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

(1) SCOTT W. BIRDWELL, (2) ROBBIE EMERY BURKE, as the Special Administratrix of the Estate of Eric Harris, Deceased, and (3) TERRY BYRUM, Plaintiffs, v. (1) STANLEY GLANZ, SHERIFF OF TULSA COUNTY, in his personal capacity and official capacity, and (2) BOARD OF COUNTY COMMISSIONERS OF TULSA COUNTY, (3) ARMOR CORRECTIONAL HEALTH SERVICES, INC., (4) UNKNOWN NURSE #1, and (5) UNKNOWN ATTENDING PHYSICIAN #1, (6) ROBERT C. BATES, (7) MICHAEL HUCKEBY, (8) JOSEPH BYARS, and (9) RICARDO VACA, Defendants.	)	Case No.: 15-CV-00304-TCK-TLW ATTORNEY LIEN CLAIMED JURY TRIAL DEMANDED

SECOND AMENDED COMPLAINT

COME NOW, Plaintiffs, Scott W. Birdwell ("Birdwell" or "Mr. Birdwell"), Robbie Emery Burke ("Ms. Burke"), as the Special Administratrix of the Estate of Eric Harris, Deceased ("Mr. Harris" or "Harris") and Terry Byrum ("Mr. Byrum" or "Byrum") (hereinafter, collectively referred to as "Plaintiffs"), and for their causes of action against the above-named Defendants, allege and state the following:

INTRODUCTORY STATEMENT

1. The parties and claims are joined herein as they are logically related. All of the claims raised by Plaintiffs stem from policies, procedures and/or customs for which Defendant Sheriff Stanley Glanz ("Sheriff Glanz") and/or Defendant Board of County Commissioners of Tulsa County ("BOCC") bear ultimate responsibility. Whether within the Tulsa County Jail or on the streets of Tulsa County, Birdwell, Harris and Byrum were injured -- and in Harris' case, killed -- as a result of inadequate and unconstitutional training and supervision fostered by Sheriff Glanz. Fundamentally, Sheriff Glanz has exhibited, time and time again, over a period of many years, deliberate indifference to the health and safety of inmates and citizens on the street, alike.

2. Sheriff Glanz has displayed a remarkable willingness to place his personal, political and financial relationships over the safety of inmates and the community-at-large. Whether it is his relationship with the CEO of the former private medical provider at the Jail or his relationship with Defendant Robert C. Bates ("Bob Bates" or "Bates"), Sheriff Glanz has continually over-prioritized these relationships at the expense of public safety. Sheriff Glanz's unchecked cronyism has badly clouded his judgment to the great detriment of inmates at the Jail and the public-at-large. With respect to the medical and mental health care provided to inmates in the Jail, the Tulsa County Sheriff's Office ("TCSO") has shown an inclination to conceal the truth, going so far as to condone the falsification of medical records in an effort to hide deficient care. In a similar vein, TCSO has knowingly covered up Bates' lack of necessary field training, as a reserve deputy, and recklessly permitted him to participate in volatile and

dangerous law enforcement operations.

3. Overall, Sheriff Glanz has overseen operations of the Jail and law enforcement operations in the streets in a common and unconstitutional manner. As detailed herein, Birdwell, Harris and Byrum all fell victim to this unconstitutional and dangerous system in which cronyism trumps safety.

PARTIES, JURISDICTION AND VENUE

4. Plaintiff Scott W. Birdwell ("Mr. Birdwell" or "Birdwell") is a citizen of Oklahoma.

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

6. Plaintiff Terry Byrum ("Mr. Byrum" or "Byrum") is a citizen of Oklahoma.

7. Defendant Stanley Glanz ("Sheriff Glanz" or "Defendant Glanz") is, and was at all times relevant hereto, the Sheriff of Tulsa County, Oklahoma, residing in Tulsa County, Oklahoma and acting under color of state law. Defendant Glanz, as Sheriff and the head of the Tulsa County Sheriff's Office ("TCSO"), was, at all times relevant hereto, responsible for ensuring the safety and well-being of inmates detained and housed at the Tulsa County Jail, including the provision of appropriate medical and mental health care and treatment to inmates in need of such care, pursuant to 57 Okla. Stat. § 47. In addition, Defendant Glanz is, and was at all times pertinent hereto, responsible for creating, adopting, approving, ratifying,

and enforcing the rules, regulations, policies, practices, procedures, and/or customs of TCSO and the Tulsa County Jail, including the policies, practices, procedures, and/or customs that violated Plaintiff's rights as set forth in this Amended Complaint. In addition, Sheriff Glanz is responsible for TCSO's law enforcement filed operations, including its Reserve Deputy Program. Defendant Glanz is sued in his individual and official capacities.

8. Defendant Board of County Commissioners of Tulsa County ("BOCC") is a statutorily-created governmental entity. 57 Okla. Stat. § 41 provides that "[e]very county, by authority of the *board of county commissioners* and at the expense of the county, *shall have a jail* or access to a jail in another county *for the safekeeping of prisoners lawfully committed***.**" (emphasis added). BOCC must discharge its responsibilities to the Tulsa County Jail in a constitutional manner. BOCC is properly sued under the provision of the Oklahoma Governmental Tort Claims Act.

9. Defendant Armor Correctional Health Services, Inc. ("ARMOR") is a foreign corporation doing business in Tulsa County, Oklahoma and was at all times relevant hereto responsible, in part, for providing medical services and medication to Birdwell while he was in the custody of TCSO. ARMOR was additionally responsible, in part, for creating and implementing policies, practices and protocols that govern the provision of medical and mental health care to inmates at the Tulsa County Jail, and for training and supervising its employees. ARMOR was, at all times relevant hereto, endowed by Tulsa County with powers or functions

governmental in nature, such that ARMOR became an agency or instrumentality of the State and subject to its constitutional limitations.

10. Defendant Unknown Nurse # 1, whose identity is presently unknown, was, at all times relevant hereto, an employee and/or agent of ARMOR, who was, in part, responsible for overseeing Birdwell's health and well-being, and assuring that Birdwell's medical and mental health needs were met, during the time he was in the custody of TCSO. Defendant Unknown Nurse # 1, was, at all times, acting under color of state law and within the scope of her employment. Defendant Unknown Nurse # 1 is being sued in her individual capacity.

11. Defendant Unknown Attending Physician #1, whose identity is presently unknown, was at all times relevant hereto, an employee and/or agent of ARMOR, who was, in part, responsible for overseeing and treating Birdwell's health and well-being, and assuring that Birdwell's medical needs were met, during the time he was in the custody of TCSO. Defendant Unknown Attending Physician #1 is being sued in his individual capacity.

12. Defendant Robert C. Bates ("Bob Bates" or "Bates"), is a resident of Tulsa County, State of Oklahoma. Bates was, at all times relevant hereto, acting under color of state law, and in the scope of his employment, as an employee or agent of the TCSO.

13. Defendant Michael Huckeby ("M. Huckeby"), is a citizen of Oklahoma. M. Huckeby was, at all times relevant hereto, acting under color of state law, and in the scope of his employment, as an employee or agent of the TCSO.

14. Defendant Joseph Byars ("Byars"), is a citizen of Oklahoma. Byars was, at all times relevant hereto, acting under color of state law, and in the scope of his employment, as an employee or agent of the TCSO.

15. Defendant Ricardo Vaca ("Vaca"), is a citizen of Oklahoma. Vaca was, at all times relevant hereto, acting under color of state law, and in the scope of his employment, as an employee or agent of the TCSO.

16. 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 Fourth, Eighth and 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.

17. 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 Fourth, Eighth and Fourteenth Amendments to the United States Constitution and 42 U.S.C. § 1983.

18. 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.

19. Venue is proper under 28 U.S.C. § 1391(b) because a substantial part of the events or omissions giving rise to Plaintiffs' claims occurred in this District.

STATEMENT OF FACTS

20. Paragraphs 1-19 are incorporated herein by reference.

A. Facts Pertinent to Birdwell

21. On or about June 7, 2014, Birdwell was a trustee at the David L. Moss Criminal Justice Center (hereinafter referred to as "Jail" or "Tulsa County Jail"), and was cleaning laundry when he was assaulted by another inmate.

22. Birdwell was struck by the inmate above his left eye by an unknown object, resulting Birdwell suffering a serious laceration on the skin above his left eyebrow. However, this was not the fullest extent of his injuries, and Birdwell conveyed to ARMOR medical staff at the Jail that he needed further treatment at the hospital.

23. Despite the Birdwell's multiple complaints of pain and his requests to be sent to the hospital, responsible medical staff at the Jail disregarded Birdwell's request to be examined thoroughly. Birdwell's eye was not examined and no x-ray, MRI or other diagnostic procedures were performed, despite the obvious severity of Birdwell's injuries.

24. The Jail medical staff, namely Defendant Unknown Attending Physician #1, installed 23 stitches in an attempt to close the laceration.

25. The procedure lasted approximately ninety (90) minutes. Birdwell was told by Defendant Unknown Attending Physician #1 that "[a]n experienced E.R. doctor would have had these stitches in about twenty (20) minutes." Defendant Unknown Attending Physician #1 even joked that he should have studied plastic surgery more. To Birdwell, however, this was no laughing matter.

26. Suturing Birdwell's wounds took as long as it did because the local

anesthesia used was not manufactured for prolonged medical procedures. Again, no x-ray, MRI or other diagnostic procedures were performed, despite the obvious severity of Birdwell's injuries.

27. After the suture procedure, Birdwell was taken back to his cell. ARMOR medical staff instructed Birdwell to return to the medical unit in five (5) days to have the stitches removed in order to reduce Birdwell's chance of severe scarring of his laceration.

28. Despite Birdwell's repeated pleas to be seen by medical staff five (5) days after receiving the stitches, ***ten days (10) passed*** before Jail medical staff made an attempt to remove his stitches.

29. Upon his return to the Jail's medical unit, Birdwell again brought up the severity of his injuries to Unknown Attending Physician #1, and he communicated to the physician that his injuries had worsened with time. Specifically, along with pain at the laceration site, Birdwell presented with added complaints of head pain, loss of vision, and blurred vision. These symptoms are directly related to the injuries he sustained from the assault on June 7, 2014.

30. Despite Birdwell's requests for medical treatment for his rapidly worsening injuries, his request was denied and Defendant Unknown Nurse #1 began to prepare to remove Birdwell's stitches. Defendant Attending Physician #1 failed to observe the procedure despite Defendant Unknown Nurse #1's lack of experience with removing stitches.

31. Indeed, Defendant Unknown Nurse #1 communicated to Birdwell that she'd never removed stitches before.

32. With no oversight from a supervisor or attending physician, Defendant Unknown Nurse #1 ripped the sutures back open, resulting in the laceration splitting open. The five (5) day delay of treatment past the recommended point for the removal of stitches played a substantial role in the sutures splitting open, as Birdwell's skin grew over his sutures.

33. Upon information and belief, and contrary to the policies and procedures of the Tulsa County Jail, Unknown Attending Physician #1 forgot to have Birdwell sign a medical consent form prior to Birdwell's treatment, and expressed his hope that he wouldn't be terminated as a result. Unknown Attending Physician #1 also commented that he wished that he had more experience as an Emergency Room doctor.

34. Birdwell filed a grievance on June 23, 2014, complaining of severe migraines, physical damage to his eye, a loss of partial vision, shooting pains into his ear and throat, swelling on the left side of his head near the location of the laceration, and a possible brain hemorrhage.

35. On June 24, Nurse Gail Osborn, an employee or agent of ARMOR, told the physician on call that, given the severity of Birdwell's injuries, he should have been sent to the hospital immediately after he was assaulted by the inmate.

36. Birdwell sustained personal injuries as a result of Defendant's conduct.

37. Prior to filing this Complaint, Birdwell sent notice to Tulsa County pursuant to the Oklahoma Governmental Tort Claims Act, 51 O.S. § 156, on the 15th of September, 2014. Ninety (90) days have passed since that time and Defendant has not approved Birdwell's claim in its entirety, with

the constructive denial date falling on the 31st of November, 2014. Birdwell has filed a timely claim against the Defendant within 180 days of the constructive denial date of the 29th of May, 2015. Therefore, this action is timely brought pursuant to 51 O.S. § 157.

38. The deliberate indifference to Birdwell's serious medical needs, as summarized *supra*, was in furtherance of and consistent with policies, customs and/or practices which Sheriff Glanz promulgated, created, implemented or possessed responsibility for the continued operation of.

39. There are longstanding, systemic deficiencies in the medical and mental health care provided to inmates at the Tulsa County Jail. Sheriff Glanz has long known of these systemic deficiencies and the substantial risks to inmates like Birdwell, but has failed to take reasonable steps to alleviate those deficiencies and risks.

40. For instance, in 2007, the National Commission on Correctional Health Care ("NCCHC"), a corrections health accreditation body, conducted an on-site audit of the Jail's health services program. At the conclusion of the audit, NCCHC auditors reported serious and systemic deficiencies in the care provided to inmates, including failure to perform mental health screenings, failure to fully complete mental health treatment plans, failure to triage sick calls, failure to conduct quality assurance studies and failure to address health needs in a timely manner. NCCHC made these findings of deficient care despite Sheriff Glanz's/TCSO's efforts to defraud the auditors by concealing information and falsifying medical records and charts.

41. Sheriff Glanz failed to change or improve any health care policies or practices in response to the NCCHC's findings.

42. NCCHC conducted a second audit of the Jail's health services program in 2010. After the audit was completed, the NCCHC placed the Tulsa County Jail on probation.

43. NCCHC once again found numerous serious deficiencies with the health services program. As part of the final 2010 Report, NCCHC found, *inter alia*, as follows: "The [Quality Assurance] multidisciplinary committee does not identify problems, implement and monitor corrective action, nor study its effectiveness"; "There have been several inmate deaths in the past year.... The clinical mortality reviews were poorly performed"; "The responsible physician does not document his review of the RN's health assessments"; "the responsible physician does not conduct clinical chart reviews to determine if clinically appropriate care is ordered and implemented by attending health staff"; "...diagnostic tests and specialty consultations are not completed in a timely manner and are not ordered by the physician"; "if changes in treatment are indicated, the changes are not implemented..."; "When a patient returns from an emergency room, the physician does not see the patient, does not review the ER discharge orders, and does not issue follow-up orders as clinically needed"; and "... potentially suicidal inmates [are not] checked irregularly, not to exceed 15 minutes between checks. Training for custody staff has been limited.

Follow up with the suicidal inmate has been poor." 2010 NCCHC Report (emphasis added).

44. Sheriff Glanz only read the first two or three pages of the 2010 NCCHC Report. Sheriff Glanz is unaware of any policies or practices changing at the Jail in response to 2010 NCCHC Report.

45. Over a period of many years, Tammy Harrington, R.N., former Director of Nursing ("DON") at the Jail, observed and documented many concerning deficiencies in the delivery of health care services to inmates. The deficiencies observed and documented by Director Harrington include: chronic failure to triage inmates' requests for medical and mental health assistance; doctors refusing/failing to see inmates with life-threatening conditions; a chronic lack of supervision of clinical staff; and repeated failures of medical staff to alleviate known and significant deficiencies in the health services program at the Jail.

46. On or about June 28, 2011, Ms. Lisa Salgado, died at the Jail due to grossly deficient medical care.

47. On September 29, 2011, the U.S. Department of Homeland Security's Office of Civil Rights and Civil Liberties ("CRCL") reported its findings in connection with an audit of the Jail's medical system – pertaining to U.S. Immigration and Customs Enforcement ("ICE") detainees -- as follows: ***"CRCL found a prevailing attitude among clinic staff of indifference...."***; "*Nurses are undertrained*. Not documenting or evaluating patients properly."; "Found one case clearly demonstrates a lack of training, perforated appendix due to *lack of training and*

supervision"; "Found two ... detainees with clear mental/medical problems that have not seen a doctor."; "[Detainee] has not received his medication despite the fact that detainee stated was on meds at intake"; "TCSO medical clinic is using a homegrown system of records that 'fails to utilize what we have learned in the past 20 years". "ICE-CRCL Report, 9/29/11 (emphasis added).

48. Director Harrington did not observe any meaningful changes in health care policies or practices at the Jail after the ICE-CRCL Report was issued.

49. On the contrary, less than 30 days after the ICE-CRCL Report was issued, on October 27, 2011, another inmate, Elliott Earl Williams, died at the Jail as a result of truly inhumane treatment and reckless medical neglect which defies any standard of human decency.

50. In the wake of the Williams death, which was fully investigated by TCSO, Sheriff Glanz made no meaningful improvements to the medical system. This is evidenced by the fact that yet another inmate, Gregory Brown, died due to grossly deficient care just months after Mr. Williams.

51. On November 18, 2011, AMS-Roemer, the Jail's own retained medical auditor, issued its Report to Sheriff Glanz finding multiple deficiencies with the Jail's medical delivery system, including "[documented] deviations [from protocols which] increase the potential for preventable morbidity and mortality" and issues with ***"nurses acting beyond their scope of practice [which] increases the potential for preventable bad medical outcomes."*** AMS-Roemer Report, 11/8/11 at CHM0171-72. AMS-Roemer specifically commented on no less than six

(6) inmate deaths (including the death of Mr. Jernegan), finding deficiencies in the care provided to each. *Id.* at CHM0168-69; 0171.

52. It is clear that Sheriff Glanz did little, if anything, to address the systemic problems identified in the November 2011 AMS-Roemer Report, as AMS-Roemer continued to find serious deficiencies in the delivery of care at the Jail. For instance, as part of a 2012 Corrective Action Review, AMS-Roemer found "[d]elays for medical staff and providers to get access to inmates," "[n]o sense of urgency attitude to see patients, or have patients seen by providers," failure to follow NCCHC guidelines "to get patients to providers," and "[n]ot enough training or supervision of nursing staff." Corrective Action Review at CHM1935 – 1938.

53. There is a longstanding policy, practice or custom at the Jail of TCSO refusing to send inmates with emergent needs to the hospital for purely financial purposes. This practice has been continued under ARMOR as part of the structure of its business model. That is, under ARMOR's contract with BOCC/TCSO, there are financial disincentives to send patients in need of urgent or even emergent medical attention to outside facilities.

54. In November 2013, BOCC/TCSO/Sheriff Glanz retained ARMOR as the new private medical provider. However, this step has not alleviated the constitutional deficiencies with the medical system. Medical staff is still undertrained and inadequately supervised and inmates are still being denied timely and sufficient medical attention. Bad medical outcomes have persisted due to inadequate supervision and training of medical staff,

and due to the contractual relationship between BOCC/TCSO/Sheriff Glanz and ARMOR (which provides financial disincentives the transfer of inmates in need of care from an outside facility). Sheriff Glanz and ARMOR have known of the deficiencies, and the substantial risks posed to inmates like Birdwell, but have failed to take reasonable steps to alleviate the risks.

55. As alleged herein, there are deep-seated and well-known policies, practices and/or customs of systemic, dangerous and unconstitutional failures to provide adequate medical and mental health care to inmates at the Tulsa County Jail. This system of deficient care -- which evinces fundamental failures to train and supervise medical and detention personnel -- created substantial, known and obvious risks to the health and safety of inmates like Birdwell. Still, Sheriff Glanz and ARMOR have failed to take reasonable steps to alleviate the substantial risks to inmate health and safety, in deliberate indifference to Birdwell's serious medical needs.

B. Facts Pertinent to Harris and Byrum

56. Paragraphs 1-55 are incorporated herein by reference.

Sheriff Glanz and the Reserve Deputy Program (Generally)

57. Defendant Sheriff Stanley Glanz ("Sheriff Glanz") was first elected Tulsa County Sheriff in 1989. Clark Brewster, who now serves as defense counsel in multiple civil rights cases against Sheriff Glanz, was Sheriff Glanz's first campaign manager. Since 1989, Sheriff Glanz has been re-elected six (6) times, and remains Sheriff to this day. Over the years, Sheriff Glanz has vanquished would-be challengers by terminating TCSO

employees whom he believed might pose a political threat.

58. As Sheriff, Sheriff Glanz is the final policymaker for the Tulsa County Sheriff's Office ("TCSO"). With respect to a county sheriff's law enforcement duties, Oklahoma law specifically provides that "[i]t shall be the duty of the sheriff, undersheriffs and deputies to keep and preserve the peace of their respective counties...." 19 Okla. Stat. § 516. By policy, Sheriff Glanz also has a duty to "maximize resources and improve the quality of service provided by the Sheriff's Office." Chapter 1, Policy 1, § 1.1.

59. Oklahoma law further provides that county sheriffs may "appoint as many reserve force deputy sheriffs as are necessary to preserve the peace and dignity of the county." 19 Okla. Stat. § 547. On information and belief, TCSO has continuously maintained a Reserve Deputy Program during Sheriff Glanz's tenure. TCSO's publicly accessible website describes the Reserve Deputy Program as follows:

> The Tulsa County Sheriff's Office Reserve Deputy Program is a vital part of the Sheriff's Office. The purpose of the TCSO Reserve Deputy Program is to provide trained civilian volunteers to ***augment*** the manpower of the Sheriff's Office. Reserve deputies work in all areas of TCSO, as well as at many special events throughout the year. These dedicated reserve deputies work full time jobs in the community and volunteer their time in a myriad of events such as the ***Special Olympics and Tulsa State Fair***.
>
> The Reserve Deputy Program has allowed the Tulsa County Sheriff's Office to build a better relationship with the community by allowing citizens to participate in the daily operations of the Sheriff's Office.

See http://www.tcso.org/tcsoweb/Reserves.aspx (emphasis added).

60. The Reserve Deputy Program is further defined, and governed, by TCSO policy, namely Chapter 16, Policy 4. In pertinent part, the TCSO Reserve Deputy Program policy provides as follows:

❖ "[R]eserve deputies will adhere to and be accountable for all Sheriffs Office policies, rules and regulations, standard operating procedures, and local, state and federal laws." Policy 16-4.1

❖ "Reserve deputies functioning in an official capacity will be under the direction and charge of the Sheriff and ***will subordinate themselves*** to the supervision of the Sheriffs Office during their tenure of service." *Id*.

❖ "The candidates for reserve deputy positions must meet the same selection criteria as full-time deputies." Policy 16-4.4-B.1.

❖ "Applicants accepted as candidates for the Tulsa County Reserve Deputy Program will complete the Reserve Law Enforcement Training Academy prescribed by C.L.E.E.T. consisting of 240 hours before being commissioned by the Sheriffs Office." Policy 16-4.4-C.1. [1]

❖ "Reserve deputies will wear the same uniform and ***carry the same equipment*** as the regular deputies with the exception that the reserve deputies will wear a badge with 'RESERVE' clearly marked." Policy 16-4.4-D.2.

❖ "All reserve deputies will be required to complete the two-hour mental health training annually." Policy 16-4.4-D.4.

❖ "All reserve deputies will be required to complete 23 hours of C.L.E.E.T. training and 2 hours of mental health training ***each year."*** Policy 16-4.4-D.6.

❖ "Reserve deputies will be tested for firearms proficiency ***at least annually*** during firearms qualifications arid adhere to the requirements and policies set forth in the Sheriffs Office policies and procedures." Policy 16-4.4-D.7.a.

❖ "Reserve deputies not completing C.L.E.E.T. mandated training of 23 hours continuing education, 2 hours mental health training and firearms qualification annually ***will be placed on suspension."*** Policy 16-4.4-D.8.

❖ ***"Reserve deputies will abide by the same code of ethics and rules and regulations as regular deputies."*** Policy 16-4.4-E.2.b.

(emphasis added).

---

[1] "C.L.E.E.T." is an acronym for the Council on Law Enforcement, Education and Training.

61. TCSO Reserve Deputies are divided into five (5) classifications: (A) Limited Service Basic Classification; (B) Basic Classification; (C) Intermediate Classification; (D) Advanced Classification; and (E) Transportation Reserve Deputy. *See, e.g.* Policy 16-4.4.-F.

62. The Advanced Classification "is the only reserve deputy classification that may perform normal field duties by themselves and without the direct supervision of a certified deputy." Policy 16-4.4.F.4.d. With the additional powers come additional and distinct prerequisites. In this regard, Advanced Reserve Deputies must *"complete and document **480 hours** of the TCSO Field Training Officer program."* Policy 16-4.4.F.4.c (emphasis added).

63. These Reserve Deputy policies, which are designed to protect the public, have been routinely and knowingly violated by Sheriff Glanz and TCSO for the benefit of Defendant Robert "Bob" Bates ("Bob Bates"). The knowing violation of these Reserve Deputy policies constitutes deliberate indifference to the Fourth Amendment rights of the public, including Eric Harris and Terry Byrum.

64. Over the years, several of Sheriff Glanz's close friends have served as Reserve Deputies. These include Bob Bates, County Assessor Ken Yazel and local attorney Reuben Davis.

The Seeds of Undue Influence: Bob Bates' Personal Relationship with Sheriff Glanz and "Donations" to TCSO

65. Bob Bates first became a TCSO Reserve Deputy in 2008. At the time, Bates was sixty-six (66) years old.

66. Sheriff Glanz's personal relationship with Bates began long before 2008.

67. According to Sheriff Glanz's own public statements, he has been friends with Bob Bates for approximately fifty (50) years. Bates is a wealthy insurance executive who has described his Reserve Deputy work as a "hobby".

68. Over the years, Sheriff Glanz has been on numerous vacations and trips with Bob Bates, including at least one trip to the Bahamas. Sheriff Glanz has stayed at Bates' home in Florida and goes fishing with Bates on a frequent basis.

69. In 2012, Bob Bates served as Chairman of Sheriff Glanz's Re-Election Committee. That same year, Bates donated $2,500 to Sheriff Glanz's campaign.

70. Over an extended period of time, TCSO has accepted many expensive gifts from Bob Bates. In 2009, Bates donated three (3) automobiles to TCSO's "Drug Task Force", two (2) Dodge Chargers and a Crown Victoria. Additionally, Bates donated a computer for placement in one of the new cars and a $5,000 "forensic camera" and lens kit.

71. In 2010, TCSO accepted a 2007 Ford F-150 and a 2010 Chevy Tahoe from Bates. That same year, Bates donated a hand-held radio "to be used by the drug unit for surveillance work…."

72. In 2011, Bates donated a 1997 Toyota Avalon to TCSO for "use as an undercover car by the drug task force."

73. Bates has also donated multiple pistols, a "key fob" covert video recorder, covert video recorder Oakley glasses and a pepper ball gun.

74. Moreover, there is evidence that Bates has given expensive gifts and/or other benefits to former TCSO Undersheriff and Chief Deputy Tim Albin ("Albin") and former TCSO Major Tom Huckeby ("Huckeby"). Huckeby was Bates' supervisor on TCSO's Violent Crimes Task Force. On information and belief, Bates has assisted high ranking TCSO employees with the payment of their mortgages, permitting these high ranking employees to live well above their means.

The Reserve Deputy Program, "Political Patronage" and a History of Problems

75. Several years before Bob Bates joined TCSO as a Reserve Deputy, another Reserve Deputy, and close friend of Sheriff Glanz's, found himself in embroiled in controversy.

76. As noted, County Assessor Ken Yazel, a friend of Sheriff Glanz, has served as a Reserve Deputy. As Sheriff Glanz has publicly admitted, he "helped" Yazel get elected as County Assessor. After Yazel was elected, he hired Sheriff Glanz's wife. In turn, Sheriff Glanz later hired Yazel's wife. Though Yazel's spouse was hired as an entry level employee with TCSO, she was paid around two times (2X) what such entry level employees are to be paid pursuant to policy. Sheriff Glanz provided Yazel's wife with additional preferential treatment by waiving the educational requirements for her position.

77. Sheriff Glanz has also publicly admitted that he appoints supporters to assessor positions as a "political patronage". These appointments have included ***Bob Bates' daughter***, Reserve Deputy Reuben Davis and the

wife and daughter of Clark Brewster (an attorney who represents Sheriff Glanz in multiple civil rights lawsuits and represents Bob Bates in criminal and civil cases). These "political patronage" positions pay upwards of $51,000 annually for as little as one (1) day of work per week. Glanz appoints these supporters to assessor positions despite the fact that he does not know what the job entails. It is unclear what, if any, role the County Assessor, Mr. Yazel, has in supervising Glanz's "political patronage" appointees.

78. In 2005, Yazel was involved in a shooting while on duty as a TCSO Reserve Deputy. At the time, Yazel was purportedly supporting a task force in the arrest of a man -- Danny Foutch -- in Okmulgee County on a Tulsa County warrant. Yazel was one of ***six (6) Reserve Deputies*** on the scene of this dangerous arrest. Though some of the facts surrounding the incident remain unresolved, there is no dispute that Yazel shot Foutch in the hip.

79. After the shooting, Okmulgee County Sheriff Eddy Rice disputed aspects of the incident and questioned the conduct of the TCSO Reserve Deputies on the scene. Sheriff Rice specifically noted that there were two (2) other accidental shots fired during the incident -- in addition to the shot that injured Foutch -- which heightened the dangerousness of the situation and seemed to evince inadequate training of the Reserve Deputies. Based on these concerns, Sheriff Rice demanded an investigation into TCSO's Reserve Deputy Program.

80. Though the shooting was ostensibly "investigated" by TCSO, on information and belief, Foutch was never interviewed. Further, on

information and belief, TCSO conducted no meaningful investigation of its Reserve Deputy Program in response to the incident. On information and belief, the crime scene was illegally manipulated and tampered with in an effort to secure a criminal conviction against Foutch. On information and belief, TCSO did not meaningfully change its Reserve Deputy Program in response to the shooting.

81. Yazel is currently on TCSO's active Reserve Deputy roster.

Special Treatment, an Atmosphere of Intimidation and the Falsification of Training Records / The IA Investigation and Report

82. As noted *supra*, Bob Bates joined TCSO's Reserve Deputy Program in 2008, at the age of sixty-six (66).

83. From the beginning of his tenure as a Reserve Deputy, it was clear that, contrary to TCSO's written policies, Bates would be given highly preferential treatment and would ***not*** "adhere to and be accountable for all [TCSO] policies, rules and regulations, standard operating procedures, and local, state and federal laws." Policy 16-4.1.

84. In 2009, an internal affairs ("IA") investigation was conducted by TCSO concerning two issues: (1) whether Bates was "treated differently than other Reserve Deputies in the past…"; and (2) whether there was "any pressure exerted on any employees by [TCSO] supervisors to aid Reserve Deputy Bates in this regard." IA Report at 1. Ultimately, as documented in a August 12, 2009 Report ("IA Report), IA Investigator Rob Lillard found: "policy has been violated and continues to be violated by both Capt. Tom Huckeby and Chief Deputy Tim Albin with regard to special treatment

shown to Reserve Deputy Robert Bates with regard to his field training" and that Albin had created "an atmosphere in which employees were intimidated to fail to adhere to policies in a manner which benefits Reserve Deputy Bates." *Id.* at 11.

85. The IA Report, including the attached evidentiary materials, contains disturbing details surrounding Bates' field training, or lack thereof.

86. As part of the IA investigation, Lillard interviewed Sergeant Randy Chapman, who was, at pertinent times, TCSO's Reserve Deputy Coordinator. Chapman quickly noted several concerns about Reserve Deputy Bates. First, Bates was admitted to the Reserve Deputy Program without Chapman's knowledge. According to Chapman, as the Reserve Coordinator, he should have been notified of Bates' entry into the Program. Second, after Chapman explained the Program's rules to Bates, he learned that ***"Bates was driving a personally owned car with police equipment prior to achieving the necessary level to do so."*** Upon discovery of this, on December 17, 2008, Chapman wrote a memorandum to TCSO Captain Larry Merchant, characterizing TCSO's favoritism toward Bates as "deliberate indifference" and inquiring, *"[w]hat is the purpose of having policy if members of [TCSO] do not follow it and we as supervisors allow violations because of who the persons are?"* Third, Bates was performing traffic stops and operating in the field without direct supervision, in violation of Policy. As noted above, only *Advanced* Reserve Deputies, with at least 480 hours of field training, "may perform normal field duties by themselves and without the direct

supervision of a certified deputy." Policy 16-4.4.F.4.d. After Bates expressed a desire to "stop vehicles and do patrol functions on his own", Chapman informed Bates that he would need to complete 480 hours of field training before he could operate in such a manner. Nevertheless, after this conversation with Bates, Chapman learned that Bates ***"was out stopping vehicles on his own without completing the [field training] program."*** When Chapman informed Bates that he could not make stops prior completing the training, Bates replied, *"Well I can do it and if you don't like it you can talk to Tim Albin or Sheriff Glanz because I'm going to do it".*

87. Chapman never received ***any*** documentation of Bates' field training. In addition, Chapman was advised by at least two (2) other deputies that Bates' field operations were "a little scary".

88. After Chapman went to then-Chief Deputy Albin with his concerns about Bates, he received only harassment and retaliation in return. Albin stated to Chapman, "This is a shit sandwich and you'll just have to eat it but not acquire a taste for it." At another point, Albin angrily stated, "I'm tired of you fucking with this guy [i.e., Bates] and I'm tired of your shit." On another occasion, Albin yelled at Chapman, "Your [sic] dicking with Bates ... you need to stop messing with him because he does a lot of good for the County." Ultimately, Albin told Chapman *"not to have any contact or talk with Bates at all, removing him (Chapman) from supervising [Bates]."*

89. Having nowhere else to turn, ***Chapman met directly with Sheriff Glanz to bring all the mounting issues concerning Bates to the***

Sheriff's attention. After Chapman met with Glanz, *no corrective action* was taken. Instead, Albin, in an obvious act of retaliation, "assigned [Chapman] to work a week of Midnight shift." Chapman was subsequently removed, completely, from the Reserve Deputy Program and transferred to Special Services. When Chapman asked why this transfer was being made, he was told, "Chief Albin does not want you to have any contact with Bob Bates anymore."

90. Chapman ***met with Sheriff Glanz for a second time*** to complain about the transfer from his position as Reserve Deputy Coordinator. However, yet again, Sheriff Glanz took no action. Chapman asked another supervisor, Captain Larry Merchant, if he could provide any assistance. Merchant replied that he could not do anything because "Bates has bought [then-Captain] Huckeby watches and takes [Albin and Huckeby] fishing and stuff." Chapman determined that "Albin and Huckeby had been bought off because ***Bates can do whatever he wants and there has [sic] been no consequences."***

91. Lillard also interviewed Sergeant Eric Kitch concerning Bob Bates. Kitch had supervisory authority over Bates. According to Kitch, upon Bates' hiring, he "did not complete an entry test or MMPI (mental evaluation) as stated by policy." This is confirmed by Bates' "Background Synopsis". Kitch was subsequently notified that Bates was operating as an Advanced Reserve, despite an apparent lack of training. Kitch specifically came to "doubt[] the training Bates received because there [were] ***no records or Daily Observation Reports."*** In addition, Kitch learned that Bates

had ***"fail[ed] to meet firearms requirements."*** Kitch never received any "documentation of Bates having received the required 480 hours of Field Training to achieve" Advanced Reserve status. Kitch documented these concerns in memoranda and voiced the concerns to TCSO supervisors. Yet again, no meaningful corrective action was taken. On the contrary, similar to the mistreatment encountered by Chapman, Kitch was chastised by Albin and relieved of any supervisory authority over Bates.

92. A letter written by TCSO Corporal Warren Crittenden on May 13, 2009, credited Bates with 328 training hours, though ***only 72 hours*** *of training* were documented. Crittenden was intimidated into signing off on Bates' field training though he knew the training was incomplete. According to the IA Report: "Crittenden was shown two memorandums apparently written by him in reference to Reserve Deputy Bates. He stated that ***he did not write either of them***. ... He was given them by Captain Huckeby and told to initial them." (emphasis added). Crittenden further noted that Bates was in need of remedial training as he was not good at traffic stops and operations. Crittenden stated that Bates was ***not capable of functioning in the field.*** Yet, despite his inadequacies and lack of documented field training, Bates was permitted to operate in the field "as a normal field trained Deputy." Again, per TCSO Policy, only Reserves who have obtained "Advanced" classification are "may perform normal field duties by themselves and without the direct supervision of a certified deputy." Policy 16-4.4.F.4.d.

93. In addition to the statements from Chapman, there is other evidence in the

IA investigation file that Sheriff Glanz had actual notice of serious concerns regarding Bates' lack of requisite training. Specifically, on August 5, 2009, TCSO Deputy Bonnie Fiddler wrote a memorandum to Sheriff Glanz indicating that an in-service training certificate for Bates, which was signed by Sheriff Glanz and Albin, was falsified.

94. More generally, on July 1, 2009, Sheriff Glanz met with twenty (20) TCSO employees to discuss "concerns with illegal, unethical and unprofessional issues with [the] Services Division." In a follow-up email to Sheriff Glanz from Sergeant Chis Maxey, dated August 5, 2009, it was clarified that the concerns centered on Albin's intimidation tactics and misrepresentation of the TCSO Academy curriculum.

95. Despite these serious known concerns about Bates' lack of training and inadequate supervision, Sheriff Glanz took no discernable corrective action. Bates was permitted to continue operating as an Advanced Reserve Deputy, without the required training. In fact, Bates later went on to join the Drug Task Force and Violent Crimes Task Force, regularly and actively participating in highly dangerous arrests and other operations, in spite of his lack of training and advanced age.

96. The IA Report, documenting Lillard's findings concerning Bates, was submitted to then-Undersheriff Brian Edwards on August 12, 2009. TCSO's public statements about the IA Report have been inconsistent, false and misleading. Initially, TCSO denied that the IA Report existed. Later, Sheriff Glanz conceded that an investigation occurred, but TCSO claimed that the Report could not be located. After the IA Report was

released to the public (by the press), on April 24, 2015, Sheriff Glanz's spokesman claimed that Sheriff Glanz had never seen it before. ***Glanz later admitted that he had seen the IA Report, though he did not read it "word for word", around the time it was issued.*** *See* Tulsa World TV Interview.

97. Sheriff Glanz was put on notice of additional evidence that Huckeby was harassing and intimidating TCSO employees and assaulting African-American inmates. In 2008, Sheriff Glanz pledged that he would investigate allegations from an African-American TCSO supervisor of harassment, intimidation, retaliation and a racially hostile working environment encouraged by Huckeby at the Jail. In 2010, a former TCSO employee at the Jail signed a sworn affidavit, which was filed in litigation against Sheriff Glanz, testifying to Huckeby's excessive use of force against African-American inmates and acts of intimidation against employees.

98. Huckeby was not disciplined for his known pattern of gross misconduct. Neither Huckeby nor Albin were punished for their transgression in covering up and falsifying Bates' training records. There were no repercussions for Albin and Huckeby's intimidation of TCSO employees on Bates' behalf. On the contrary, both ***Albin and Huckeby were*** subsequently ***promoted*** (Albin to Undersheriff and Huckeby to Major).

99. In this sense, Glanz ratified Albin and Huckeby's decisions -- and the bases for them -- in their handling of Bob Bates.

100. In sum, Sheriff Glanz knew, at least by August 2009, that Bates had received special treatment, did not have the requisite training necessary to

operate as an Advanced Reserve and was not being adequately supervised. Simply put, Sheriff Glanz knew that allowing Bates to operate as an Advanced Reserve Deputy posed an excessive and substantial risk that citizens' constitutional rights would be violated. Yet, Sheriff Glanz utterly disregarded these known and substantial risks.

The Terry Byrum Incident

101. Thursday, February 12, 2015, began as a ordinary day for Plaintiff Terry Byrum ("Byrum"). At around 12:30 pm, Byrum, along with his girlfriend Heather and her friend, Jennifer, drove to the nearby Warehouse Market, located around 6700 N. Peoria, to do some grocery shopping. At the time Byrum was driving Heather's white Ford Thunderbird.

102. As Byrum was standing in line at the grocery store, he looked out of the window and noticed a black Chevrolet Tahoe circling around his girlfriend's Thunderbird in the parking lot.

103. After Byrum purchased his groceries, he got in the Thunderbird and began driving back to the residence where he was staying at the time. He pulled into a local residential area and noticed a white marked Tulsa County Sheriff's Office ("TCSO") vehicle pursuing with its blue and red lights flashing. Byrum immediately pulled off of the street into a residential driveway and stopped the Thunderbird.

104. After stopping, Byrum, Heather and Jennifer were all ordered out of the car by TCSO Deputy Evan Foster. Byrum complied with the order and exited the vehicle. Shortly thereafter, the same black Tahoe he had

seen earlier at the grocery store arrived at the stop. An older man, later identified as Defendant Bob Bates, exited the Tahoe and began speaking with Heather and Jennifer.

105. Immediately upon exiting the Thunderbird, Byrum was handcuffed and placed under arrest. Deputy Foster patted Byrum down, but found no contraband or weapons. When Byrum asked why he had been arrested, Deputy Foster stated, "you were driving with a suspended license." However, at this point, Byrum had not revealed that he was driving with a suspended license.

106. After handcuffing Byrum, Deputy Foster began walking Byrum to his TCSO vehicle. Byrum saw that Heather and Jennifer were standing outside of the Thunderbird and speaking to Bob Bates. Byrum turned his head and asked Heather to make arrangements to have him bonded out of Jail.

107. After Byrum turned his head to talk to Heather, Deputy Foster forcefully took Byrum down onto the pavement. Byrum was surprised by this as he had not resisted arrest, attempted to flee or threatened Deputy Foster in any way.

108. After Deputy Foster forcibly took Byrum down to the pavement, he placed his knee into Byrum's back. At this time, Byrum was lying on his stomach, handcuffed, unarmed and not resisting. Nonetheless, a second officer, now known to be former Reserve Deputy Bob Bates, approached and placed his foot on the back of Byrum's head / upper neck. Byrum was completely subdued by the point. Still, one of the officers stated, "tase

him", and Bates proceeded to administer his Taser on Byrum's leg. Byrum screamed out in pain. It felt like he had been electrocuted.

109. The force used by Bates was objectively unreasonable. Bates' use of a Taser on Byrum when he was handcuffed, on the ground and subdued was completely unnecessary. Because Byrum did not pose any immediate threat and was not actively resisting arrest, Bates had no reasonable basis to employ *any* force on Byrum. The use of a Taser under the circumstances constitutes clearly excessive use of force.

110. After Bates Tased Byrum, Bates and Foster stood Byrum up and he was transferred to TCSO headquarters for questioning. Byrum was interrogated by TCSO Deputy Lance Ramsey. Ramsey claimed that they served two search warrants and uncovered a meth lab and drugs at Byrum's purported residence. Ramsey further stated, "we lost some dope, what happened to it?" Byrum had, and to this day has, no idea what Ramsey was referring to.

111. While Byrum remains in custody on pre-existing "Light Horse Warrants", *he was never charged with any crime in connection with the February 12 arrest*.

112. On February 13, 2015, Deputy Foster drafted a probable cause affidavit in connection with Byrum's arrest. The probable cause affidavit, which was never filed because the District Attorney declined to file charges, contains misinformation. Notably, Foster asserts, "Deputy Bob Bates … ***had*** to taser [Byrum] *to get him to comply* with verbal commands." While it is true that Bates "taser[ed]" Byrum, it is untrue that

Bates did so to get Byrum to comply. Again, at the time of this use of force, Byrum was not resisting, was handcuffed and subdued.

113. No one from TCSO ever interviewed Byrum concerning Reserve Deputy Bates' use of force. On information and belief, the use of force on Byrum was not investigated by TCSO. On information and belief, Bates was not disciplined as a result of his excessive use of force on Byrum. On information and belief, Bates was not provided any remedial training as a result of the use of force on Byrum.

114. Byrum has suffered injuries as a direct and proximate result of Bates' unreasonable and excessive use of force, and Sheriff Glanz's unconstitutional failure to train and failure to supervise Bates.

The Eric Harris Incident

115. On April 2, 2015, TCSO's Violent Crimes Task Force was involved in a sting operation targeting Eric Harris. Specifically, an undercover officer had arranged to purchase a firearm from Mr. Harris in the parking lot of a Dollar General store in North Tulsa. Remarkably, the Violent Crimes Task Force[2] chose to conduct this ostensibly dangerous sting operation in close proximity to Celia Clinton Elementary School, while children were outside on the playground. No one from TCSO provided any advance notice of the sting operation to Celia Clinton Elementary School or Tulsa Public Schools, needlessly placing these young children in danger.

116. A "key fob" covert camera -- which, ironically enough, was donated

[2] There is also evidence that, at the urging of Bates, the Violent Crimes Task Force improperly and illegally assisted the law firm of Brewster & DeAngelis in gaining an unfair advantage in unrelated domestic litigation.

to TCSO by Bates -- captured the first part of what would quickly become a tragic disaster. In the initial discussion between Mr. Harris and the undercover deputy, Mr. Harris indicates that he had brought a gun -- in a backpack -- to sell to the undercover officer. Importantly, Mr. Harris made it clear that this single firearm, a 9 millimeter Luger, was the ***only*** firearm he had in his possession. Mr. Harris can then be seen pulling the handgun out of a backpack and handing it to the undercover deputy.

117. After the gun was no longer in Mr. Harris' possession, an unmarked car sped into the parking lot and abruptly stopped next to the undercover deputy's truck. Realizing that he had he had been tricked and that an arrest was likely imminent, Harris exited the truck and began to run north up a sidewalk and into the street. A second TCSO Deputy, Defendant Ricardo Vaca ("Vaca") pursued Mr. Harris, first in his vehicle, and then on foot. Though Vaca had less than one (1) year of experience as a TCSO Deputy at the time of the incident, he was already a member of the "elite" Violent Crimes Task Force. Sheriff Glanz has since publicly stated that a deputy with such minimal experience should not have been assigned to the Violent Crimes Task Force.

118. At the time of the pursuit, Vaca happened to be wearing covert video recorder glasses, which recorded a portion of the incident. Mr. Harris ran down the street, at a jogger's pace, for a short period of time. Mr. Harris was wearing a t-shirt and gym shorts, and was clearly unarmed. Vaca, who on information and belief is highly trained and skilled in martial arts, tackled Mr. Harris and quickly brought him down to the

ground.

119. According to Bates' own written statement, he had had driven to the location of the Dollar Store parking lot a short time after he heard that the "arrest team was moving in." With so many other deputies involved in the arrest -- including Vaca, Defendant Michael Huckeby ("M. Huckeby"), Defendant Joseph Byars ("Byars"), Evan Foster ("Foster"), Layman Boyd ("Boyd"), Lance Ramsey ("Ramsey") and Miranda Munson ("Munson") -- it is unclear why Bates, an undertrained 73-year-old Reserve Deputy, was deployed to the scene to begin with. In any event, Bates claims that he saw Vaca pursuing Mr. Harris, "grabbed [his] pepper ball launcher" and got out of his vehicle "[n]ot knowing whether the suspect would be caught by Vaca...."

120. By the time Bates walked up to the location where Vaca had tackled Harris, four (4) other deputies, M. Huckeby, Byars, Foster and Layman, had already arrived to assist. On information and belief, at least two (2) of these deputies, and perhaps all four (4), were physically holding Mr. Harris down on the pavement. Indeed, Foster was standing on Mr. Harris' legs, making it impossible for him to flee or actively resist.

121. Bates asserts in his written statement that when he walked up to the scene, he "drew what [he] thought was [his] TASER" with the intent of discharging the Taser into Mr. Harris' right shoulder. However, video of the incident proves that: (A) Bates is lying; or (B) Bates' purported "belief" that he drew his Taser was objectively unreasonable. As the video plainly shows, Bates' Taser, which is bright fluorescent yellow, was, at all times,

securely fastened to the front-upper-left side of his TCSO-issued protective vest. By contrast, TCSO deputies secure their firearms on the right hip, an obviously and distinctly different location than the front-upper-left side of a protective vest. In fact, Mr. Bates stated, and demonstrated, during a nationally-televised television interview with the Today Show, that he routinely keeps his Taser on the front-upper-left side of his protective vest, while keeping his firearm on his right hip toward the back.

122. Nonetheless, even accepting Bates' statements as true, Bates did ***not*** draw his Taser from the front-upper-left side of his protective vest. Rather, according to Bates' own statement, ***he drew a Smith & Wesson .357 revolver from a holster on his right hip.*** The .357 revolver was Bates' own personal firearm. It was not issued to him by TCSO. Consistent with Sheriff Glanz/TCSO's failure to train and supervise Bates, and in violation of TCSO Policy, there is no evidence that Bates was ever trained or certified to use the .357 revolver as his service weapon.

123. Further, the Smith & Wesson .357 revolver was not on the list of approved firearms deputies can carry on duty.

124. The appearance of Bates' .357 revolver is vastly different than the appearance of his Taser. While the .357 is dark grey and metallic, the Taser is bright yellow and plastic. In addition, the grips on the two weapons are different, much shorter on the Taser.

125. When one considers the differences between the location, appearance and feel of the two weapons, no reasonable officer could have mistaken the .357 for a Taser.

126. Contrary to Bates' statement that he "drew" the .357 revolver after exiting his vehicle, statements from former TCSO Detective Billy McKelvey indicate that Bates grabbed the gun from his truck and had it in his right hand from the moment he left his vehicle.

127. Accepting Bates' version of events, after Bates drew his .357 revolver, ***he shot Mr. Harris, at close range, in the back, under his right arm.*** Under McKelvey's version of events, Bates did not "draw" the .357, but shot Mr. Harris with the .357 already in his hand as he approached Harris on foot. Under *either* scenario, Bates' use of force of force was excessive and objectively unreasonable.

128. The use of the unapproved .357 revolver, which Bates was not trained or certified to use as his service weapon, was objectively unreasonable and excessive under the circumstances. Specifically, at the time of the shooting, Harris was unarmed, not fleeing and had been subdued by the other deputies on the scene. In fact, because Bates did not have the requisite training or certification to use the .357 revolver, it would have been objectively unreasonable for Bates to discharge the weapon under ***any*** circumstances.

129. Moreover, even if Bates had used his Taser, as was his claimed intent, the use of a Taser under the circumstances would have been objectively unreasonable and excessive.

130. The sound of the gunshot can be clearly heard from the audio picked up by Vaca's video recorder glasses. After Harris was shot, he repeatedly told the deputies he had been shot -- yelling, "He shot me!" --

and blood could be seen trickling down his right arm. Bates can be heard on the video saying he had shot Harris, stating: "Oh, I shot him. I'm sorry." Harris can be heard saying, "I'm losing my breath," to which a Byars callously replies, ***"Fuck your breath!"***

131. M. Huckeby is shown in the video kneeling on Harris' head, with all of his weight, as one of the deputies yells at Harris, "You shouldn't have ran," and "Shut the fuck up."

132. The force used by M. Huckeby in kneeling on Mr. Harris' head, after he had been subdued and shot in the back by Bates, was objectively unreasonable and excessive. While Sheriff Glanz has publicly attempted to defend M. Huckeby's use of force by stating "that's simply a tactical move that controls that person when they're down," (See Pat Campbell Interview), the Director of CLEET would disagree. In a story posted to radio station KFAQ's website, CLEET Director Steve Emmons is quoted as saying, that CLEET trainers ***"never teach anything with the head or the neck as a control point*** ... [i]t's all done with the shoulder and the upper back." (emphasis added).

133. Bates, Vaca, M. Huckeby and Byars were all deliberately indifferent to Mr. Harris', obvious, known and serious medical needs. These deputies wasted valuable time in getting Harris the emergency medical treatment he obviously needed after being shot. Rather than assure that Harris received timely medical attention for his life-threatening injuries, Byars screamed and cursed at Harris as he was rapidly approaching death in the street. M. Huckeby forcefully grinded Harris' head into the concrete with

his knee while he was in need of emergency medical attention.

134. Neither M. Huckeby nor Byars was disciplined for their heinous misconduct. M. Huckeby was not properly trained in the use of force in deliberate indifference to the strong likelihood of constitutional violations.

135. Indeed, M. Huckeby and Vaca should not have been involved in the arrest to begin with. While both M. Huckeby and Vaca were being paid out of the Sheriff's Jail operations fund, they were improperly serving in the field with the Violent Crimes Task Force. In addition, while on the Task Force, M. Huckeby was being supervised by his father, Tom Huckeby. Sheriff Glanz has publicly admitted that this was improper. Additionally, neither M. Huckeby nor Vaca had sufficient time working in the field to be assigned to the Violent Crimes Task Force.

136. At approximately 10:13 am, Emergency Medical Services Authority ("EMSA") was called. EMSA arrived at the scene at approximately 10:20am, and found Mr. Harris lying in the street in shackles. EMSA personnel noted that Harris had a "gunshot wound to the right armpit that had blood oozing from" it; Mr. Harris became "unresponsive, pulseless". First responders attempted to revive Mr. Harris to no avail.

137. Mr. Harris was transported to St. Johns Hospital, where additional attempts at resuscitation were unsuccessful. Harris was pronounced dead at 11:06 am.

138. The Medical Examiner determined the cause of death to be a "gunshot wound to the right axilla".

139. Mr. Harris died as proximate result of Bates' unreasonable and

excessive use of force, and Sheriff Glanz's unconstitutional failure to train and failure to supervise Bates.

140. Mr. Harris was injured as a proximate result of M. Huckeby's unreasonable and excessive use of force, and Sheriff Glanz's unconstitutional failure to train and failure to supervise M. Huckeby.

141. Mr. Harris suffered injuries as a proximate result of Bates, Vaca, M. Huckeby and Byars' deliberately indifference to Mr. Harris, obvious, known and serious medical needs.

142. Overall, Sheriff Glanz and TCSO have provided highly preferential treatment to Bates by knowingly failing to enforce their own Reserve Deputy Policies, training and supervision requirements for the benefit of Bates. In utter disregard for the known, obvious and substantial risks to the public, Glanz and TCSO permitted Bates to repeatedly participate in highly dangerous law enforcement operations, without the necessary supervision, training or certification. In essence, Bob Bates was not adequately trained, Sheriff Glanz/TCSO acted to cover this up, and Sheriff Glanz/TCSO knowingly and dangerously allowed an undertrained and under-qualified 73-year old insurance executive to play cop. Eric Harris died as a result.

CAUSES OF ACTION

A. Plaintiff Birdwell

NEGLIGENCE
(Defendants BOCC, ARMOR, Unknown Physician #1 and Unknown Nurse #1)

143. Paragraphs 1-142 are incorporated herein by reference.

144. Defendants BOCC and ARMOR are vicariously liable for the acts of its employees and/or agents under the doctrine of *respondeat superior*.

145. Defendants BOCC and ARMOR, through their employees and/or agents at the Tulsa County Jail, owe a duty to Birdwell, and all other inmates incarcerated at the Tulsa County Jail, to tender medical treatment with reasonable care, taking caution not to cause additional harm during the course of medical treatment.

146. As described herein, BOCC and ARMOR, through their employees and/or agents, particularly Defendant Unknown Attending Physician #1 and Defendant Unknown Nurse #1, breached their duty to Birdwell, and all other inmates, by failing to provide competent medical treatment as required by applicable standards of care, custom and law.

147. Defendant Unknown Attending Physician #1 and Defendant Unknown Nurse #1, both agents and/or employees of BOCC and ARMOR, failed to provide adequate or timely evaluation and treatment, even as Birwell's known medical condition deteriorated and he had specifically requested medical attention while in TCSO's custody. Defendant Unknown Attending Physician #1 and Defendant Unknown Nurse #1, both agents and/or employees of BOCC and ARMOR, failed to reasonably or timely treat Birdwell's serious medical condition, and prevented his timely transfer to a medical facility for proper care.

148. Defendants' negligence is the direct and proximate cause of Birdwell's injuries.

149. As a result of Defendant's negligence, Birdwell has suffered damages.

CRUEL AND UNUSUAL PUNISHMENT IN VIOLATION OF THE EIGHTH AND/OR FOURTEENTH AMENDMENT TO THE CONSTITUTION OF THE UNITED STATES (42 U.S.C. § 1983) (Defendants Glanz, BOCC, ARMOR, Unknown Physician #1 and Unknown Nurse #1)

150. Paragraphs 1-149 are incorporated herein by reference.

151. Defendants knew there was a strong likelihood that Birdwell was in danger of serious personal harm due to the head injuries he suffered after being assaulted by an inmate. Birdwell had obvious, serious and emergent medical issues that were known or obvious to Defendants following the assault. The inmate hit Birdwell with an unidentified object, using enough force to cause a serious laceration above Birdwell's left eye. This assault required twenty-three (23) stitches to the region above Birdwell's left eye. Furthermore, Birdwell complained of pain and a significant loss of vision in his left eye over the course of waiting for further treatment.

152. Birdwell voiced his concerns repeatedly over the course of his treatment. After receiving stitches for the laceration over his left eye, Birdwell was denied further examination despite his multiple pleas to the medical staff to have his head and eye examined at the hospital. Any person of reasonable prudence would determine that Plaintiff was at a serious risk for a head injury that would require further medical diagnosis and treatment.

153. Further, Birdwell's injuries deteriorated rather than improved

under the care of Defendants Unknown Nurse #1 and Attending Physician #1. In fact, along with the mistakes that both Defendant's made during the course of Plaintiff's treatment, the medical staff made comments to Plaintiff during his treatment that caused Birdwell to doubt Defendant Unknown Nurse #1 and Unknown Attending Physician #1's professional competency.

154. However, Defendants repeatedly disregarded the known and obvious risks to Birdwell's health and safety. As documented herein, Defendants did nothing as the state of Birdwell's injuries declined. This indifference is evidenced by the Birdwell's failure to provide further medical treatment to Birdwell, despite the clear evidence that Birdwell suffered a serious head injury as a result of the assault, of which would require Birdwell to be examined at a hospital with the necessary diagnostic equipment and personnel.

155. As a direct and proximate result of Defendants' conduct, Birdwell experienced physical pain, severe emotional distress, mental anguish, loss of his health, and the damages alleged herein.

156. As a direct and proximate result of Defendants' conduct Birdwell has suffered damages and is entitled to pecuniary and compensatory damages. Birdwell is entitled to damages due to the Defendant's deprivation of Birdwell's rights secured by the Fourth, Sixth, and Eighth Amendments through Fourteenth Amendment of the U.S. Constitution.

SUPERVISOR LIABILITY/OFFICIAL CAPACITY LIABILITY
(42 U.S.C. § 1983)
(Sheriff Glanz)

157. Paragraphs 1-153 are incorporated herein by reference.

158. There is an affirmative link between the aforementioned acts and/or omissions of Defendants in being deliberately indifferent to Birdwell's serious medical needs, health and safety and policies, practices and/or customs which Defendant Sherriff Stanley Glanz promulgated, created, implemented and/or possessed responsibility for (*See* ¶¶ 39-55, *supra*)

159. Defendant Glanz 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 inmates like Birdwell.

160. Defendant Glanz disregarded the known and/or obvious risks to the health and safety of inmates like Birdwell.

161. Defendant Glanz, through his continued encouragement, ratification, and approval of the aforementioned policies, practices, and/or customs, in spite of their known and/or obvious inadequacies and dangers, was deliberately indifferent to inmates', including Birdwell's, serious medical needs.

162. There is an affirmative link between the unconstitutional acts of their subordinates and Defendant Glanz's adoption and/or maintenance of the aforementioned policies, practices and/or customs.

163. As a direct and proximate result of the aforementioned policies, practices and/or customs, Birdwell suffered injuries and damages as

alleged herein.

MUNICIPAL LIABILITY
(as to ARMOR)
(42 U.S.C. § 1983)

164. Paragraphs 1-163 are incorporated herein by reference.

165. ARMOR is a "person" for purposes of 42 U.S.C. § 1983.

166. At all times pertinent hereto, ARMOR was acting under color of state law.

167. ARMOR has been endowed by Tulsa County with powers or functions governmental in nature, such that ARMOR became an instrumentality of the State and subject to its constitutional limitations.

168. ARMOR is charged with implementing and assisting in developing the policies of Sheriff Glanz/TCSO with respect to the medical and mental health care of inmates at the Tulsa County Jail and has shared responsibility to adequately train and supervise its employees.

169. There is an affirmative causal link between the aforementioned acts and/or omissions in being deliberately indifferent to Birdwell's serious medical needs, health, and safety, and violating Plaintiff's civil rights and above-described customs, policies, and/or practices carried out by ARMOR.

170. ARMOR 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 inmates like Birdwell. Nevertheless, ARMOR failed to take reasonable steps to alleviate those

risks in deliberate indifference to inmates', including Birdwell's, serious medical needs.

171. ARMOR tacitly encouraged, ratified, and/or approved of the acts and/or omissions alleged herein.

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

B. Plaintiff Burke (for the Estate of Mr. Harris)

EXCESSIVE USE OF FORCE
(Fourth Amendment; 42 U.S.C. § 1983)
(Bates, M. Huckeby and Glanz
(supervisory liability and official capacity))

173. Paragraphs 1-172 are incorporated herein by reference.

174. At the time of the complained of events, Mr. Harris, as a free person, had a clearly established constitutional right under the Fourth Amendment to be secure in his person and free from unreasonable seizure through objectively unreasonable excessive force to injure him and his bodily integrity.

175. Any reasonable police officer knew or should have known of these rights at the time of the complained of conduct as they were clearly established at that time.

176. In the totality of the circumstances, at the time that deadly force was used by Bob Bates, Mr. Harris was unarmed, had been subdued by as many as four (4) deputies, and thus, posed no immediate threat, was not actively resisting and was no longer attempting to evade TCSO by flight.

177. The use of deadly force by Bates under such circumstances was excessive and objectively unreasonable.

178. In fact, because Bates did not have the requisite training or certification to use the .357 revolver, it would have been objectively unreasonable for Bates to discharge the weapon under ***any*** circumstances.

179. Even accepting the claim that Bates mistakenly drew, or grabbed, his .357 revolver, believing it to be his Taser, such mistake was objectively unreasonable.

180. Further, even if Bates had deployed his Taser instead of his .357 revolver, such use of force would have been excessive and objectively unreasonable under the circumstances.

181. The force used by M. Huckeby in kneeling on Mr. Harris' head, after he had been subdued and shot in the back by Bates, was objectively unreasonable and excessive, contrary to training and established standards of law enforcement practice.

182. Bates and M. Huckeby seized Mr. Harris by means of objectively unreasonable, excessive physical force, thereby unreasonably restraining Mr. Harris of his freedom and causing him very serious and multiple bodily injuries, as well as mental pain and anguish.

183. The use of force, as described herein, also involved reckless, callous, and deliberate indifference to Mr. Harris' federally protected rights.

184. As a direct proximate result of Bates' unlawful conduct, Mr. Harris suffered actual physical injuries (including death), mental and physical

pain and suffering and other damages and losses as described herein entitling Ms. Burke to recover compensatory and special damages on behalf of Mr. Harris' Estate, in amounts to be determined at trial.

185. As a direct proximate result of M. Huckeby's unlawful conduct, Mr. Harris suffered actual physical injuries, mental and physical pain and suffering and other damages and losses as described herein entitling Ms. Burke to recover compensatory and special damages on behalf of Mr. Harris' Estate, in amounts to be determined at trial.

186. As a further result of the Defendants' unlawful conduct, Ms. Burke is entitled to recover special damages, including medically related and funeral expenses, in amounts to be established at trial.

187. Ms. Burke is entitled to punitive damages on her claims brought pursuant to 42 U.S.C. § 1983 as Defendants' conduct, acts and omissions alleged herein constitute reckless or callous indifference to Mr. Harris' federally protected rights.

DELIBERATE INDIFFERENCE TO SERIOUS MEDICAL NEEDS
(Fourteenth Amendment; 42 U.S.C. § 1983)
(Bates, M. Huckeby, Byars, Vaca and Glanz
(supervisory liability and official capacity))

188. Paragraphs 1-187 are incorporated herein by reference.

189. It is well-established that arresting police officers may be held liable for being deliberately indifferent to an arrestee's serious medical needs. *See, e.g., Olsen v. Layton Hills Mall,* 312 F.3d 1304, 1315-17 (10th Cir. 2002); *Garcia v. Salt Lake County,* 768 F.2d 303 (10th Cir.1985); *Prado v. Lane,* 98 F. App'x 757, 759-60 (10th Cir. 2004).

190. As described *supra*, Bates, Vaca, M. Huckeby and Byars were all deliberately indifferent to Mr. Harris' obvious, known and serious medical needs. These deputies wasted valuable time in getting Harris the emergency medical treatment he obviously needed after being shot. Rather than assure that Harris received timely medical attention for his life-threatening injuries, Byars screamed and cursed at Harris as he was rapidly approaching death in the street. M. Huckeby forcefully grinded Harris' head into the concrete with his knee while he was in need of emergency medical attention.

191. These Defendants exacerbated Mr. Harris' injuries and pain and suffering in deliberate indifference to his serious and emergent medical needs.

192. As a direct proximate result of these Defendants' deliberate indiffernce, Mr. Harris unnecessarily suffered prolonged exacerbated mental and physical pain and suffering and other damages and losses as described herein entitling Ms. Burke to recover compensatory and special damages on behalf of Mr. Harris' Estate, in amounts to be determined at trial.

193. Ms. Burke is entitled to punitive damages on her claims brought pursuant to 42 U.S.C. § 1983 as Defendants' conduct, acts and omissions alleged herein constitute reckless or callous indifference to Mr. Harris' federally protected rights.

SUPERVISOR LIABILITY/OFFICIAL CAPACITY LIABILITY
(42 U.S.C. § 1983)
(Sheriff Glanz)

194. Paragraphs 1-193 are incorporated herein by reference.

195. There is an affirmative link between the aforementioned excessive force utilized by Bates and M. Huckeby and policies, practices and/or customs which Defendant Sherriff Stanley Glanz promulgated, created, implemented and/or possessed responsibility for.

196. Defendant Glanz 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 citizens like Mr. Harris.

197. Defendant Glanz disregarded the known and/or obvious risks to the health and safety of citizens like Mr. Harris.

198. First, Sheriff Glanz failed to properly train Bates and M. Huckeby. As set forth *supra*, the training was in fact inadequate, and: (A) Bates and M. Huckeby exceeded constitutional limitations on the use of force; (B) the use of force arose under circumstances that constitute a usual and recurring situation with which deputies, particularly deputies on the Violent Crimes Task Force, must deal; (C) the inadequate training demonstrates a deliberate indifference on the part of Sheriff Glanz toward persons with whom the deputies come into contact, and (D) there is a direct causal link between the constitutional deprivation and the inadequate training.

199. Second, Sheriff Glanz failed to adequately supervise Bates and M. Huckeby. As set forth Sheriff Glanz utterly failed to assure that Bates and M. Huckeby were properly and adequately supervised, despite their known

lack of training and enhanced risks they posed to the public, which amounts to deliberate indifference to the federal rights of persons with whom the TCSO deputies come into contact. Further, there is a direct causal link between the constitutional deprivation and the inadequate supervision.

200. Third, by the time that Mr. Harris was shot dead in the street, there was an established and unabated custom of excessive use of force by TCSO Reserve Deputies. These prior instances of excessive force put Sheriff Glanz on notice that the Reserve Deputies, including Bates, were inadequately trained and/or supervised with respect to the use of force. Sheriff Glanz knew that there were serious deficiencies with the Reserve Deputy Program that created excessive risks, but he failed to alleviate those risks.

201. Fourth, Sheriff Glanz knowingly failed to enforce policies necessary to the safety of citizens like Mr. Harris in deliberate indifference to their constitutional rights. More particularly, as summarized *supra*, Sheriff Glanz was notified that the TCSO Reserve Deputy Program policies with respect to field training, firearm certification and supervision were being violated to the benefit Bates. The obvious purpose behind these policies is to ensure that Reserve Deputies, like Bates, have all the needed training certifications and supervision so that citizens who encounter Reserve Deputies are not placed in enhanced danger that their constitutional rights will be violated. Sheriff Glanz disregarded these risks by knowingly failing to enforce TCSO Reserve Deputy Policies, training and supervision

requirements for the benefit of Bates. In utter disregard for the known, obvious and substantial risks to the public, Glanz and TCSO permitted Bates to repeatedly participate in highly dangerous law enforcement operations, without the necessary supervision, training or certification. This failure to enforce policy was a proximate cause of Mr. Harris' death.

202. Fifth, Sheriff Glanz ratified the decisions—and the basis for them—of subordinates to whom authority was delegated subject to his review and approval. More particularly, after receiving notice that Huckeby and Albin covered up Bates' lack of required training and supervision and intimidated and retaliated against TCSO employees on Bates' behalf, Glanz took no corrective action. On the contrary, both ***Albin and Huckeby were*** subsequently ***promoted*** (Albin to Undersheriff and Huckeby to Major). In this sense, Glanz ratified Albin and Huckeby's decisions -- and the bases for them -- in their handling of Bob Bates in deliberate indifference to the constitutional violations that were likely to result.

203. There is an affirmative link between the unconstitutional acts of his subordinates and Defendant Glanz's adoption and/or maintenance of the aforementioned policies, practices and/or customs.

204. As a direct and proximate result of the aforementioned policies, practices and/or customs, Mr. Harris suffered the injuries, including death, and damages as alleged herein.

205. Ms. Burke is entitled to punitive damages on her claims brought against Sheriff Glanz in his individual capacity as his conduct, acts and omissions alleged herein constitute reckless or callous indifference to Mr.

Harris' federally protected rights.

C. Plaintiff Byrum

EXCESSIVE USE OF FORCE
(Fourth Amendment; 42 U.S.C. § 1983)
(Bates and Glanz (supervisory liability and official capacity))

206. Paragraphs 1-205 are incorporated herein by reference.

207. At the time of the complained of events, Mr. Byrum, as a free person, had a clearly established constitutional right under the Fourth Amendment to be secure in his person and free from unreasonable seizure through objectively unreasonable excessive force to injure him and his bodily integrity.

208. Any reasonable police officer knew or should have known of these rights at the time of the complained of conduct as they were clearly established at that time.

209. In the totality of the circumstances, at the time that force was used by Bob Bates, Mr. Byrum was unarmed, handcuffed, on the ground and subdued. Because Byrum did not pose any immediate threat and was not actively resisting arrest, Bates had no reasonable basis to employ *any* force on Byrum. The placement of his foot on the back of Byrum's head/neck and use of a Taser under the circumstances constitutes clearly excessive use of force.

210. Bates seized Byrum by means of objectively unreasonable, excessive physical force, thereby unreasonably restraining Byrum of his freedom and causing him bodily injury, as well as mental pain and anguish.

211. As a direct proximate result of Bates' unlawful conduct, Byrum

suffered actual physical injuries, mental and physical pain and suffering and other damages and losses as described herein entitling Byrum to recover compensatory and special damages in amounts to be determined at trial.

SUPERVISOR LIABILITY/OFFICIAL CAPACITY LIABILITY
(42 U.S.C. § 1983)
(Sheriff Glanz)

212. Paragraphs 1-211 are incorporated herein by reference.

213. There is an affirmative link between the aforementioned excessive force utilized by Bates and policies, practices and/or customs which Defendant Sherriff Stanley Glanz promulgated, created, implemented and/or possessed responsibility for.

214. Defendant Glanz 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 citizens like Byrum.

215. Defendant Glanz disregarded the known and/or obvious risks to the health and safety of citizens like Byrum.

216. First, Sheriff Glanz failed to properly train Bates. As set forth *supra*, the training was in fact inadequate, and: (A) Bates exceeded constitutional limitations on the use of force; (B) the use of force arose under circumstances that constitute a usual and recurring situation with which deputies, particularly deputies on the Violent Crimes Task Force, must deal; (C) the inadequate training demonstrates a deliberate indifference on the part of Sheriff Glanz toward persons with whom the deputies come into contact, and (D) there is a direct causal link between

the constitutional deprivation and the inadequate training.

217. Second, Sheriff Glanz failed to adequately supervise Bates. As set forth Sheriff Glanz utterly failed to assure that Bates was properly and adequately supervised, despite the known lack of training and enhanced risks Bates posed to the public, which amounts to deliberate indifference to the federal rights of persons with whom the TCSO deputies come into contact. Further, there is a direct causal link between the constitutional deprivation and the inadequate supervision.

218. Third, by the time Bates used excessive force on Byrum, there was an established and unabated custom of excessive use of force by TCSO Reserve Deputies. The prior instance(s) of excessive force put Sheriff Glanz on notice that the Reserve Deputies, including Bates, were inadequately trained and/or supervised with respect to the use of force. Sheriff Glanz knew that there were serious deficiencies with the Reserve Deputy Program that created excessive risks to the public, but he failed to alleviate those risks.

219. Fourth, Sheriff Glanz knowingly failed to enforce policies necessary to the safety of citizens like Byrum in deliberate indifference to their constitutional rights. More particularly, as summarized *supra*, Sheriff Glanz was notified that the TCSO Reserve Deputy Program policies with respect to field training, firearm certification and supervision were being violated to the benefit of Bates. The obvious purpose behind these policies is to ensure that Reserve Deputies, like Bates, have all the needed training, certifications and supervision so that citizens who encounter

Reserve Deputies are not placed in enhanced danger that their constitutional rights will be violated. Sheriff Glanz disregarded these risks by knowingly failing to enforce TCSO Reserve Deputy Policies, training and supervision requirements for the benefit of Bates. In utter disregard for the known, obvious and substantial risks to the public, Glanz and TCSO permitted Bates to repeatedly participate in highly dangerous law enforcement operations, without the necessary supervision, training or certification. This failure to enforce policy was a proximate cause of Byrum's injuries.

220. Fifth, Sheriff Glanz ratified the decisions—and the basis for them—of subordinates to whom authority was delegated subject to his review and approval. More particularly, after receiving notice that Huckeby and Albin covered up Bates' lack of required training and supervision and intimidated and retaliated against TCSO employees on Bates' behalf, Glanz took no corrective action. On the contrary, both ***Albin and Huckeby were*** subsequently ***promoted*** (Albin to Undersheriff and Huckeby to Major). In this sense, Glanz ratified Albin and Huckeby's decisions -- and the bases for them -- in their handling of Bob Bates in deliberate indifference to the constitutional violations that were likely to result.

221. There is an affirmative link between the unconstitutional acts of his subordinates and Defendant Glanz's adoption and/or maintenance of the aforementioned policies, practices and/or customs.

222. As a direct and proximate result of the aforementioned policies, practices and/or customs, Byrum suffered the injuries and damages as

alleged herein.

223. Byrum is entitled to punitive damages on his claims brought against Sheriff Glanz in his individual capacity as his conduct, acts and omissions alleged herein constitute reckless or callous indifference to Byrum's federally protected rights.

WHERFORE, based on the foregoing, Plaintiffs pray this Court grant them the relief sought, including but not limited to actual and punitive damages in excess of Seventy-Five Thousand Dollars ($75,000.00), with interest accruing from the date of filing suit, the costs of bringing this action, a reasonable attorneys' fee, along with such other relief as is deemed just and equitable.

Respectfully submitted,

SMOLEN, SMOLEN & ROYTMAN, PLLC

/s/Daniel E. Smolen
Daniel E. Smolen, OBA #19943
Donald E. Smolen, II, OBA #19944
Robert M. Blakemore, OBA #18656
701 S. Cincinnati Avenue
Tulsa, Oklahoma 74119
(918) 585-2667 P
(918) 585-2669 F

Attorneys for Plaintiffs