bar under the sink.

Amazingly, ***Lang did not remove the sheet from Billy's neck.*** Instead, he closed the door, ***leaving Billy in Room 1 with the sheet still around his neck***, and instructed staff to place the other residents on lock down. Lang did not perform CPR on Billy. Moreover, and inexplicably, Lang actually ***instructed Miller <u>not</u> to conduct CPR. None*** of the staff members performed CPR. Lang's only explanation for this is that he was in shock and panicked. Lang knew that Billy's purplish color meant that he had been depleted of oxygen. Yet, he still refused any attempt to assist him, while also obstructing Miller from providing CPR. Rather than take any measures to resuscitate or otherwise assist the unresponsive Mr. Woods, ***Lang exited the Facility and "smoked a bunch of cigarettes."*** While Lang was taking this smoke break, a sixteen-year-old boy under his care was still in Room 1, unresponsive with a make-shift noose around his neck.

Lang's handling of this situation constitutes a shocking level of neglect, inhumanity and utter indifference to Billy's serious, obvious and emergent medical needs.

MJDC policy requires that "[i]f a juvenile is seriously injured or has a medical emergency, the following procedures should be followed: 1) One staff member is to administer first aid if necessary. One staff member is to secure the remaining population. 2) The Administrator is to be called immediately. ***If it is a life or death situation the shift supervisor is to call 911 before notifying the Administrator."*** Here, wasting more valuable time, in violation of this policy, staff called the Facility Administrator prior to calling 9-1-1. Indeed, 9-1-1 was not called until 8:56pm, ***twenty (20) minutes after Billy had been discovered unconscious in Room 1.*** Detention worker Angela Miller was tasked with calling 911, but can provide no explanation for the twenty-minute delay. As the clock ticked, and Lang puffed on his cigarette, any hope of saving Billy's life quickly withered away.

According to the Medical Examiner's Report, Billy was pronounced dead at 9:05pm on December 15, 2016. The stated "cause of death" was "hanging" and the "manner of death" was "suicide". But the true cause of death was the prevailing attitude of indifference and gross incompetence exhibited by the MJDC staff.

A subsequent investigation was conducted by the Oklahoma Department of Human Services' ("DHS") Office of Client Advocacy ("OCA"). The investigation focused on whether personnel at MJDC, including Lang, Miller, Angela Miller and Marietta Winkle, violated the Oklahoma Children's Code's proscription of child "Neglect" and/or child "Abuse". Through the investigation, OCA determined that the allegations of neglect against Lang, Miller, Angela Miller and Marietta Winkle were substantiated and the allegations of abuse against Lang were substantiated. Therefore, Plaintiff may properly allege and establish negligence *per se* liability. *See, e.g., Howard v. Zimmer, Inc.,* 2013 OK 17, ¶ 13, 299 P.3d 463, 467-68.

Billy's horrific death was no freak accident. On the contrary, his death was as foreseeable as it was preventable. Through their established policies, practices, and

customs, the County and MCCOYS disregarded known and substantial risks to the health and safety of inmates like Billy Woods.

Failure to Train / Failure to Supervise Despite being promoted to a supervisor position, Lang did not receive any formal training in how to work, let alone supervise, at the Facility. It is mandated that "[a]ll staff shall be trained on facility policy and procedure and a training record be established for each staff member." OAC 377:3-13-43(8). Nevertheless, there was general confusion and disagreement about the Facility policies and protocols due to a lack of training and education. Detention workers and supervisors alike did not know or understand the Facility policies. For example, and pertinently, the Facility's suicide precaution policy requires that "When the juvenile is in his/her room they are monitored by intercom and visually observed ***every five (5) minutes."*** However, Lang, Miller and Winkle had no knowledge of the 5-minute observation requirements for suicide watch, and none of them knew residents were to be monitored with the intercom. While A. Miller was stationed at the control center, and could have monitored Billy via intercom, she failed to do so, presumably due to her lack of training on the policies and procedures. This simple measure, of using the intercom to monitor Billy, very well could have saved his life. However, the County and MCCOYS did not care enough about the welfare of MJDC residents to train the staff concerning this basic policy and safety measure.

The Juvenile Detention Standards additionally require that "[t]he secure juvenile detention facility shall develop and maintain written policy and procedure which: ... assures that detention staff and other personnel are trained to respond to health related situations; and establishes a training program that includes: ... administration of first aid and cardiopulmonary resuscitation (CPR) [and] signs and symptoms of mental illness, retardation and drug and alcohol abuse...." OAC 377:3-13-45(6)(E). The County and MCCOYS also fundamentally failed to comply with these requirements.

As noted above, despite Shift Supervisors being tasked with conducting suicide assessments, the supervisors were provided with no formal training on recognizing signs and symptoms of suicidal ideation or behaviors. Lang and the other staff were simply left to their own devices to "figure things out...." This failure to train and supervise the under-qualified staff was destined for disaster. Without anyone with the requisite training and qualifications in mental health at MJDC, the entire resident population, including Billy, was put at unnecessary and excessive risk of harm.

Overall, the County and MCCOYS utterly failed to train and supervise MJDC staff with respect to basic, and essential, policies and procedures necessary to the safety of the juvenile residents, in deliberate indifference to the harm likely to result.

Inadequate Staffing The Facility also has severe and chronic staffing deficiencies which place the residents at increased and substantial risk of harm. Lang was promoted to Shift Supervisor after working at the Facility for approximately four (4) months. And before being promoted, Lang turned the promotion down twice. Lang was promoted so quickly because ***the Facility was "short staffed."*** All of the staff at the Facility in

December 2016 had worked there for ***less than one (1) year*** and were considered to be "short-term".

With respect to staffing, the Juvenile Detention Standards require "[a] ***minimum of two direct-care staff*** ... on duty at all times in the facility ... [and that] [j]uveniles in detention shall be supervised ***at all times.***" OAC 377:3-13-44(4). According to Ms. Winkle, on Friday and Saturday nights, she is the only direct care staff member at the Facility. And the Facility relies upon maintenance personnel to "check on" the residents. The lack of adequate and competent staff was a moving force behind Billy suffering and death.

Other Disturbing Evidence of an Unconstitutional Custom Unfortunately, though unsurprisingly, it appears that the reckless neglect of Billy was not an isolated incident. OCA uncovered evidence that other young residents were mistreated at the Facility and that the Facility lacked basic equipment necessary to safely care for the juvenile population. For instance, as OCA found, "[a]n unknown male resident was left unsupervised, by Miller, with access to a shaving razor for approximately four minutes" and "[v]ideo showed the resident picking up the razor and rubbing his thumb over the blades." OCA further found that MJDC staff failed to check on other residents for upwards of one hour and forty-five minutes, despite falsely documenting that such checks took place every fifteen minutes. A staff member verbally abused yet another juvenile referring to him as a "retard". Lastly, OCA found that the Facility was not equipped with a "cut down" tool for hanging victims or a defibrillator.

3. Legal Authority

The purpose of this letter is to comply with the provisions of 51 Okla. Stat. §151 *et seq*, requiring citizens to notify the State or political subdivision of any intent to sue or prosecute a tort claim against that political subdivision. At this time, I would like to give notice that Claimant intends to pursue: (A) tort claims – including, *inter alia*, claims for negligence and intentional infliction of emotional distress; and/or (B) claims for violations of the Oklahoma Constitution (Article II §§ 7 and 9) -- against the above-addressed parties. Claimant seeks compensation at the maximum amount allowed under Oklahoma law.

Also, though Claimant is not required to notify respondents of her federal claims, for informational purposes only, Claimant hereby notifies the above parties that she plans to bring claims under the United States Constitution, pursuant to 42 U.S.C. § 1983.

"[C]laims based on a jail suicide are considered and treated as claims based on the failure of jail officials to provide medical care for those in their custody." *Barrie v. Grand Cty.*, 119 F.3d 862, 866 (10th Cir.1997). Under the Eighth Amendment, prisoners possess a constitutional right to medical care, and that right is violated when doctors or officials are deliberately indifferent to a prisoner's serious medical needs. *See, e.g., Estelle v. Gamble*, 429 U.S. 97, 103-04 (1976). Pretrial detainees who have not been convicted of a crime, have a constitutional

right to medical and psychiatric care under the Due Process Clause of the Fourteenth Amendment with the standard for deliberate indifference at least as protective as for convicted prisoners. *See Bell v. Wolfish*, 441 U.S. 520, 545 (1979); *Martin v. Bd. of County Com'rs of County of Pueblo,* 909 F.2d 402, 406 (10th Cir. 1990).

"Deliberate indifference involves both an objective and subjective component." *Olsen v. Layton Hills Mall,* 312 F.3d 1304, 1315 (10th Cir. 2002) (quoting *Sealock v. Colorado,* 218 F.3d 1205, 1209 (10th Cir. 2000)) (internal quotation marks omitted). To satisfy the objective component, "the alleged deprivation must be 'sufficiently serious' to constitute a deprivation of constitutional dimension." *Self v. Crum,* 439 F.3d 1227, 1230 (10th Cir. 2006). The subjective component requires evidence that the official "knows of and disregards an excessive risk to inmate health or safety." *Mata v. Saiz,* 427 F.3d 745, 751 (10th Cir. 2005). A civil rights defendant is deliberately indifferent where he "has knowledge of a substantial risk of serious harm to inmates . . . [and] fails to take reasonable steps to alleviate that risk." *Tafoya v. Salazar,* 516 F.3d 912, 916 (10th Cir. 2008).

"Because it is difficult, if not impossible, to prove another person's actual state of mind, whether an official had knowledge may be inferred from circumstantial evidence." *DeSpain v. Uphoff,* 264 F.3d 965, 975 (10th Cir. 2001). For instance, "the existence of an obvious risk to health or safety may indicate awareness of the risk." *Rife v. Oklahoma Dep't of Pub. Safety,* 854 F.3d 637, 647 (10th Cir. 2017), *cert. denied sub nom. Dale v. Rife,* No. 17-310, 2017 WL 3731208 (U.S. Oct. 16, 2017), and *cert. denied sub nom. Jefferson v. Rife,* No. 17-314, 2017 WL 3731324 (U.S. Oct. 16, 2017) (citing *Farmer v. Brennan,* 511 U.S. 825, 842 (1994)). "[I]t does not matter whether the risk comes from a single source or multiple sources, any more than it matters whether a prisoner faces an excessive risk ... for reasons personal to him *or because all prisoners in his situation face such a risk." Farmer,* 511 U.S. at 843.

The Tenth Circuit recognizes two types of conduct constituting deliberate indifference in the corrections medical context. *See Sealock,* 218 F.3d at 1211. "First, a medical professional may fail to treat a serious medical condition properly.... The second type of deliberate indifference occurs when ***prison officials prevent an inmate from receiving treatment or deny him access to medical personnel capable of evaluating the need for treatment."*** *Id.* (emphasis added). A non-medical professional who serves "solely ... as a gatekeeper for other medical personnel capable of treating the condition" may be held liable under the deliberate indifference standard if she "delays or refuses to fulfill that gatekeeper role." *Id. See also Blackmon v. Sutton,* 734 F.3d 1237, 1245 (10th Cir. 2013).

Here, applying these legal standards, the evidence establishes that MJDC staff was deliberately indifferent to Billy's serious medical and mental health needs. In addition, there is sufficient evidence of an unconstitutional policy or custom such that the County and/or MCCOYS may be held liable under a municipal liability theory. *See, e.g., Monell v. New York City Dept. of Social Servs.,* 436 U.S. 658 (1977); *Bd. of Cnty. Comm'rs of Bryan Cnty., Okl. v. Brown,* 520 U.S. 397, 403 (1997); *Bryson v. City of Oklahoma City,*

627 F.3d 784, 788 (10th Cir. 2010); *Dubbs v. Head Start, Inc.*, 336 F.3d 1194, 1216 (10th Cir. 2003) ("Although the Supreme Court's interpretation of § 1983 in *Monell* applied to municipal governments and not to private entities acting under color of state law, case law from [the Tenth Circuit] and other circuits *has extended the Monell doctrine to private § 1983 defendants.*") (emphasis added).

Also, please be advised that an attorney's lien is claimed in this matter and any further correspondence should take place between this office and yourself and/or your attorney(s). Please provide copies of any documents, materials, photographs, video and audio you may have in your file regarding this matter.

Thank you for your attention to this matter. If you have any questions, please do not hesitate to contact me. Thank you.

Sincerely,

Daniel Smolen

cc: Robbie Burke