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

(1) ROBBIE EMERY BURKE, as Special Administratrix of the Estate of BILLY WOODS, Deceased, Plaintiff, vs. (1) MUSKOGEE COUNTY COUNCIL OF YOUTH SERVICES ("MCCOYS"), a Domestic Not-for-Profit Corporation, (2) BOARD OF COUNTY COMMISSIONERS OF MUSKOGEE COUNTY, OKLAHOMA, (3) STATE OF OKLAHOMA, *ex rel.*, OFFICE OF JUVENILE AFFAIRS ("OJA"), (4) JERROD LANG, (5) BRANDON MILLER, (6) ANGELA MILLER, (7) MARIETTA WINKLE, and (8) STEVEN BUCK, Defendants.	Case No.: 18-CV-108-RAW Jury Trial Demanded Attorney Lien Claimed

COMPLAINT

COMES NOW the Plaintiff Robbie Emery Burke ("Plaintiff"), as the Special Administratrix for the Estate of Billy Woods, deceased ("Billy" or "Mr. Woods"), and for her Complaint against the above-named Defendants alleges and states as follows:

INTRODUTORY STATEMENT

1. 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 young man 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 Defendant 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 and serious medical and mental health needs.

2. 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's 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.

PARTIES

3. Plaintiff, Robbie Emery Burke ("Plaintiff"), is a resident of Tulsa County, Oklahoma, and the duly-appointed Special Administratrix of the Estate of Mr. Woods. The survival causes of action in this matter are based on violations of Mr. Woods' rights under

the Eighth and/or Fourteenth Amendment to the United States Constitution and Oklahoma Law.

4. Defendant Muskogee County Council of Youth Services ("MCCOYS") is a private, domestic, not-for-profit corporation. At all pertinent times, MCCOYS staffed and operated the Muskogee County Regional Juvenile Detention Center under a subcontract with Defendant Board of County Commissioners for Muskogee County. MCCOYS was at all times relevant hereto responsible, in part, for assuring that the basic medical, mental health and safety needs of residents at MJDC, including Billy, were met. MCCOYS was additionally responsible, in part, for creating and implementing policies, practices, protocols and customs related to the protection of, and provision of medical and mental health care to, residents at MJDC, and for training and supervising its employees. MCCOYS was, at all times relevant hereto, endowed by the County with powers or functions governmental in nature, such that MCCOYS became an agency or instrumentality of the State and subject to its constitutional limitations.

5. Defendant Board of County Commissioners of Muskogee County ("BOCC" or the "County") is a statutorily-created governmental entity. As a matter of Oklahoma law and contract with OJA, the County has a duty to provide for the temporary detention of children who are or may be subject to secure detention as required by l0A O.S. §2- 3-103. Additionally, the County was authorized, pursuant to Oklahoma statutory law (10A O.S. §2-3-103), to contract with a private agency, such as MCCOYS, for the operation of a juvenile detention facility. The County had a duty to ensure that any such "subcontractor", like MCCOYS, had the ability to comply with applicable court orders and standards for juvenile detention services and facilities adopted by the Board of Juvenile

Affairs, OAC 377:3-13, Part 3. *Requirements for Secure Detention Facilities.* The County had a Constitutional duty to ensure that all residents at MJDC were properly cared for, and protected, within the minimum standards required under the United States and Oklahoma Constitutions. The County was additionally responsible, in part, for creating and implementing policies, practices, protocols and customs related to the protection of, and provision of medical and mental health care to, residents at MJDC.

6. Defendant State of Oklahoma *ex rel* Office of Juvenile Affairs ("OJA") is a sovereign entity sued for money damages only to the extent allowed by the Oklahoma Governmental Tort Claims Act ("GTCA") or other applicable law. Juvenile residents at MJDC, including Billy, were under OJA custody. As such, OJA had a legal and Constitutional duty to ensure the safekeeping of residents like Billy. In this regard, OJA adopted standards for juvenile detention services and facilities, OAC 377:3-13, Part 3. *Requirements for Secure Detention Facilities.* As such, OJA had an obligation to take reasonable measures to assure that these minimal standards were complied with at MJDC.

7. Defendant Jerrod Lang ("Lang") was, at all times relevant hereto, a staff member, and supervisor, at MJDC, acting under color of state law, and within the scope of his employment, as an employee or agent of MCCOYS, the County and OJA. Lang was responsible, in part, for assuring that the MJDC residents under his care and supervision, like Billy, were adequately cared for and that their basic safety, medical and mental health care needs were met.

8. Defendant Brandon Miller ("Miller") was, at all times relevant hereto, a staff member at MJDC, acting under color of state law, and within the scope of his employment, as an employee or agent of MCCOYS, the County and OJA. Miller was

responsible, in part, for assuring that the MJDC residents under his care and supervision, like Billy, were adequately cared for and that their basic safety, medical and mental health care needs were met.

9. Defendant Angela Miller ("A. Miller") was, at all times relevant hereto, a staff member at MJDC, acting under color of state law, and within the scope of her employment, as an employee or agent of MCCOYS, the County and OJA. A. Miller was responsible, in part, for assuring that the MJDC residents under her care and supervision, like Billy, were adequately cared for and that their basic safety, medical and mental health care needs were met.

10. Defendant Marietta Winkle ("Winkle") was, at all times relevant hereto, a staff member at MJDC, acting under color of state law, and within the scope of her employment, as an employee or agent of MCCOYS, the County and OJA. Winkle was responsible, in part, for assuring that the MJDC residents under her care and supervision, like Billy, were adequately cared for and that their basic safety, medical and mental health care needs were met.

11. Defendant Steven Buck ("Mr. Buck"), was, at all pertinent times, Executive Director of OJA. As Executive Director, Mr. Buck is responsible for the overall management of the agency's portfolio of operated and contracted programs and services. As Executive Director, Mr. Buck has responsibility for maintaining OJA policies, protocols and customs and a supervisory duty to assure that juvenile residents under OJA custody, like Billy, have their basic safety, medical and mental health care needs met. At all times, Mr. Buck was acting under color of state law. Mr. Buck is sued in his individual capacity under a supervisory liability theory.

JURISDICTION AND VENUE

12. The acts giving rise to this lawsuit occurred in Muskogee County, State of Oklahoma, within this judicial district.

13. Prior to bringing this Complaint, Plaintiff complied with the tort claim notice provisions of the Oklahoma Government Tort Claim Act ("GTCA"), 51 O.S. § 151, *et seq.*, by notifying Defendants of her intent to file state law claims in connection with the events and injuries described herein. The GTCA process has been exhausted. This action is timely brought pursuant to 51 O.S. § 157.

14. The jurisdiction of this Court is invoked pursuant to 28 U.S.C. § 1343 to secure protection of, and to redress deprivations of, rights secured by the Eighth and/or Fourteenth Amendments to the United States Constitution as enforced by 42 U.S.C. § 1983, which provides for the protection of all persons in their civil rights and the redress of deprivation of rights under color of law.

15. The jurisdiction of this Court is also invoked under 28 U.S.C. § 1331 to resolve a controversy arising under the Constitution and laws of the United States, particularly the Eighth and/or Fourteenth Amendments to the United States Constitution and 42 U.S.C. § 1983.

16. This Court has supplemental jurisdiction over the state law claims asserted herein pursuant to 28 U.S.C. § 1367, since the claims form part of the same case or controversy arising under the United States Constitution and federal law.

17. Venue is proper under 28 U.S.C. § 1391(b) because a substantial part of the events or omissions giving rise to Plaintiff's claims occurred in this judicial district.

FACTUAL ALLEGATIONS

18. Billy Woods was just a 16-year-old boy when he was brought to MJDC 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 Defendant Board of County Commissioners for Muskogee County (the "County" or "BOCC").[1] Shift Supervisor Lang, a MCCOYS employee, arrived at MJDC at around 3:00 p.m. 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 the intake process completed. 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.

19. 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

[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.

> 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).

20. 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 and dangers.

21. 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.

22. 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 MCCOYS, the County and OJA failed to assure that the Facility had any qualified mental health professional to administer suicide assessments for the youthful residents.

23. The obvious and excessive risks of placing Billy in Room 1 *could* have been lessened by compliance with Oklahoma's minimal 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 […]."

24. 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).

25. As noted above, Billy was infrequently monitored during the 3:00 p.m. to 11:00 p.m. shift of December 15, 2016. The daily notes form indicates that detention worker Defendant Brandon Miller ("Miller") and Lang checked on Billy at 6:45 p.m., 7:00 p.m., 7:15 p.m., 7:30 p.m., 7:45 p.m., 8:00 p.m., 8: 15 p.m., and 8:30 p.m. However, video evidence proves that ***none of these purported welfare checks actually occurred.*** As one particularly stunning example of neglect, at approximately 7:32 p.m., Miller placed his hand on the door to Billy's room, but did not bother to check on him. Then, at around 7:37 p.m., Miller was standing right beside the door to Room 1, but failed to look in on him. This constitutes deliberate indifference to Billy's serious medical and mental health needs. In addition, Lang and Defendant Marietta Winkle ("Winkle") can be seen, on numerous occasions, right outside of Billy's cell, but neither Lang nor Winkle took the minimum, and mandated, action of checking on him.

26. When Lang finally got around to actually checking on Billy, at 8:36 p.m., 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.

27. 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 ***instructed Miller not to conduct CPR. None*** of the staff members performed CPR. Winkle admitted that while he did enter Billy's room after he was found unresponsive, she did not attempt to loosen the sheet around his neck, check for a pulse, check for respiration, or perform CPR.

28. Lang's only explanation for his failure to assist Billy 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.

29. 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. And Miller and Winkle's failure to intervene and provide assistance to Billy also constitutes deliberate indifference to his serious, obvious and emergent medical needs.

30. 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 911. Indeed, 911 was not called until 8:56 p.m., ***twenty (20) minutes after Billy had been discovered unconscious in Room 1.*** Detention worker Angela Miller ("A. 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 vanished.

31. According to the Medical Examiner's Report, Billy was pronounced dead at 9:05 p.m. 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, including Lang, Miller, A. Miller and Winkle.

32. 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 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.

33. 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

34. 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 "[w]hen 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 safety measure.

35. 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.

36. 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 having 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.

37. 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

38. 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”.

39. 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 was 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's suffering and death.

Other Disturbing Evidence of an Unconstitutional Custom

40. 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.

CLAIMS FOR RELIEF

FIRST CLAIM FOR RELIEF

Cruel and Unusual Punishment in Violation of the Eighth and/or Fourteenth Amendments to the Constitution of the United States (42 U.S.C. § 1983)

A. Underlying Constitutional Violations

41. Plaintiff re-alleges and incorporate by reference paragraphs 1 to 40, as though fully set forth herein.

42. Lang, Miller, A. Miller and Winkle knew, or it was obvious, that Billy was at significant risk of serious injury and harm, including death, as set forth herein.

43. Lang, Miller, A. Miller and Winkle failed to provide Billy with, or assure that Billy was provided with, adequate medical care, mental health care, supervision and protection while he was housed at MJDC.

44. Lang, Miller, A. Miller and Winkle's acts and/or omission as alleged herein, including but not limited to their failure to provide Billy with, or assure that Billy was provided with, adequate safety precautions and supervision protection, medical and mental health supervision, assessment and treatment, constitute deliberate indifference to Billy's serious health and safety needs.

45. As a direct and proximate result of Lang, Miller, A. Miller and Winkle's deliberate indifference, Billy experienced physical pain, severe emotional distress, mental anguish, death and the damages alleged herein.

46. Lang enhanced the known dangers and excessive risks to Billy's health and safety by verbally abusing, belittling and humiliating him.

B. Municipal/*Monell* Liability (MCCOYS and the County)

47. Plaintiff re-alleges and incorporates by reference paragraphs 1 through 46 as though fully set forth herein.

48. MCCOYS and the County are "persons" for purposes of 42 U.S.C. § 1983.

49. At all times pertinent hereto, MCCOYS and the County were acting under color of state law.

50. MCCOYS was endowed by the County with powers or functions governmental in nature, such that MCCOYS became an instrumentality of the state and subject to its Constitutional limitations.

51. MCCOYS and the County were charged with implementing, maintaining and assisting in developing the policies and custom in place at MJDC, including the standards adopted by OJA, with respect to the safekeeping, protection, supervision and medical and mental health care of the juvenile residents at MJDC, including Billy, and have a shared responsibility to adequately train and supervise their employees and agents/MJDC staff.

52. There is an affirmative causal link between the aforementioned deliberate indifference to Billy's serious medical and mental health needs, his safety, and his civil rights; and the following customs, policies, and/or practices which MCCOYS and the County carried, maintained or otherwise possessed responsibility for.

Failure to Train / Failure to Supervise

53. 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 "[w]hen 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 safety measure.

54. 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.

55. 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 having 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.

56. 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

57. 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".

58. 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 was 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's suffering and death.

Other Disturbing Evidence of an Unconstitutional Custom

59. 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.

60. MCCOYS and the County knew (either through actual or constructive knowledge), or it was obvious, that these policies, practices and/or customs posed substantial risks to the health and safety of residents like Billy. Nevertheless, MCCOYS and the County failed to take reasonable steps to alleviate those risks in deliberate indifference to inmates', including Mr. Pratt's, serious mental health needs.

61. MCCOYS and the County tacitly encouraged, ratified, and/or approved of the unconstitutional acts and/or omissions alleged herein.

62. There is an affirmative causal link between the aforementioned customs, policies, and/or practices and Billy's injuries and damages as alleged herein.

C. Supervisory Liability (Mr. Buck)

63. Plaintiff re-alleges and incorporates by reference paragraphs 1 through 62 as though fully set forth herein.

64. Mr. Buck was, at all pertinent times, Executive Director of OJA. As Executive Director, Mr. Buck is responsible for the overall management of the agency's portfolio of operated and contracted programs and services. As Executive Director, Mr. Buck has responsibility for maintaining OJA policies, protocols and customs and a supervisory duty to assure that juvenile residents under OJA custody, like Billy, have their basic safety, medical and mental health care needs met.

65. There is an affirmative link between the aforementioned violation of Billy's constitutional rights and policies, practices and/or customs (described more fully in paragraphs 53-59, *supra*) which Mr. Buck possessed responsibility for.

66. Mr. Buck knew and/or it was obvious that the maintenance of the aforementioned policies, practices and/or customs posed an excessive risk to the health and safety of residents like Billy.

67. Mr. Buck disregarded the known and/or obvious risks to the health and safety of citizens like Billy.

68. There is an affirmative causal link between the aforementioned customs, policies, and/or practices and Billy's injuries and damages as alleged herein (including death).

SECOND CLAIM FOR RELIEF

Failure to Intervene
(42 U.S.C. § 1983)

69. Plaintiff re-alleges and incorporates by reference paragraphs 1 through 68 as though fully set forth herein.

70. In the manner described above, by their conduct and under color of law, during the constitutional violations committed by Lang, Miller, A. Miller and Winkle, each of these Defendants stood by without intervening to prevent the violation of Billy's constitutional rights, even though they had the opportunity and duty to do so.

71. As a direct and proximate result of Lang, Miller, A. Miller and Winkle's failure to intervene to prevent the violation of Billy's constitutional rights, Billy suffered the injuries and damages as alleged herein (including death).

72. These Defendants had a reasonable opportunity to prevent this harm, but failed to do so.

73. The misconduct described in this Claim for Relief was objectively unreasonable and was undertaken intentionally, with malice, willful and/or reckless indifference to Billy's constitutional rights.

THIRD CLAIM FOR RELIEF

Negligence
(Defendants MCCOYS, OJA, County, Lang, Miller, A. Miller and Winkle)

74. Plaintiff re-alleges and incorporates by reference paragraphs 1 through 73 as though fully set forth herein.

75. MCCOYS, OJA, County, Lang, Miller, A. Miller and Winkle owed a duty to Billy, and all other residents in custody, to use reasonable care to provide reasonable protection from harm, safety precautions, supervision, and necessary medical and mental health care.

76. MCCOYS, OJA, County, Lang, Miller, A. Miller and Winkle breached that duty by failing to provide Billy with prompt and adequate medical and mental health care despite Billy's obvious needs.

77. MCCOYS, OJA, County, Lang, Miller, A. Miller and Winkle additionally breached the duty of care by failing to provide Billy with reasonable protection, supervision and safekeeping.

78. As a direct and proximate result of these Defendants' negligence, Billy experienced physical pain, severe emotional distress, mental anguish, death and the damages alleged herein.

79. MCCOYS, OJA and the County are vicariously liable for the negligence of its employees and agents.

FOURTH CLAIM FOR RELIEF

Violation of Article II § 9 of the Constitution of the State of Oklahoma
Cruel and Unusual Punishment and Deliberate Indifference
(Defendants MCCOYS, OJA, County, Lang, Miller, A. Miller and Winkle)

80. Plaintiff re-alleges and incorporates by reference paragraphs 1 through 79, as though fully set forth herein.

81. Article II § 9 of the Oklahoma Constitution prohibits the infliction of cruel and unusual punishment. Under the Oklahoma Constitution's Due Process Clause, Article II § 7, the right to be free from cruel and unusual punishment extends to pre-trial detainees, like Billy, who have yet to be convicted of a crime (in addition to convicted prisoners who are clearly protected under Article II § 9).

82. The protections afforded to pre-trial detainees under the Oklahoma Constitution's Due Process Clause, Article II § 7, include the provision of adequate mental health care and protection from harm while in custody.

83. As set forth herein, Defendants knew, or it was obvious, that Billy was at significant risk of serious injury and harm.

84. Defendants failed to provide adequate protection, medical care, mental health care and supervision to Billy while he was in custody.

85. Defendants' acts and/or omission as alleged herein, including but not limited to their failure to provide Billy with adequate protection, medical and mental health care and supervision, assessment and treatment, and/or or to assure that Billy receive adequate protection, medical and mental health care and supervision, assessment and treatment, constitute deliberate indifference to Billy's health and safety.

86. As a direct and proximate result of these Defendants' deliberate indifference, Billy experienced physical pain, severe emotional distress, mental anguish, death and the damages alleged herein.

87. At all times relevant, the MJDC personnel described in this Complaint were acting within the scope of their employment and under the direct control of MCCOYS, the County and/or OJA.

88. MCCOYS, OJA and the County are vicariously liable for the violations of the Oklahoma Constitution committed by their employees and agents.

PRAYER FOR RELIEF

89. WHEREFORE, based on the foregoing, Plaintiffs pray that this Court grant them the relief sought including, but not limited to, actual damages in excess of Seventy-Five Thousand Dollars ($75,000.00), with interest accruing from date of filing of suit, punitive damages (for the reckless disregard of Billy's rights as described above) in excess of Seventy-Five Thousand Dollars ($75,000.00), reasonable attorney fees, and all other relief deemed appropriate by this Court.

Respectfully submitted,

/s/Daniel E. Smolen
Daniel E. Smolen, OBA #19943
Robert M. Blakemore, OBA #18656
Smolen, Smolen & Roytman, PLLC
701 S. Cincinnati Ave.
Tulsa, Oklahoma 74119
P: (918) 585-2667
F: (918) 585-2669

-and-

Joel A. LaCourse, OBA #17082
Caleb Salmon, OBA # 32272
LaCourse Law, PLLC
715 S. Elgin Ave.
Tulsa, Oklahoma 74120
Telephone: 918.744.7100
Facsimile: 918.477.2299
Joel@lacourselaw.com

Attorneys for Plaintiff