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

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

PLAINTIFF CHRISTINE HAMILTON F/K/A CHRISTINE WRIGHT'S RESPONSE IN OPPOSITION TO DEFENDANT CORRECTIONAL HEALTHCARE COMPANIES, INC.'S MOTION FOR SUMMARY JUDGMENT (DKT. #244)

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Introductory Statement

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

Plaintiff brings her constitutional claims, as Special Administrator of Ms. Salgado's Estate, against Defendant Correctional Healthcare Companies, Inc. ("CHC" or "CHC Defendants"), under a municipal liability/*Monell* theory. All of Plaintiff's § 1983 claims against CHC stem from its promulgation, implementation, and/or maintenance of policies, practices and/or customs that deprived Ms. Salgado of her federally protected

rights. As demonstrated herein, those claims are well-supported. For many years, CHC knowingly maintained a systemically deficient medical delivery program at the Jail. And that unconstitutional system was a "moving force" behind Ms. Salgado's pain, suffering and death.

CHC's Motion for Summary Judgment (Dkt. #244) should be denied.

LCvR 56.1(c) Statement of Facts

A. Response to Defendants' "Statement of Uncontroverted Facts"

1. Admit.

2. Ms. Salgado was seen at Saint Francis on June 16, 2011, which is ***not*** a day "immediately preceding her booking into the jail." *See, e.g.,* SFH Records (Ex. 1) at SFHS01103.

3. The chest pain described by Ms. Salgado at the Jail was ***not*** consistent with the pain during her prior hospitalizations. Rather, the pain had increased in severity, was radiating to her neck and was accompanied by severe shortness of breath and hyperventilation. *See* Jail Medical Records (Ex. 2) at GLANZ-Revilla05505-5507. These are all "warning signs" according to Ms. Salgado's discharge instructions from Saint John. Saint John Records (Ex. 3) at 708-709. Yet, as detailed herein, those warning signs were disregarded by CHC's medical staff.

4. There was no definitive diagnosis during Ms. Salgado's previous hospitalizations. In any event, and as detailed *infra*, her records from Saint Francis and Saint John document serious and continuing concerns regarding Ms. Salgado's cardiovascular health. *See, e.g.,* SFH Records (Ex. 1) at SFHS01103, 1107, 1109, 1111; Saint John Records (Ex. 3) at SJS00595.

5-6. On June 16, 2011, Ms. Salgado presented at Saint Francis complaining of "nausea, vomiting and chest pain…." SFH Records (Ex. 1) at SFHS01103. Ms. Salgado was assessed as having "coronary artery disease…." *Id.* at 1107. It was specifically noted that Ms. Salgado had ***"a heart attack in the past"***, a "medical history … for ***stent placement"*** and a family history of ***"coronary artery disease."*** *Id.* at 1109 (emphasis added). Dr. Paul Beck, at Saint Francis, noted that Ms. Salgado was experiencing chest pain and nausea, and that her electrocardiogram ("EKG" or "ECG") "revealed sinus rhythm." *Id.* at 1111. She was admitted to the Intensive Care Unit ("ICU"). *Id.*

7-11. Ms. Salgado had a history at Saint John prior to June 23, 2011. For instance, in June of 2007, Ms. Salgado presented to Saint John and was assessed as having ***"chest pain"***, ***"[h]istory of myocardial infarction in 11/2005 with stent placement"***, ***"[c]oronary artery disease"***, "[t]ype 1 diabetes", "alcoholism" and "Hypercholesterolemia". Saint John Records (Ex. 3) at SJS00028 (emphasis added). Drs. Greta Warta and David Brewer ordered a ***"cardiac catheterization"*** to be performed the morning of June 25, 2007. *Id.* at 31 (emphasis added).

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

And despite Defendants' attempts to minimize Ms. Salgado's condition, providers at Saint John reported Ms. Salgado's serious risks for acute coronary disease. When Ms. Salgado presented at Saint John on June 23, 2011, medical staff noted her complaints of

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

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

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

Saint John Records (Ex. 3) at SJS00595 (emphasis added).[1] Dr. Shah, Plaintiff's expert in cardiology, agrees that, based on her symptoms and history, Ms. Salgado should have received a noninvasive nuclear stress test, or some type of ischemia testing, prior to leaving Saint John. *See, e.g.,* Shah Depo. (Ex. 4) at 105:4 – 106:17. However, as noted by Dr. Shah, Ms. Salgado received no such testing prior to leaving Saint John, against medical advice. *Id.*

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

Scott Allen, M.D. ("Dr. Allen"), Plaintiff's expert in correctional medicine, clarified that because Ms. Salgado did not receive the "definitive test of either a profusion imaging study or a cardiac catheterization" at Saint John, Ms. Salgado "could have been in acute coronary syndrome" from June 23 through 24, 2011. Allen Depo. (Ex. 5) at 214:20 – 215:8.

12-13. Ms. Salgado's arrest and criminal charges are irrelevant and inadmissible. *See, e.g.,* FRE 401, 402, 403 and 609. Nevertheless, it is noteworthy that while the Broken Arrow Police Department ("BAPD") had the good sense to take Ms. Salgado to a hospital, as shown *infra*, the Tulsa County Sheriff's Office ("TCSO") and CHC failed to send Ms. Salgado to a hospital despite all indications that she was experiencing an acute coronary event.

14-20. Ms. Salgado was brought back Saint John, by BAPD, on the morning of June 25, 2011, because she would not have "any insulin in jail." Saint John Records (Ex. 3) at SJS00700. Ms. Salgado's "discharge summary" from Saint John, dated June 25, 2011, documents that her most current EKG demonstrated "T-wave inversions in certain leads" and that she had been placed on all "cardioprotective medications." *Id.* at SJS00564. Ms. Salgado's discharge instructions, indicated that "[t]he ***exact cause*** of [her] chest pain [wa]s ***not certain."*** *Id.* at 708 (emphasis added). The discharge instructions further specified to "watch for warning signs", and to get prompt medical attention if any of the following were to occur: (1) "[a] change in the type of pain: if it feels different, becomes more severe, lasts longer, or begins to spread into your shoulder, arm, neck, jaw or back"; (2) "[s]hortness of breath or increased pain with breathing"; and (3) "[w]eakness, dizziness, or fainting." *Id.* at 709. *See also* Shah Depo. (Ex. 4) at 166:11

– 167:13. As shown *infra*, Ms. Salgado exhibited *all of these warning signs* while at the Tulsa County Jail, but her serious turn for the worse was disregarded.

21-27. Upon being booked into the Jail, Ms. Salgado filled out, or was assisted in filling out, several forms. Ms. Salgado's "Intake Screening Form" specifies that she had been treated in a hospital, clinic or emergency room within the "last 3 days". TCSO Records (Ex. 6) at GLANZ-Revilla05416 (emphasis added). Yet, there is no evidence that anyone at the Jail communicated this information to a health care provider.

During the medical screening, on the morning of June 25, Ms. Salgado reported a number of "medical problems", including "cardiac" and hypertension, as well as recent hospitalization for chest pain. *See* Jail Medical Records (Ex. 2) at GLANZ-Revilla05495. Still, the screening nurse did not place Ms. Salgado in the medical unit nor refer Ms. Salgado to be seen by a physician. *Id.* at 5497.

28-30. Ms. Salgado's diabetes, and the treatment of her diabetes, is irrelevant to the question of whether responsible health care providers were deliberately indifferent or negligent to Ms. Salgado's symptoms of acute coronary syndrome.

31. Ms. Salgado was not referred to see Dr. Washburn on June 25, 2011. *See* Dkt. #244-5 at LS00043.

32. Dr. Allen's opinions are focused on the inadequate care Ms. Salgado received, including the failure to review or consider the abnormal EKG, on June 26 through the 28, 2011. *See* Allen (Verified) Report (Ex. 7) at 16-21. However, there is at least one significant event that took place on June 25, 2011. Though CHC fails to mention it, at 2:43 and 2:44pm on June 25, Ms. Salgado was given an electrocardiogram (also referred to as an "ECG" or "EKG"). *See* Jail Medical Records (Ex. 2) at GLANZ-

Revilla05515. For reasons unexplained, Ms. Salgado's EKG results were not "uploaded" into her electronic medical chart until July 14, 2011, ***weeks after her death.*** *Id.* at 5514. The record further states: "[EKG] has been reviewed? ***N/A."*** *Id.* Even more troubling, the EKG results were not included ***at all*** in the copy of Ms. Salgado's medical records produced by the CHC Defendants. *See* Dkt. #244-5. Nonetheless, Ms. Salgado's EKG results from 2:43pm were ***"abnormal"***. *See* Jail Medical Records (Ex. 2) at GLANZ-Revilla05515 (emphasis added).

As Dr. Allen observes, "[t]here is no discussion of [Ms. Salgado's] significant cardiac risks, nor any entry [in the medical records] to reflect that the abnormal EKG has been reviewed by a physician." Allen (Verified) Report (Ex. 7) at 17. Defendant Phillip Washburn, M.D. ("Dr. Washburn") was the Jail's medical director, and staff physician, at the time Ms. Salgado was housed there. *See* Washburn Depo. (Ex. 8) at 34:9-19; 67:12 – 68:2; 157:17-18. Dr. Washburn ***admits*** that: (A) Ms. Salgado's EKG was abnormal; (B) there is no indication, in the medical records, that her abnormal EKG had been reviewed by a physician; and (C) while Ms. Salgado was seen by Dr. Washburn, "there was no notation on the medical record of his assessment." *Id.* at 201:1-24. Dr. Washburn has no specific memory of reviewing Ms. Salgado's EKG results, *does not know why he didn't note his review of the EKG results* and cannot explain why the EKG results were not uploaded to the chart until weeks after Ms. Salgado's death. *Id.* at 160:25 – 162:13. Dr. Washburn further ***admits*** that, as a matter of practice, he ***never actually reviews EKG results*** himself, but relies on nurses to read the results to him. *Id.* at 164:25 – 165:13. According to Dr. Washburn, this practice of not actually reviewing EKG results is ***"better than nothing."*** *Id.* (emphasis added).

33-35. Ms. Salgado's diabetes, and the treatment of her diabetes, is irrelevant to the question of whether responsible health care providers were deliberately indifferent or negligent to Ms. Salgado's symptoms of acute coronary syndrome.

36. On the afternoon of June 26, 2011, Jail nursing staff generated a "problem oriented record". *See* Jail Medical Records (Ex. 2) at GLANZ-Revilla05500-5507. According to nursing staff, Ms. Salgado was observed ***hyperventilating and rubbing her chest.*** *Id.* at 5506. She complained of ***nausea, shortness of breath and increased chest pain***, describing it as an ***"11" on a scale from one to ten.*** *Id.* at 5505. She further reported that the chest pain was radiating into her neck. *Id.* These are all "warning signs" according to Ms. Salgado's discharge instructions from Saint John. Saint John Records (Ex. 3) at 708-709. However, Ms. Salgado was not sent to the hospital nor seen by a physician. Rather, medical staff responded by giving her a "bag to breathe into", and Ms. Salgado was returned to her cell. *See* Jail Medical Records (Ex. 2) at GLANZ-Revilla05506. Ms. Salgado reported to nursing staff that she was too weak to hold the paper bag up to her mouth. *Id.* When reviewing this portion of the medical records during his deposition, ***Dr. Washburn laughed***, and asserted that Ms. Salgado was exaggerating her symptoms. *See* Washburn Depo. (Ex. 8) at 156:8-23.

37. The chest pain described by Ms. Salgado on June 26 was ***not*** consistent with the pain during her prior hospitalizations. Rather, the pain had increased in severity, was radiating to her neck and was accompanied by severe shortness of breath and hyperventilation. *See* LCvR 56.1(c) Statement(A)(36), *supra.*

38-39. *See* LCvR 56.1(c) Statement(A)(36), *supra.*

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

41. Admit.

42. Dr. Washburn did not actually see Ms. Salgado on June 26, 2011; rather, his medication orders were made over the phone. *See* Jail Medical Records (Ex. 2) at GLANZ-Revilla 05506-07. According to Dr. Shah, Dr. Washburn's order for nitroglycerine indicates concern about a "cardiac etiology." Shah Depo. (Ex. 4) at 189:12-14. Further, because Ms. Salgado's chest pain persisted for 15 minutes and after three doses of nitroglycerine, she was, "by definition", suffering from ***"unstable angina."*** *Id.* at 190:16 – 192:4 (emphasis added). *See also* Jail Medical Records (Ex. 2) at GLANZ-Revilla 05505-07; and Drug Admin. Log (Ex. 9) at GLANZ-Revilla 05407 (indicating that pain only resolved after 30 minutes and 4 doses of nitro). Thus, it was at this point, on the afternoon of June 26, 2011, that Ms. Salgado should have been sent to a facility with "more advanced care". Shah Depo. (Ex. 4) at 189:12-14. As Dr. Shah explains, Dr. Washburn's order (over the phone) for nitroglycerine and aspirin evinces his knowledge of "cardiac pain", and Ms. Salgado's continuing symptoms of pain "would be an indication to say this person has a ***high risk for having unstable angina or acute coronary syndrome*** and, therefore, warrants monitoring and additional therapy." *Id.* (emphasis added). However, no such monitoring or additional therapy was provided. Instead, Ms. Salgado was simply returned to her pod. *See* Jail Medical Records (Ex. 2) at GLANZ-Revilla05506.

Dr. Allen is also highly critical of Defendants' failure to provide appropriate

evaluation and care to Ms. Salgado on June 26, 2011, despite the "clear and significant risks for acute coronary syndrome…." Allen (Verified) Report (Ex. 7) at 20. Dr. Allen opines that the decision to keep Ms. Salgado in the Jail, as opposed to sending her to the hospital, was "reckless." *Id.* at 20-21.

43-46. While Nurse Hudson notes that an EKG was ordered and performed on June 26, 2011, there is ***no evidence*** of any June 26 EKG results in the records. Rather, the ***only*** EKG results in record are dated June ***25***, 2011. *See* Jail Medical Records (Ex. 2) at GLANZ-Revilla 5514-16. The June 25 EKG results, the failure to upload them (until weeks after Ms. Salgado's death) and failure to document any review of them are discussed above. *See* LCvR 56.1(c) Statement(A)(32), *supra.*

47-48. *See* LCvR 56.1(c) Statement(A)(42), *supra.*

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

> After an inmate named Lisa Salgado died at the Jail from a heart attack, it was discovered that her ***vital signs had not been recorded in the chart.*** After Ms. Salgado died, Chris Rogers ***instructed the nursing staff to doctor her medical records*** so that it would appear that Ms. Salgado's vitals had been taken and recorded. Chris Rogers routinely directed nursing staff to falsify, doctor and backdate medical records and charts in this manner.

Harrington Aff. (Ex. 10) at ¶ 19 (emphasis added).

50-51. *See* LCvR 56.1(c) Statement(A)(42), *supra.*

52-54. While Nurse Metcalf noted that she assessed Ms. Salgado at 10:24am on June 27, 2011, this note is factually inaccurate. As Nurse Metcalf ***admits***, she did ***not*** assess Ms. Salgado at 10:24am; rather, she saw Ms. Salgado at 7:00am. *See* Metcalf

Depo. (Ex. 11) at 91:16-20. Thus, the information in the chart (Jail Medical Records (Ex. 2) at GLANZ-Revilla05494) does ***not*** reflect Ms. Salgado's vital signs at 10:24am on June 27. *See* Metcalf Depo. (Ex. 11) at 91:16-20. Further, while Nurse Metcalf notes that Ms. Salgado was "seen" by Dr. Washburn on June 27, Dr. Washburn believes this note may be "wrong". *See* Washburn Depo. (Ex. 8) at 169:8-11.

In any event, at 7:00am, Ms. Salgado was again reporting nausea, vomiting and chest pain. *See* Jail Medical Records (Ex. 2) at GLANZ-Revilla05494. Yet, there is ***no evidence*** in the chart that Nurse Metcalf went back and checked on Ms. Salgado at ***any time*** during her ***12 hour shift.*** *See* Metcalf Depo. (Ex. 11) at 98:9 – 100:3. Indeed, there is no evidence in the electronic chart that ***any*** nurse, or other medical provider, assessed Ms. Salgado after 7:00 am (falsely reported as 10:24am) on June 27. *See* Jail Medical Records (Ex. 2) at GLANZ-Revilla05494. This failure to monitor Ms. Salgado was a violation of CHC's own Clinical Protocols. *See* CHC Clinical Protocols (Ex.12) at A13. There is no evidence that Ms. Salgado's "high risk for having unstable angina or acute coronary syndrome" (Shah Depo. (Ex. 4) at 189:12-14) was being addressed in any way.

Additionally, because Ms. Salgado's abnormal EKG results were not documented in the chart until *after* her death, Nurse Metcalf had no knowledge of the EKG results. *See, e.g.,* Metcalf Depo. (Ex. 11) at 121:10-22; 121:24 – 123:14. Nurse Karen Metcalf was on day shift at the Jail (7:00am to 7:00pm) on June 27 and 28, 2011. *See, e.g.,* Metcalf Depo. (Ex. 11) at 78:7-10; 90:7-9, 112:25 – 113:9, 121:10-13, 159:23-24; Jail Medical Records (Ex. 2) at GLANZ-Revilla05494; CHC Medical Records (Dkt. #244-5) at LS00006. Nurse Metcalf testified that, had Ms. Salgado's abnormal EKG results been documented in the records, she would have viewed her symptoms – *e.g.,* chest pain,

nausea and vomiting – differently, because ***"sometimes some of these symptoms can be impending heart problems."*** *See, e.g.,* Metcalf Depo. (Ex. 11) at 121:10-22; 121:24 – 123:14 (emphasis added). *See also* Kassabian Depo. (Ex. 13) at 31:22 – 32:16.

There are also serious questions about the competency of Nurse Metcalf. ***According to Defendants' own expert, Dr. Keith Kassabian, due to Nurse Metcalf's documented performance problems, including a history of falsifying medical records, he would not have permitted Metcalf to provide care or treatment to Ms. Salgado at all.*** Kassabian Depo. (Ex. 13) at 55:24 – 56:4; 81:12-21; 99:9-16. *See also* Metcalf Disciplinary File (Ex. 14).

55. *See* LCvR 56.1(c) Statement(A)(49), *supra.*

56-61. There is a note that Ms. Salgado was "refer[red]" to see Dr. Washburn at around 3:50 pm on June 27, 2011, for complaints of nausea and vomiting. Jail Medical Records (Ex. 2) at GLANZ-Revilla05507. However, Dr. Washburn does not document actually seeing her and does not note any assessment or impressions. *Id.* Dr. Washburn ***admits*** that he did ***not*** note seeing or assessing Ms. Salgado on June 27, 2011. *See* Washburn Depo. (Ex. 8) at 167:11 – 169:11. ***Indeed, Dr. Washburn does not know whether he saw Ms. Salgado on June 27, 2011.*** *Id.* Thus, there is a genuine issue of fact as to whether Dr. Washburn actually saw Ms. Salgado on June 27, 2011. Moreover, Dr. Washburn did not enter ***any*** note into Ms. Salgado's chart until June 29, 2011, the day ***after*** her death. *See* Jail Medical Records (Ex. 2) at GLANZ-Revilla05491. According to Defendants' own expert, it ***"looks bad"*** that Dr. Washburn failed to document any care or treatment of Ms. Salgado until after her death. *See, e.g.,* Kassabian Depo. (Ex. 13) at 31:22 – 34:25; 37:8-13; 96:12-25 (emphasis added). As Dr. Kassabian (Defendants'

expert) explains, it is "important" for physicians to enter ***daily*** progress notes because such notes "communicat[e] to other caregivers what [the doctor's] impressions are or what should be done with a patient". *Id.* at 31:22 – 32:16. Dr. Allen similarly testified:

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

Allen Depo. (Ex. 5) at 259:8-15 (emphasis added).

As CHC concedes, none of the medications allegedly prescribed by Dr. Washburn, on June 27, 2011, were cardioprotective medications. *See* MSJ at 8(¶61).

62. It is unclear, at best, when Ms. Salgado was admitted to the Jail's medical unit. Defendants' own expert witness, Dr. Kassabian, could not determine, from the records, when Ms. Salgado was admitted to the medical unit. *See* Kassabian Depo. (Ex. 13) at 122:12 – 123:13. Overall, Dr. Kassabian found that Defendants' records were confusing and "hard to follow…." *Id.* at 83:11 – 84:16.

Ms. Salgado's symptoms, on June 27, 2011, were much more serious than "generalized pain" (Dkt. #244-5 at LS00027) and vomiting. First, as shown *supra*, at 7:00am, Ms. Salgado was continuing to report chest pain, in addition to nausea and vomiting. Moreover, a detention officer, Joshua Walker, observed Ms. Salgado after she had reportedly ***fallen down "flat on her face".*** Incident Report (Ex. 16) at GLANZ-Revilla05286 (emphasis added). Officer Walker found Ms. Salgado to be in ***"pain and unresponsive"***. *Id.* (emphasis added). Officer Walker "notified" the nurse of these observations. *Id.* Still, there is no documentation of these serious changes in Ms. Salgado's condition anywhere in the medical record. *See* Jail Medical Records (Ex. 2) at

GLANZ-Revilla05489 – 5547. Among the "warning signs" set forth in Ms. Salgado's discharge instructions -- from Saint John -- were "[w]eakness, dizziness, or fainting." Saint John Records (Ex. 3) at SJS00709. Nevertheless, the report that Ms. Salgado had fallen flat on her face and was unresponsive was completely disregarded by responsible medical staff, in violation of Clinical Protocols. *See* CHC Clinical Protocols (Ex. 12) at A17.

63-64. As discussed above, there is evidence that Ms. Salgado's "vital signs" information was falsified. *See* LCvR 56.1(c) Statement(A)(49), *supra.* The hand-written vital signs information, which CHC relies on (Dkt. #244-5 at LS00027-28), is particularly suspect. As Nurse Metcalf testified, it was the practice to ***"always"*** place vital signs information into the computerized, electronic, medical record. Metcalf Depo. (Ex. 11) at 75:10-23. The ***only*** time she had ever placed handwritten vital signs into a chart was in Ms. Salgado's chart. *Id.* Nurse Metcalf ***admits*** that these handwritten vitals were placed in Ms. Salgado's paper file ***after*** she was found unresponsive in her cell, and ***after*** EMSA arrived. *Id.* at 74:4 – 75:23, 80:22 – 81:1. Nurse Metcalf further testified that she was instructed to provide these handwritten vital signs after Ms. Salgado had been found unresponsive in her cell. *Id.* It is also noteworthy that the handwritten vital signs ***do not appear anywhere*** in the official copy of Ms. Salgado's medical records produced by Former Sheriff Glanz. *See* Jail Medical Records (Ex. 2) at GLANZ-Revilla05489 – 5547.

65-67. Ms. Salgado's diabetes, and the treatment of her diabetes, is irrelevant to the question of whether responsible health care providers were deliberately indifferent or negligent to Ms. Salgado's symptoms of acute coronary syndrome.

68. The electronic medical record indicates that, while Ms. Salgado's blood glucose was taken at 4:20am and 5:08pm, her blood pressure, pulse, temperature, respiration and "pulse OX" were ***not*** recorded on June 28. *See* Jail Medical Records (Ex. 2) at GLANZ-Revilla05490. Indeed, there is no record of these vital signs, in the electronic medical chart, from 7:00am on June 27 through the time that Ms. Salgado was pronounced dead on June 28, 2011 (at approximately 8:00pm). *Id.* at 5490-5494. The purported vital signs data relied upon by CHC is handwritten, and ***not dated June 28, 2011.*** *See* Dkt. #244-5 at LS00028.[2] Further, again, there is evidence that Ms. Salgado's vital sign data was falsified. *See* LCvR 56.1(c) Statement(A)(49), *supra.* Consequently, there is no evidence, in the medical record, and certainly no credible evidence, that Ms. Salgado's vital signs were taken on June 28, 2011. CHC's own clinical protocols require that vital signs be taken at each shift for patients in the infirmary. *See* CHC Clinical Protocol (Ex. 12) at A13.

69-75. Dr. Washburn's purported "assessment" of Ms. Salgado on June 28 is deeply troubling for a number of reasons. While Dr. Washburn claims to have seen Ms. Salgado on June 28, 2011, there is no contemporaneous note documenting this. *See* Jail Medical Records (Ex. 2) at GLANZ-Revilla05491. Rather, Dr. Washburn's ***only*** note concerning Ms. Salgado was entered on June 29, 2011, the day ***after*** Ms. Salgado died at the Jail. *Id.* Dr. Washburn cannot explain why he did not record his supposed assessment of Ms. Salgado until the day after her death and a day after he (allegedly) saw

[2] The mere fact that Defendants lulled Nurse Jackie Moore into agreeing that Ms. Salgado's vitals were take on June 28 is immaterial. Plaintiff is no longer endorsing Nurse Moore as an expert in this case. And the record speaks for itself. Nowhere on the handwritten record that Defendants rely on is there any reference to June 28, 2011. *See* Dkt. #244-5 at LS00028.

her. *See* Washburn Depo. (Ex. 8) at 137:10-13, 137:22 – 138:2. Dr. Kassabian, ***Defendants'*** expert, testified that Dr. Washburn's failure to document any care or treatment of Ms. Salgado until after her death ***"looks bad"***. *See, e.g.,* Kassabian Depo. (Ex. 13) at 31:22 – 34:25; 37:8-13; 96:12-25 (emphasis added). As Dr. Allen states: "The documentation of Dr. Washburn is incriminating. … His only note on the record, written post-mortem, appears to document the fact that he was ***oblivious to her significant cardiac risks***, signs and symptoms." Allen (Verified) Report (Ex. 7) at 21 (emphasis added). "There is description by recollection of a incomplete medical history with ***no mention of her cardiac history or recent hospitalization, no mention of chest pain or shortness of breath,*** and cursory and incomplete physical exam." *Id.* at 19 (emphasis added). There is no mention of the abnormal EKG in Dr. Washburn's "late note". *See* Jail Medical Records (Ex. 2) at GLANZ-Revilla05491. Incredibly, Dr. Washburn does not even remark that Ms. Salgado died in her cell the following day. *Id.*

In addition to these significant omissions of fact, the limited information Dr. Washburn chose to record in the post-mortem note is inconsistent with the other evidence. For instance, while Dr. Washburn reports "no diarrhea or vomiting", TCSO's own investigator found, on the evening of June 28, that Ms. Salgado's toilet ***"contained what appeared to be vomit"*** and that nursing staff reported that she ***"had been vomiting regularly."*** Incident Report (Ex. 16) at GLANZ-Revilla-5279 (emphasis added). In this regard, Dr. Washburn ***admits*** that "persistent pain" and "persistent vomiting" are "serious" and "obvious" health care concerns. Washburn Depo. (Ex. 8) at 87:22 – 88:7.

Moreover, Dr. Washburn ***admits*** to serious concerns about Ms. Salgado's condition that were not documented by him, or any other healthcare provider, at the Jail.

In fact, ***Dr. Washburn admits that Ms. Salgado should have been sent to a hospital prior to her death.*** *See* Washburn Depo. (Ex. 8) at 221:22 – 223:25. Dr. Washburn received repeated verbal reports from nursing staff, over the course of a day, that Ms. Salgado had ***"crashed"*** or was ***"crashing"***. Washburn Depo. (Ex. 8) at 221:22 – 223:25. Yet, Dr. Washburn did not send Ms. Salgado to the hospital nor even bother to document these concerning changes in her condition. The following excerpt from Dr. Washburn's deposition is illustrative of his indifference:

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

Id. (emphasis added).

76-79. There is no credible evidence that Nurse Metcalf ever checked on Ms. Salgado on June 28, 2011. Defendants' own expert testified that he would probably: (A) question Nurse Metcalf's reports; and (B) ***not*** accept her notes at face value. *See*

Kassabian Depo. (Ex. 13) at 102:19 – 103:12. The ***only*** June 28 documentation Nurse Metcalf provides regarding Ms. Salgado is in a ***post-mortem*** "witness statement". *See* Incident Report (Ex. 16) at GLANZ-Revilla05282. She did ***not*** document ***any*** assessment or care of Ms. Salgado, on June 28, prior to her death. *See* Jail Medical Records (Ex. 2). There is specific evidence that Ms. Salgado's records were falsified. *See* LCvR 56.1(c) Statement(A)(49), *supra.* And there are repeated documented instances of Nurse Metcalf falsifying records. *See* Metcalf Disciplinary File (Ex. 14). Under this backdrop, a reasonable jury could, and should, disregard Nurse Metcalf's post-mortem, and *self-serving*, witness statement. *See also* LCvR 56.1(c) Statement(A)(63-64), *supra.* In the absence of any credible evidence to the contrary, a reasonable jury could conclude that Nurse Metcalf ***utterly failed to monitor or assess Ms. Salgado's condition*** on June 28, 2011. This, too, is a violation of CHC's own Clinical Protocols. *See* CHC Clinical Protocols (Ex. 12) at A13.

80. When Nurse Wallace arrived at the Jail at 7:00pm, Nurse Metcalf told him that "everybody was okay…." Wallace Depo. (Ex. 17) at 46:2 – 47:24. Nurse Metcalf did not tell Nurse Wallace *anything* about Ms. Salgado. *Id.* In any event, Nurse Wallace quickly determined that Ms. Salgado was ***not*** okay. *Id.* Nurse Wallace walked through the medical unit to check on the patients, and noticed that Ms. Salgado did not look good. *Id.* He banged on her cell door; Ms. Salgado did not respond. *Id.* He yelled to try to get Ms. Salgado's attention; again, she did not respond. *Id.* Nurse Wallace asked a detention officer to let him into Ms. Salgado's cell. *Id.* When Nurse Wallace entered the cell, he continued talking to Ms. Salgado, asking her if she was okay; there was no response. *Id.* He kicked her bed, but Ms. Salgado did not respond. *Id.* Nurse Wallace observed that

Ms. Salgado was pale, diaphoretic and was not moving. *Id.* At around 7:24pm, Nurse Wallace yelled for another nurse, Nurse Pinson, and they began CPR to try and revive Ms. Salgado. *Id.* at 51:15-24. *See also* Incident Report (Ex. 16) at GLANZ-Revilla05283. Nurse Pinson observed that Ms. Salgado was "cyanotic", her extremities were "mottled", she was not breathing and had no pulse. *Id.* This evinced a prolonged period of time that Ms. Salgado had gone without oxygen. Wallace Depo. (Ex. 17) at 54:14 – 55:2. Ms. Salgado's body was already cold to the touch. Incident Report (Ex. 16) at GLANZ-Revilla at 05276. Her skin was grey. Wallace Depo. (Ex. 17) at 55:10-15. Nurse Wallace believes that Ms. Salgado may have been dead for ***"awhile"*** at the point he entered her cell. *Id.* at 56:14-24.

EMSA arrived at around 7:40pm. Incident Report (Ex. 16) at GLANZ-Revilla at 05283. Additional efforts to revive Ms. Salgado were unsuccessful. *Id.* At 8:00pm, EMSA terminated its efforts to resuscitate Ms. Salgado. *Id.* TCSO subsequently reported to the Oklahoma State Department of Health ("OSDH") that Ms. Salgado died in the Jail on June 28, 2011. *See* OSDH Report (Ex. 18) at GLANZ-Revilla05337.

81-83. As established throughout this Brief, Ms. Salgado's obvious symptoms of acute coronary syndrome were disregarded by Dr. Washburn and Nurse Metcalf. Dr. Allen is highly critical of the care, or lack thereof, that Ms. Salgado received at the Jail, referring to it as ***"reckless"***, and finding that her clear risks of acute coronary syndrome were disregarded. *See, e.g.,* Allen (Verified) Report (Ex. 7) at 20-21. Indeed, the very pages of Dr. Allen's deposition, cited to by CHC, highlight his opinion that Dr. Washburn failed to properly care for Ms. Salgado, despite her clear symptoms and history of acute coronary syndrome. *See* Dkt. #244-5 at 289:8-15; *See* Dkt. #244-5 at

262:10-16. Dr. Allen specifically opines that the "inadequate care provided to Ms. Salgado by the Tulsa County Jail contributed to and more probably than not was the cause of her death." *See, e.g.,* Allen (Verified) Report (Ex. 7) at 20-21. Dr. Shah believes that, by June 26, Ms. Salgado should have been sent to a hospital as she was "at ***high risk*** for having unstable angina or acute coronary syndrome and, therefore, warrant[ed] monitoring and additional therapy." Shah Depo. (Ex. 4) at 189:12-14 (emphasis added). Defendants' own expert concluded that the healthcare system, including the Jail's healthcare system, ***"failed"*** Ms. Salgado. Kassabian Depo. (Ex. 13) at 186:7 – 187:2 (emphasis added). Dr. Washburn even admits that Ms. Salgado should have been sent to a hospital after she had "crashed" several times at the Jail. Washburn Depo. (Ex. 8) at 221:22 – 223:25.

84. As shown *supra*, the nurses did ***not*** monitor Ms. Salgado's vital signs "throughout her incarceration", and her medical record was falsified. *See, e.g.,* LCvR 56.1(c) Statement(A)(63-64, 68), *supra.*

85. Ms. Salgado's diabetes and the treatment of her diabetes are irrelevant to the question of whether responsible health care providers were deliberately indifferent or negligent to Ms. Salgado's symptoms of acute coronary syndrome.

86. Admit.

87. Ms. Salgado was never "diagnosed" with acute coronary syndrome at the Jail because Dr. Washburn ignored and disregarded the obvious signs and symptoms. As Dr. Allen opines:

> In my professional opinion, Ms. Salgado received inadequate care and care that did not meet a reasonable community standard. She had clear and significant risks for acute coronary syndrome, and at a minimum warranted immediate and careful evaluation by a qualified physician. She

> did not receive them. On her initial presentation with chest pain, shortness of breath and an abnormal EKG on June 26, 2011, she should have immediately been assessed by a qualified physician. If none was available on site at the jail, she should have been sent to the nearest emergency room. Had a qualified physician been onsite to examine her, he or she likely would have sent her to the emergency room in any event given her known history of coronary disease, her compelling symptoms and an abnormal EKG. In other words, the available evidence adequately documents the necessity of further work up for acute coronary syndrome and that workup cannot be safely done outside a hospital.
>
> ***In this case, the medical staff did not send her out and instead chose to follow her at the jail facility. In my opinion this decision was reckless. Even so, for the remainder of her stay she was not closely monitored. She continued to have symptoms. There is no evidence on this record to suggest that any health provider understood her high risk of a life threatening cardiac event even though her history and presentation are highly suggestive of such an event.***
>
> There are numerous individual and systemic deficiencies in the medical care demonstrated by this case. The documentation of Dr. Washburn is incriminating. He fails to document his findings when he sees Ms. Salgado on June 27, 2011. His only note on the record, written post-mortem, appears to document that fact that he was ***oblivious to her significant cardiac risks, signs and symptoms.*** His clinical reasoning is difficult to follow. ***The care provided by nursing is inadequate, reactive (as opposed to anticipatory) and ineffective.***
>
> It is my professional opinion that the ***inadequate care provided to Ms. Salgado by the Tulsa County Jail contributed to and more probably than not was the cause of her death.*** She had ***known and significant heart disease and related medical conditions, she presented with classic signs of acute coronary syndrome including chest pain, shortness of breath, nausea and abnormal EKG. Had she been sent to an outside hospital, the standard of care, she could have survived her illness.***

Allen (Verified) Report (Ex. 7) at 20-21 (emphasis added).[3]

[3] Though CHC argues that Dr. Allen's opinions are now limited to a critique of Dr. Washburn's documentation, it cites no deposition testimony where he limits his opinions in this manner. At the end of his deposition, Dr. Allen made it abundantly clear that he was ***not abandoning any of the opinions as stated in his Expert Report.*** *See* Allen Depo. (Ex. 5) at 359:16 – 360:18.

88. Contrary to Defendants' representations, Dr. Shah did ***not*** agree that the "chronic pancreatitis can cause chest pain similar to that complained of by Ms. Salgado." Rather, Dr. Shah testified that "it would seem unusual if you have pain radiating up into the neck [as Ms. Salgado did] that you could attribute it to pancreatitis…." Dkt. #244-11 at 68:19-24. And Dr. Allen testified that pain from pancreatitis is "typically described as ***epigastric***, radiating to the ***back***." Dkt. #244-10 at 200:19-25 (emphasis added).

89. Again, Defendants misrepresent Dr. Shah's testimony. He did not testify that nurses "assessed" Ms. Salgado's chest pain. Rather, he testified that she was not properly evaluated for cardiac issues. Dkt. #244-11 at 235. And it is clear that Nurse Metcalf utterly failed to monitor Ms. Salgado's dire condition for the better part of June 27 and June 28, 2011. *See, e.g.,* LCvR 56.1(c) Statement(A)(68-80), *supra.*

90. The only medication provided to Ms. Salgado for chest pain, nitroglycerin, on June 26, 2011, only shows Dr. Washburn's knowledge of cardiac etiology. *See, e.g.,* LCvR 56.1(c) Statement(A)(42), *supra.* As Dr. Shah explains, Dr. Washburn's order (over the phone) for nitroglycerine and aspirin evinces his knowledge of "cardiac pain", and Ms. Salgado's continuing symptoms of pain "would be an indication to say this person has a ***high risk for having unstable angina or acute coronary syndrome*** and, therefore, warrants monitoring and additional therapy." Shah Depo. (Ex. 4) at 189:12-14 (emphasis added).

91-92. Nursing staff disregarded Ms. Salgado's nausea and vomiting. For example, as noted above, TCSO's own investigator found, on the evening of June 28, that Ms. Salgado's toilet ***"contained what appeared to be vomit"*** and that nursing staff reported that she ***"had been vomiting regularly."*** Incident Report (Ex. 16) at GLANZ-

Revilla-5279 (emphasis added). Dr. Washburn ***admits*** that "persistent pain" and "persistent vomiting" are "serious" and "obvious" health care concerns. Washburn Depo. (Ex. 8) at 87:22 – 88:7. Yet, Ms. Salgado's persistent vomiting was not documented or evaluated. *See, generally,* Jail Medical Records (Ex. 2).

93. While no autopsy was performed, the medical examiner determined that the probable cause of Ms. Salgado's death was "atherosclerotic and hypertensive cardiovascular disease." ME Report (Ex. 19) at GLANZ-Revilla05453.

94. CHC's statement of "fact" No. 94 is a ***blatantly false and misleading*** misrepresentation. Dr. Shah ***never*** testified that Dr. Washburn was not deliberately indifferent to Ms. Salgado's medical needs, as CHC would have this Court believe. He merely agreed that Dr. Washburn was not deliberately indifference "because of" a lack of "resources alone". Dkt. #244-11 at 44. Dr. Shah then clarified that a physician must ***"recogniz[e] when [he] ha[s] a resource limitation [and] send the patient on to an area that has more resources."*** *Id.* at lines 8-13 (emphasis added).

95. Again, Dr. Shah actually testified that Ms. Salgado was not properly evaluated for cardiac issues. Dkt. #244-11 at 235. And there is substantial evidence that the Jail medical staff disregarded Ms. Salgado's obvious signs and symptoms of acute coronary syndrome. *See, e.g.,* LCvR 56.1(c) Statement(A)(36, 42, 68-85), *supra.*

96. While Dr. Washburn was the sole physician at the Jail, the "care" he provided to Ms. Salgado was recklessly deficient. *See, e.g.,* LCvR 56.1(c) Statement(A)(36, 42, 56-61, 69-79, 81-83, 87), *supra.*

97. Dr. Washburn disregarded Ms. Salgado's obvious signs and symptoms of acute coronary syndrome. *See, e.g.,* LCvR 56.1(c) Statement(A))(36, 42, 56-61, 69-79,

81-83, 87), *supra.*

98-99. Dr. Shah testified to "a reasonable degree of certainty that [the] most likely the cause of [Ms. Salgado's] death was an acute coronary syndrome." Shah Depo. (Ex. 4) at 240:14-16 Dr. Allen opines "to a degree of certainty" that "it's more likely than not that she died of something related to cardiovascular disease…." Allen Depo. (Ex. 5) at 197:7-17. *See also* LCvR 56.1(c) Statement(A)(93), *supra.*

100. CHC cites no evidence for its bald assertion that it does not "control" its physicians and nurses.

101. Dr. Washburn was employed by CHC as medical director at the Tulsa County Jail. *See* Washburn Depo. (Ex. 8) at 8:9-24; 12:23 – 13:3; 40:15 – 41:4.

102-105. CHC's "facts" Nos. 102-105 are addressed in LCvR 56.1(c) Statement(B), *infra*.

106. Under its contract with the Tulsa County Board of County Commissioners ("BOCC"), on behalf of the TCSO, Defendant Correctional Healthcare Management of Oklahoma, Inc. ("CHMO"),[4] agreed to "provide, on a regular basis, professional medical, dental, psychiatric, pharmaceutical, and related health care and administrative services for the" inmates at the Jail. *See, e.g.,* Health Services Contract (Ex. 20) at GLANZ0192. CHMO was required to "provide medical, dental, psychiatric, technical, pharmaceutical, ob/gyn, and support personnel necessary for the rendering of" health care services to the inmates. *Id.* at GLANZ0194-95. And CHMO was responsible for training and supervising the clinical personnel. *Id.* at GLANZ0194-96. CHC obtained the contract with TCSO under dubious circumstances. *See* Clark Depo. (Ex. 21).

[4] CHMO is a subsidiary of CHC.

B. Additional Facts Precluding Summary Judgment

1. When Dr. Washburn took the job of medical director, he had no experience in running a clinic or managing nursing staff. *See* Washburn Depo. (Ex. 8) at 40:15 – 41:4. When he was hired, Dr. Washburn did not understand what his role was as medical director, and no one at the Jail explained the position to him or provided him with any training with respect to the performance of the medical director role. *Id.* at 33:10-23. In fact, Dr. Washburn was not even aware that he had been hired as medical director until after he began working at the Jail. *Id.* at 34:9-19. Dr. Washburn does not recall any protocols at the Jail pertaining to inmate care. *Id.* at 15:13-16. As medical director, Dr. Washburn was responsible for the training and supervision of nursing staff; but he had a "problem" with that, and he informed CHC that he had a problem with training and supervision of nursing staff. *Id.* at 80:8-22.

2. The National Commission on Correctional Health Care ("NCCHC"), a corrections health accreditation body, conducted an on-site audit of the Jail's health services program in 2007. *See, e.g.,* Harrison Depo. (Ex. 22) at 7:9-16; 36:1-10. The NCCHC standards are not "best practices" but are merely standards for an "appropriate healthcare delivery system for correctional facilities." *Id.* at 115:4-19. Part of the rationale behind the NCCHC mental health standards is to alleviate or reduce risks to inmate health and safety. *Id.* at 64:8-19. The Tulsa County Sheriff's Office is ***required***, under a Settlement Order with the Department of Justice, to maintain compliance with NCCHC standards. *See* Settlement Order (Ex. 23) at 19; and Signature Pages (Ex. 24). The Settlement Order is, itself, evidence of long standing, and serious, problems with TCSO's delivery of medical care to inmates.

3. Sheriff Glanz relies exclusively on NCCHC accreditation as evidence that his medical system is adequate. *See* Glanz Depo. (Ex. 25) at 83:25 – 84:13. Before the NCCHC auditors arrived, Sheriff Glanz had a meeting with the department heads at the Jail. *See* Maloy Depo. (Ex. 26) at 122:18 – 123:5. During this meeting, Sheriff Glanz emphasized the importance of the NCCHC audit and stated that CHC would lose the contract with TCSO if the Jail failed the audit. *Id.* Sheriff Glanz and Chief Deputy Tim Albin told the department heads to keep any "problem" medical charts away from the NCCHC auditors. *Id.* at 188:9 – 189:3. Diane Maloy, medical records supervisor at the Jail, was instructed by CHC and TCSO to hide and falsify medical records and charts. *Id.* at 117:10 – 120:22; 189:22-24. Specifically, Ms. Maloy and nursing staff were instructed to create "dummy charts" by removing unaddressed sick calls from medical records, concealing charts of inmates who were ill and altering records after the fact. *Id.* CHC representative Pam Hoisington would go through the charts and remove portions she felt were "damning". *Id.* at 192:9-21. These "dummy charts" were created by CHC for the specific purpose of passing the NCCHC audit. *Id.* at 120:23 – 121:1. When the NCCHC auditors arrived, CHC and TCSO provided the auditors with baskets of the doctored "dummy" charts in hopes that the auditors would review the dummy charts and the Jail would pass the audit. *Id.* at 121:2 – 122:18. During the audit process, TCSO actually moved certain inmates around the Jail, and even off the premises, so that they could not speak with the auditors. *Id.* at 189:4-18.

4. Despite CHC and TCSO's efforts to defraud the auditors, an early report (spring of 2007) from NCCHC documented incomplete health assessments, failure to perform mental health screenings, failure to fully complete mental health treatment plans,

failure to triage sick calls and failure to conduct quality assurance studies. *See* "NCCHC Action Plans", 4/17/07 (Ex. 27). Despite the efforts to conceal and alter the facts, the Tulsa County Jail failed the 2007 NCCHC audit. *See, e.g.,* Maloy Depo. (Ex. 26) at 123:15-18. A September 1, 2007 email from Dennis Hughes, an officer at CHC, expressed "disappointment with the audit results", acknowledging that CHC had "let our staff down, our client down, and to a **lesser extent** our patients." Email from Hughes to Payas, 9/1/07 (Ex. 28) (emphasis added).

5. NCCHC issued its final audit report for the 2007 accreditation period on November 9, 2007. See Harrison Depo. (Ex. 22) at 48:6-7; 49:7-13. The final 2007 NCCHC report included the following findings: (A) "*health needs identified during receiving screening are not addressed in a timely manner*"; (B) "the follow up of inmates with mental health needs is not of sufficient frequency to meet their needs"; (C) "there was a noted delay in responding to routine mental health-related requests submitted by the inmates". *Id.* at 50:17-23; 52:8-20; 62:4-17 (emphasis added).

6. Despite the serious deficiencies found by the NCCHC as part of the 2007 audit process, Sheriff Glanz cannot point to a single mental health policy or practice that has changed at the Jail since 2007. *See* Glanz Depo. (Ex. 25) at 163:2-9. Similarly, CHC is unaware of a *single practice* that CHC changed as a result of the 2007 NCCHC audit. *See* Jordan Depo. (Ex. 29) at 176:14-17.

7. After failing the 2007 NCCHC audit, the NCCHC only required that CHC and TCSO formulate written action plans to address how the identified deficiencies would be corrected. *See* Maloy Depo. (Ex.26) at 123:25 – 124:10. Pam Hoisington, by this time Health Services Administrator ("HSA") at the Jail, drafted the written action

plans. *Id.* at 123:25 – 124:22. While Ms. Hoisington wrote out the plans of correction, those plans were never implemented. *Id.* NCCHC never followed up to ensure that the action plans were being implemented and followed. Harrison Depo. (Ex. 22) at 54:9-16.

8. In August of 2009, the American Correctional Association ("ACA") conducted a "mock audit" of the Jail. *See* Gondles Report (Ex. 30) at 007. The ACA's mock audit revealed that the Jail was non-compliant with "mandatory health standards" and "substantial changes" were suggested. *Id.* Based on these identified and known "deficiencies" in the health delivery system at the Jail, the Jail Administrator sought input and recommendations from Elizabeth Gondles, Ph.D. ("Dr. Gondles"). *Id.* at 1 and 7. Dr. Gondles was associated with the ACA as its medical director or medical liason. *See* Robinette Depo. (Ex. 31) at 35:10-21. After reviewing pertinent documents, touring the Jail and interviewing medical and correctional personnel, on October 9, 2009, Dr. Gondles generated a Report, entitled "Health Care Delivery Technical Assistance" (hereinafter, "Gondles Report"). *See* Gondles Report (Ex. 30). The Gondles Report was provided to the Jail Administrator, Michelle Robinette. *Id.* at 001; Robinette Depo. (Ex. 31) at 48:9-16. As part of her Report, Dr. Gondles identified numerous "issues" with the Jail's health care system, as implemented by ***Defendant CHM***.[5] *See, e.g.,* Gondles Report (Ex. 30) at 007, 10-19. After receiving the Gondles Report, Chief Robinette held a conference -- to discuss the Report -- with the Undersheriff, Administrative Captain ***and CHC/CHM.*** Robinette Depo. (Ex. 31) at 50:20-24.

9. Among the issues identified by Dr. Gondles, as outlined in her Report, were: (a) *understaffing* of medical personnel due to CHM misreporting the average daily

[5] CHM is a subsidiary of CHC.

inmate population; (b) deficiencies in "doctor/PA coverage"; (c) a *lack of health services oversight and supervision*; (d) *failure to provide new health staff with formal training*; (e) *delays* in inmates receiving necessary medication; (g) nurses failing to document the delivery of health services; (h) *systemic nursing shortages*; (h) failure to provide timely health appraisals to inmates; and (i) 313 health-related grievances within the past 12 months. *See, e.g.,* Gondles Report (Ex. 30) at 007, 10-19. Dr. Gondles concluded that "[m]any of the health service delivery issues outlined in this report are a result of the ***lack of understanding of correctional healthcare issues by jail administration*** and contract oversight and monitoring of the private provider." *Id.* at 22. Based on her findings, Dr. Gondles "strongly suggest[ed] that the Jail Administrator establish a central Office Bureau of Health Services" to be staffed by a TCSO-employed Health Services Director ("HSD"). *Id.* According to Dr. Gondles, without such an HSD in place, TCSO could not properly monitor the competency of the Jail's health staff or the adequacy of the health care delivery system. *Id.*

10. Nonetheless, the Jail's leadership chose ***not*** to follow Dr. Gondles' recommendations. *See, e.g.,* Robinette Depo. (Ex. 31) at 71:20 – 72:7; Weigel Depo. (Ex. 32) at 53:6 – 54:14. TCSO did ***not*** establish a central Office Bureau of Health Services nor hire the "HSD" as recommended. *Id.*

11. On March 12, 2010, at 12:03 pm, an inmate at the Jail was found to have altered level of consciousness and breathing difficulties. *See* AMS-Roemer Report, 11/8/11 (Ex. 33) at GLANZ-EW3050. The inmate had ***documented chest pain over the past week.*** *Id.* The Jail's physician at the time, Dr. Andrew Adusei, arrived at around 12:25pm. *Id.* The inmate subsequently went into ***cardiac arrest*** and EMSA was called at

12:45pm with apparent arrival at 1250. *Id.* The inmate ***died*** from a pulmonary embolus. *Id.* The Jail's own internal medical auditor later found that the delay in calling EMSA may have contributed to the inmate's death. *Id.* at GLANZ-EW3050-51.

12. ***Another inmate died*** at the Jail, after going into ***cardiac arrest***, on June 17, 2010. AMS-Roemer Report, 11/8/11 (Ex. 33) at GLANZ-EW3051. The Jail's internal auditor found "***several standard of care issues*** in the care of this inmate." *Id.* Specifically, the auditor noted a lack of monitoring even "after ***considerable risk*** of continued rise in her [blood level potassium] which could lead to cardiac arrest…." *Id.* (emphasis added). The auditor further noted "***inadequate system protocols***, and [a lack of] real time auditing of protocols, for treatment, monitoring, referral." *Id.*

13. On October 28, 2010, Assistant District Attorney Andrea Wyrick wrote an email to Josh Turley, TCSO's "Risk Manager". *See* Wyrick Email (Ex. 34). In the email, Ms. Wyrick voiced concerns about whether the Jail's medical provider, Defendant *CHMO, a subsidiary of CHC*, was complying with its contract. *Id.* Ms. Wyrick further made an ominous prognosis: "This is very serious, especially in light of the three cases we have now — what else will be coming? It is one thing to say we have a contract .. to cover medical services and they are indemnifying us … It is another issue to ***ignore any and all signs we receive of possible [medical] issues*** or violations of our agreement with [CHC] for [health] services in the jail. The bottom line is, ***the Sheriff is statutorily … obligated to provide medical services."*** *Id.* (emphasis added).

14. NCCHC conducted a second audit of the Jail's health services program in 2010. *See* 2010 NCCHC Report, 11/12/10 (Ex. 35) at Glanz.02 00069-89. After the audit was completed, the NCCHC placed the Tulsa County Jail on probation. *Id.* at 00069.

15. The NCCHC once again found numerous serious deficiencies with the health services program at the Jail. *See, e.g.,* 2010 NCCHC Report, 11/12/10 (Ex. 35). As part of the final 2010 Report, NCCHC found, *inter alia*, as follows: "The [Quality Assurance] multidisciplinary committee does not identify problems, implement and monitor corrective action, nor study its effectiveness"; "There have been several inmate deaths in the past year…. The clinical mortality reviews were poorly performed"; "The responsible physician does not document his review of the RN's health assessments"; "the ***responsible physician does not conduct clinical chart reviews to determine if clinically appropriate care is ordered and implemented*** by attending health staff"; "*…diagnostic tests and specialty consultations are not completed in a timely manner and are not ordered by the physician*"; "if changes in treatment are indicated, the changes are not implemented…"; "When a patient returns from an emergency room, the ***physician does not see the patient, does not review the ER discharge orders***, and does not issue follow-up orders as clinically needed"; and "… potentially suicidal inmates [are not] checked irregularly, not to exceed 15 minutes between checks. Training for custody staff has been limited. Follow up with the suicidal inmate has been poor." *Id.* at Glanz.02 00074, 00076, 00080, 00083, 00084, 00086. The parallels between the deficiencies found by NCCHC and the inadequate care provided to Ms. Salgado are obvious. During the auditing process, CHC again attempted to defraud NCCHC by removing unacceptable medical charts from the Jail. *See also* Harrington Aff. (Ex.11) at ¶ 8.

16. Sheriff Glanz only read the first two or three pages of the 2010 NCCHC. *See* Glanz Depo. (Ex. 25) at 140:16 – 141:8. Sheriff Glanz and CHC former Director of Nursing are unaware of any policies or practices changing at the Jail since the 2010

NCCHC Report was issued, other than the retention of an auditor. *Id.* at 162:25 – 163:13; Harrington Aff. (Ex. 10) at ¶ 9 ("Overall, CHC/CHM/CHMO communicated no real concern about improving the deficient care being provided to the inmates.").

17. On December 14, 2010, yet ***another*** inmate ***died*** from a ***cardiac arrest*** at the Jail. *See* AMS-Roemer Report, 11/8/11 (Ex. 33) at GLANZ-EW3051. The inmate had a noted history of coronary artery bypass graft and heart attacks and had been prescribed Metoprolol. *Id.* Only two attempts were made, by Jail medical staff, to verify the Metoprolol prescription. *Id.* Then, attempts to confirm the prescription were abandoned. *Id.* As Jail's medical auditor found, "[t]he main concern in this inmate's care relates to the ***lack of follow up*** on his metoprolol medication." *Id.* (emphasis added). As the auditor concluded, "[i]f inmate had been on this medicine, ***his chances of having a fatal cardiac event would have been significantly decreased."*** *Id.* (emphasis added).

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

19. On September 29, 2011, the Immigration and Customs Enforcement ("ICE") reported U.S. Department of Homeland Security's Office of Civil Rights and Civil Liberties' ("CRCL") findings in connection with an audit of the Jail's medical system as follows: ***"CRCL found a prevailing attitude among clinic staff of indifference…."***; "*Nurses are undertrained*. Not documenting or evaluating patients properly."; "Found two ICE detainees with clear mental/medical problems that have not seen a doctor."; and "TCSO nurse documented mental issues during intake but failed to refer to a provider*"*. ICE-CRCL Report, 9/29/11, (Ex. 36) at Glanz.02 00066 (emphasis

added); *See also* Memo from Lillard to Edwards, 9/26/11 and CHC Attachment (Ex. 37).

20. Sheriff Glanz saw the ICE-CRCL Audit Report. *See* Glanz Depo. (Ex. 25) at 153:16-23. Nonetheless, it is unclear what, if any, policies or practices changed at the Jail since the ICE-CRCL Report was issued. *Id.* at 162:25 – 163:13. And CHC/CHM/CHMO never conveyed any intention to actually do anything to improve the medical care provided to inmates at the Jail. *See* Harrington Aff. (Ex. 11) at ¶ 22.

21. An inmate named Elliott Williams died in the Jail, due to deliberate indifference to his serious medical needs, less than thirty (30) days after the ICE-CRCL Report was issued. *See, e.g., Burke v. Glanz,* No. 11-CV-720-JED-PJC, 2016 WL 3951364 (N.D. Okla. July 20, 2016). Similar to Ms. Salgado, Mr. Williams exhibited obvious symptoms of serious, and emergent, health care needs, that were disregarded by responsible medical and detention staff. *Id.*

22. On November 18, 2011, Advanced Medical Systems ("AMS")/Howard Roemer, M.D. ("Roemer" or "Dr. Roemer"), the Jail's retained medical auditor, issued its Report to Sheriff Glanz finding multiple deficiencies with the Jail's medical delivery system, including "[documented] deviations [from protocols which] ***increase the potential for preventable morbidity and mortality"*** and issues with "nurses acting beyond their scope of practice [which] increases the potential for preventable bad medical outcomes." AMS/Roemer Report, 11/8/11 (Ex. 33) at GLANZ-EW3053-54. AMS/Roemer specifically commented on no less than six (6) inmate deaths, spanning ***from 2009 through December 2010***, finding deficiencies in the care provided to each. *Id.* at GLANZ-EW3050-51, 3053. Once again, there is no evidence that any specific practices or policies changed at the Jail as a result of AMS/Roemer's findings. *See, e.g.,*

Glanz Depo. (Ex. 25) at 182:13 – 183:10.

23. As part of its ongoing auditing function, and well after Ms. Salgado's death, AMS/Roemer continued to find serious deficiencies in the delivery of care at the Jail. *See, e.g.,* Corrective Action Review (Ex. 38) at CHM1935 – 1941; Response to 2012 Audit (Ex. 39) at CHM1969 – 1971. For instance, AMS/Roemer found "[d]elays for medical staff and providers to get access to inmates", ***"[n]o sense of urgency attitude to see patients, or have patients seen by providers"***, failure to follow NCCHC and CHC policies "to get patients to providers", and ***"[n]ot enough training or supervision of nursing staff".*** Corrective Action Review (Ex. 38) at CHM1935 – 1938. After conducting an audit on April 16, 2012, Dr. Roemer found "deficiencies in meeting [the] majority of action plans … [of which] [s]everal … are of *major concern as they involve high risk issues*." Response to 2012 Audit (Ex. 39) at CHM1971 (emphasis added).

24. The former Director of Nursing at the Jail, Tammy Harrington, R.N., has stated that the provision of quality care to the inmates was simply not a priority at the Jail and rates the care provided as three (3) on a scale from one (1) to ten (10), one being the lowest. Harrington Aff. (Ex. 10) at ¶ 6. During her years working at the Jail for ***CHC***, Nurse Harrington observed, *inter alia*: (a) a chronic failure to triage inmates' requests for medical and mental health assistance; (b) a "check the box" intake/booking process that did not provide true medical and mental health screening and put inmates at substantial risk; (c) *doctors refusing/failing to see inmates with life-threatening conditions*; (d) CHC's Health Services Administrator ("HSA"), Defendant Chris Rogers, repeatedly instructing staff to doctor and falsify medical records; (e) a *chronic lack of supervision* of clinical staff; and (g) repeated failures to alleviate known and significant deficiencies in

the health services program at the Jail. *See generally* Harrington Aff. (Ex. 10). *See also* Mason Aff. (Ex. 40).

ARGUMENT

I. CHC IS *NOT* ENTITLED TO SUMMARY JUDGMENT ON PLAINTIFF'S CONSTITUTIONAL CLAIMS

A. CHC May Properly be Held Liable Under a Municipal Liability Theory

Plaintiff has brought her Constitutional claims against CHC, pursuant to 42 U.S.C. § 1983, under a municipal liability -- or "*Monell*" -- theory. CHC argues that because it is a private corporation, it cannot be held liable for violation of Ms. Salgado's Constitutional rights. This argument is demonstrably void of merit. First, it is well-established that "when private individuals or groups are endowed by the State with powers or functions governmental in nature, they become agencies or instrumentalities of the State and subject to its constitutional limitations." *Evans v. Newton,* 382 U.S. 296, 299 (1966). As the Tenth Circuit has reasoned, where a corporate defendant acts "for the government in carrying out a government program in accordance with government regulations, [the corporate defendant is] a person 'acting under color of state law.'" *Dubbs v. Head Start, Inc.,* 336 F.3d 1194, 1216, n. 13 (10th Cir. 2003). The United States Supreme Court has specifically held that a private physician treating prisoners under a contract with state prison authorities acted under color of state law for purposes of the Eighth Amendment. *West v. Atkins,* 487 U.S. 42, 57 (1988); *see also Ancata v. Prison Health Services,* 769 F.2d 700 (11th Cir. 1985) (medical services corporation acting on behalf of a county is a "person" for the purposes of § 1983).

Further, "[a]lthough the Supreme Court's interpretation of § 1983 in" *Monell v. New York City Dept. of Social Servs.,* 436 U.S. 658 (1977) "applied to municipal

governments and not to private entities acting under color of state law, caselaw from [the Tenth Circuit] and other circuits *has extended the Monell doctrine to private § 1983 defendants." Dubbs,* 336 F.3d 1216 (citations omitted) (emphasis added).

To hold a municipality liable under § 1983, a plaintiff must demonstrate (1) the existence of a municipal policy or custom by which the plaintiff was denied a constitutional right and (2) that the policy or custom was the moving force behind the constitutional deprivation (i.e. "whether there is a direct causal link between [the] policy or custom and the alleged constitutional deprivation"). *See City of Canton v. Harris*, 489 U.S. 378, 385 (1989); *Monell*, 436 U.S. at 694; *Bryson v. City of Okla. City*, 627 F.3d 784, 788 (10th Cir. 2010) (citations omitted).

An unconstitutional policy may be established by proof of "an informal custom amounting to a *widespread practice that, although not authorized by written law or express municipal policy, is so permanent and well settled as to constitute a custom or usage* with the force of law…." *Bryson v. City of Okla. City,* 627 F.3d 784, 788 (10th Cir. 2010) (emphasis added). Plaintiff may also establish the CHC's liability through evidence of a "failure to adequately train or supervise employees, so long as that failure results from deliberate indifference to the injuries that may be caused." *Bryson,* 627 F.3d at 788.

Here, as discussed *infra*, there is ample evidence of policies or customs, carried out by CHC, that were the moving force behind Ms. Salgado's Constitutional injuries.[6] As such, CHC is not entitled to summary judgment.

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[6] CHC also argues that it cannot be held liable because it is not a final policymaker for Tulsa County. However, as this Court has previously recognized, "[a] municipal entity may be liable where its policy is the moving force behind the denial of a

B. There is Abundant Evidence that Ms. Salgado's Constitutional Rights Were Violated

Under the Eighth Amendment, prisoners possess a constitutional right to medical care, and that right is violated when doctors or officials are deliberately indifferent to a prisoner's serious medical needs. *Estelle v. Gamble*, 429 U.S. 97, 103-04 (1976). Pretrial detainees, like Ms. Salgado, who have not been convicted of a crime, have a constitutional right to medical and psychiatric care under the Due Process Clause of the Fourteenth Amendment with the standard for deliberate indifference at least as protective as for convicted prisoners. *See Bell v. Wolfish*, 441 U.S. 520, 545 (1979); *Martin v. Bd. of County Com'rs of County of Pueblo,* 909 F.2d 402, 406 (10th Cir. 1990).

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

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constitutional right, *see Monell,* 436 U.S. at 694, 98 S.Ct. 2018, ***or*** for an action by an authority with final policymaking authority, *see Pembaur v. City of Cincinnati,* 475 U.S. 469, 480, 482–83, 106 S.Ct. 1292, 89 L.Ed.2d 452 (1986)" *Revilla v. Glanz,* 8 F. Supp. 3d 1336, 1339 (N.D. Okla. 2014)(emphasis added). Because Plaintiff is proceeding pursuant to *Monell*, she need not establish that CHC has final policymaking authority for Tulsa County. *See also Birdwell v. Glanz,* No. 15-CV-304-TCK-FHM, 2016 WL 2726929, at *6 (N.D. Okla. May 6, 2016).

substantial risk of serious harm to inmates . . . [and] fails to take reasonable steps to alleviate that risk." *Tafoya v. Salazar,* 516 F.3d 912, 916 (10th Cir. 2008).

The Tenth Circuit recognizes two types of conduct constituting deliberate indifference in the medical context. *See Sealock,* 218 F.3d at 1211. "First, a medical professional may fail to treat a serious medical condition properly.... The second type of deliberate indifference occurs when … officials ***prevent an inmate from receiving treatment or deny him access to medical personnel capable of evaluating the need for treatment."*** *Id.* Further, "[a] prisoner may satisfy the subjective component by showing that defendants' ***delay*** in providing medical treatment caused either ***unnecessary pain or a worsening of [his] condition. Even a brief delay may be unconstitutional."*** *Mata,* 427 F.3d at 755 (emphasis added). [7]

"Because it is difficult, if not impossible, to prove another person's actual state of mind, whether an official had knowledge may be inferred from circumstantial evidence." *DeSpain v. Uphoff,* 264 F.3d 965, 975 (10th Cir. 2001). For instance, "the existence of an obvious risk to health or safety may indicate awareness of the risk." *Rife v. Oklahoma Dep't of Pub. Safety,* No. 16-7019, 2017 WL 280700, at *6 (10th Cir. Jan. 23, 2017) (citing *Farmer v. Brennan,* 511 U.S. 825, 843 (1994)). "[I]t does not matter whether the risk comes from a single source or multiple sources, any more than it matters whether a prisoner faces an excessive risk ... for reasons personal to him *or because all prisoners in his situation face such a risk." Farmer,* 511 U.S. at 843.

[7] Though CHC claims that Plaintiff must prove a "total denial of care" to establish deliberate indifference. MSJ at 38. That is simply not consistent with current Tenth Circuit law. *See, e.g., Sealock* and *Mata.*

CHC does not address the objective component in its Motion. Nevertheless, there is no doubt that Ms. Salgado's condition, including severe chest pain, and death from acute coronary syndrome, are sufficiently serious to constitute a deprivation of constitutional dimension. *See, e.g., Mata,* 427 F.3d at 753 ("[B]oth Ms. Mata's severe chest pain and her heart attack each are sufficiently serious to satisfy the objective prong").

Further, despite CHC arguments to the contrary, Plaintiff has presented ample evidence to satisfy the subjective component. CHC spends pages and pages of its Motion rehashing the purported "undisputed" facts,[8] taking deposition testimony out of context and even misrepresenting deposition testimony, in a labored, unorganized and ineffective attempt to demonstrate a lack of deliberate indifference. However, as shown in Plaintiff's LCvR 56.1(c) Statement of Facts *supra*, there are numerous genuine disputed issues of fact in this matter. While it may be true that Jail medical personnel treated *some* of Ms. Salgado's symptoms, there is evidence, sufficient to defeat summary judgment, that her most dire and life-threatening symptoms of acute coronary syndrome, were repeatedly, and recklessly, disregarded.

1. There is Significant Evidence of "Underlying Violations"

Typically, courts will not hold a municipality liable without proof of an "underlying constitutional violation by [one] of its officers." *Olsen v. Layton Hills Mall,* 312 F.3d 1304, 1317–18 (10th Cir. 2002).[9] In this case, there is substantial evidence of

[8] Plaintiff responds to CHC's "fact"-based arguments in the LCvR 56.1(c) Statement, *supra.* Thus, Plaintiff does not waste space in the Argument section with a repetitive "back and forth" regarding the disputed facts.

[9] CHC argues that, in order to hold CHC liable under a municipal liability theory, Plaintiff must sue each individual CHC agent or employee who allegedly violated Ms.

underlying violations of Ms. Salgado's constitutional rights, such that summary judgment is inappropriate.

First, **Ms. Salgado's symptoms of acute coronary syndrome, including chest pain, were not taken seriously, and were disregarded.** It is well established, as a matter of Tenth Circuit authority, that chest pain is a symptom that must be treated seriously and urgently by responsible medical personnel. In *Sealock,* 218 F.3d 1205, 1211–12 (10th Cir. 2000), the Court found evidence of deliberate indifference, sufficient to survive summary judgment, where a nurse knew of an inmate's unexplained chest pain, but failed to call an ambulance. Similarly, in *Mata v. Saiz,* 427 F.3d 745, 758–59 (10th Cir. 2005), the Court reasoned that "[s]ince Ms. Mata produced evidence that Ms. Weldon was aware of Ms. Mata's medical condition as well as the seriousness of unexplained severe chest pain …, a jury could reasonably find that Ms. Weldon's alleged inaction on that date demonstrated deliberate indifference to Ms. Mata's serious medical needs."

Here, by the second day of her stay at the Jail, **June 26, 2011**, Ms. Salgado was complaining of extreme, increasing and radiating chest pain. In addition, she was hyperventilating, rubbing her chest and complaining of nausea. Ms. Salgado asserted that she was so weak that she couldn't lift a paper bag (which Dr. Washburn[10] later scoffed at). These are all well-known symptoms of unstable angina or acute coronary syndrome. Dr. Washburn was called, and clearly recognized that risk of cardiac etiology. Ms.

Salgado's constitutional rights. MSJ at 19 and 34. This is not the law. *See, e.g., Askins v. Doe No. 1,* 727 F.3d.248, 253 (2d Cir.2013); *Wilson v. Town of Mendon,* 294 F.3d 1, 7 (1st Cir. 2002).

[10] CHC claims that Dr. Wasburn was not an CHC "employee". This is disputed. *See* LCvR 56.1(c) Statement(A)(100), *supra.* In any event, Washburn was plainly an agent of CHC.

Salgado's continuing symptoms, even after multiple doses of nitroglycerine, were indicative of a "***high risk*** for having unstable angina or acute coronary syndrome" (Shah Depo. (Ex. 4) at 189:12-14), emergent and life-threatening conditions. Yet, she was not seen by a physician nor sent to a hospital. Rather, she was sent back to her pod with a paper bag to breathe into. In failing to secure emergency room evaluation and treatment, thereby worsening her condition, CHC's medical staff was deliberately indifferent. *See, e.g., See Sealock,* 218 F.3d at 1211; and *Mata,* 427 F.3d at 755. [11]

The following day, **June 27**, Ms. Salgado was referred to see Dr. Washburn, but apparently never actually saw him. At 7:00 in the morning, Ms. Salgado was continuing to report chest pain, nausea and vomiting. Still, though the nurse assigned to Ms. Salgado, Nurse Metcalf, recognized that she had "symptoms [of] impending heart problems", Metcalf did not document checking on Ms. Salgado for the remainder of her 12-hour shift. Moreover, a detention officer observed Ms. Salgado in pain and ***unresponsive*** after reportedly falling down flat on her face. And while the officer "notified" the nurse of these observations, the serious, and emergent, changes in Ms. Salgado's condition were neither documented nor otherwise addressed in any way. These facts too, are indicia of deliberate indifference to Ms. Salgado's obvious symptoms of a serious and life-threatening condition.

There are no notes, dated **June 28, 2011,** in the medical record documenting that ***any*** medical provider assessed Ms. Salgado's condition at all prior to her death. From the period of 12:00 am through 8:44pm, despite her known, obvious and serious risks of acute coronary syndrome, no health professional at the Jail recorded ***any*** observation of

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

Ms. Salgado, good or bad. While nurses had observed Ms. Salgado "vomiting regularly", this is not recorded in the medical record, and thus, disregarded. There is no evidence, certainly no ***credible*** evidence, that Ms. Salgado's vital signs were taken at any time, prior to her being found unresponsive on June 28, 2011. By the time any nurse bothered to check on Ms. Salgado, at around 7:00pm, she was cold to the touch, pulseless and without respiration. She had been dead "awhile". Predictably, Ms. Salgado had died from acute coronary syndrome. While Dr. Washburn noted seeing Ms. Salgado, he did not report his alleged assessment of her until June 29, 2011, the day ***after*** her death. Defendants' own expert opines that this post-mortem note "looks bad". Dr. Allen finds it "incriminating". And even what Dr. Washburn chose to note, albeit post-mortem, demonstrates that he was "oblivious to [Ms. Salgado's] significant cardiac risks, signs and symptoms…."[12] The long delay, and failure to monitor, assess, or treat Ms. Salgado, on June 28, caused her pain, a worsening of her condition, and death. This is deliberate indifference.

This is not simply a case of a "missed diagnosis" or a reasonable "judgment call"[13] as the Defendants would have this Court believe. And the mere fact that

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[12] Though CHC argues that Dr. Allen's opinions are now limited to a critique of Dr. Washburn's documentation, it cites no deposition testimony where he limits his opinions in this manner. *See* MSJ at 34-37. Dr. Allen's critique goes far beyond bad charting. *See* Allen (Verified) Report (Ex. 7) at 20-21. And at the end of his deposition, Dr. Allen made it abundantly clear that he was ***not abandoning any of the opinions as stated in his Expert Report.*** *See* Allen Depo. (Ex. 5) at 359:16 – 360:18. And despite CHC's argument to the contrary, there is evidence of medical causation. *See, e.g., See, e.g.,* LCvR 56.1(c) Statement(A)(87, 90, 98-99), *supra.*

[13] In this regard, CHC continually states that Dr. Washburn "ruled out acute coronary syndrome", without citing any evidence to that effect. As discussed at length, Dr. Washburn was oblivious to, and disregarded the clear and obvious symptoms of acute coronary syndrome. ***Now*** Dr. Washburn attempts to remake history to characterize his

Defendants were treating Ms. Salgado's diabetes is of no moment in the face of evidence that her symptoms of acute coronary syndrome were being disregarded. There is significant evidence of repeated failure to provide Ms. Salgado with proper monitoring, diagnostic and palliative care, despite clear symptoms of a life threatening and emergent coronary condition. This is evidence of deliberate indifference. *See Sealock,* 218 F.3d at 1211; and *Mata,* 427 F.3d at 755.

Second, CHC's own Clinical Protocols were violated. While published requirements for health care do not create constitutional rights, violation of such protocols constitutes circumstantial evidence of deliberate indifference. *See, e.g., Mata,* 427 F.3d at 757. Under CHC's Clinical Protocols, inmates admitted to the infirmary must be monitored daily, which includes the taking of vital signs at each shift. *See* CHC Clinical Protocol (Ex. 12) at A13.[14] Here, there is evidence strongly suggesting, on June 28, Ms. Salgado was not monitored by nursing staff at all, and her vital signs were not taken, despite her symptoms of acute coronary syndrome. Additionally, the CHC Protocols provide that where an inmate is found unresponsive, medical staff is required to: (1) have the Officer call 911 to request an Emergency Ambulance; (2) begin CPR, apply AED, if available; (3) notify the provider on call; and (4) document in patient's chart. *Id.* at A17. Here, ***none*** of these potentially life-saving measures was taken after Ms. Salgado was found unresponsive in her cell on June ***27***, 2011. This is strong

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treatment of Ms. Salgado as a reasonable "judgment call." MSJ at 45. But the evidence presented by Plaintiff counters, and conflicts with, this.

[14] CHC assertion that CHC policy "did not require vital signs to be take every day" (MSJ at 33) is plainly incorrect.

evidence of deliberate indifference.[15]

Third, key diagnostic testing results (*e.g.,* the EKG) were either totally ignored or disregarded. Ms. Salgado's abnormal EKG results, dated June 25, 2011, which provide further reason for concern, were ***not*** evaluated by the physician. Dr. Washburn does not reference the EKG in his post-mortem note, and admittedly did not actually review or read the EKG results. One nurse, Nurse Metcalf, testified that she would have viewed Ms. Salgado's symptoms more urgently had the abnormal EKG results been timely placed in the record. However, they were not. Dr. Washburn and CHC's failure to review, communicate or document the abnormal EKG results is additional evidence that substantial risks to Ms. Salgado's health were disregarded.[16]

Fourth, Dr. Washburn *admits* that Ms. Salgado should have been sent to the hospital after she repeatedly "crashed" at the Jail. During one of the more bizarre portions of Dr. Washburn's deposition, he admitted to receiving several reports from nursing staff that Ms. Salgado was "crashing" and getting worse. *See, e.g.,* LCvR 56.1(c) Statement(A)(69-75), *supra.* Of course, neither he, nor any of the nurses, took the time to document these concerning "crashing" episodes in the medical record. *Id.* Nonetheless, Dr. Washburn acknowledges that Ms. Salgado should have been transported to a hospital after she "crashed again" in the evening. *Id.* Dr. Washburn does not, however, explain why he failed to report, in the record, Ms. Salgado's "crashing" episodes, or why she was not sent to the hospital. This is an admission of deliberate indifference. *See, e.g., Self v.*

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[15] Plainly, Ms. Salgado's medical conditions were not being "treated appropriately" as CHC asserts. MSJ at 34.

[16] CHC claims that Ms. Salgado had a history of abnormal EKGs (MSJ at 41-42), but does not explain how this absolves Dr. Washburn's failure to review, document or consider the June 25 abnormal EKG, especially in light of Ms. Salgado's history of heart attack and stent placement.

Crum, 439 F.3d 1227, 1232–33 (10th Cir. 2006) ("If a prison doctor … responds to an obvious risk with treatment that is patently unreasonable, a jury may infer conscious disregard.").

Fifth, there is evidence that Ms. Salgado's medical record was falsified. "While falsification of medical records does not constitute a separate claim, it may support [an] Eighth Amendment claim if determined to be relevant…." *Van Riper v. Wexford Health Sources, Inc.,* 67 F. App'x 501, 504 (10th Cir. 2003) (citing *Green v. Branson,* 108 F.3d 1296, 1304 (10th Cir. 1997)). Here, the falsification of Ms. Salgado's records is clearly relevant to -- and indicative of -- deliberate indifference. Specifically, there is evidence that Defendant Chris Rogers instructed nursing staff to place false vital signs into Ms. Salgado's medical record, ***after*** she had been found dead. *See, e.g.,* LCvR 56.1(c) Statement(A)(49), *supra.* This calls into question the validity and reliability of the entire medical record and also tends to show that responsible medical staff were covering up their failure to provide appropriate health care to Ms. Salgado. This specific instance of falsification is also consistent with evidence of a pattern of similar misconduct by Ms. Rogers, Nurse Metcalf and even Sheriff Glanz. *See, e.g.,* LCvR 56.1(c) Statement(A)(49, 76-79); (B)(3), *supra.*

Sixth, Ms. Salgado's significant history of cardiac arrest and stent placement was disregarded. It is also apparent that responsible medical personnel, Dr. Washburn, in particular, ignored, and failed to take into account, Ms. Salgado's medical history of severe heart disease, including myocardial infarction. This, too, is evidence of deliberate indifference. *See Plemmons v. Roberts,* 439 F.3d 818, 825 (8th Cir. 2006) (holding that a 20 minute delay in providing treatment was deliberate indifference because jailers did not

acknowledge prisoners' severe symptoms and ignored a history of heart attacks); *Easter v. Powell,* 467 F.3d 459, 464-65 (5th Cir. 2006) (allegation that prison nurse ignored complaints of severe chest pain despite her awareness that inmate had a history of cardiac problems held sufficient to state a claim for deliberate indifference and overcome defense of qualified immunity).

2. Plaintiff Has Identified Official Policies and/or Customs That Were the "Moving Force" Behind the Constitutional Deprivations

The evidence of unconstitutional policies or customs, as fostered by CHC, is overwhelming. *See* LCvR 56.1(c) Statement(B), *supra.* As this Court previously determined in *Burke v. Glanz,* No. 11-CV-720-JED-PJC, 2016 WL 3951364, at *23 (N.D. Okla. July 20, 2016):

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

(emphasis added). Of course, this "constitutionally deficient medical care" was delivered by ***CHC*****,** as the Jail's contract medical provider. The Court specifically found evidence of a policy or custom of "failing to provide medical care in response to serious medical needs of Jail inmates, failing to provide Jail staff with proper training and supervision regarding inmate medical needs, and continuing to adhere to a constitutionally deficient system of care for detainees with serious medical needs." *Burke,* 2016 WL 3951364, at *27. With respect to causation, the *Burke* Court determined that "[t]he record … supports a finding that the foregoing practices were the 'moving force' behind the violations of Mr. Williams's constitutional rights" and that "[t]he jury could also find that the County, via the former Sheriff and other TCSO officials, was on notice as to the

problems with the Jail's medical care system and, had they taken any timely remedial steps to abate the resulting risks, Mr. Williams's condition would not have deteriorated and his death would have been avoided." *Id.* at *28.

Plaintiff has presented much of the same evidence of a "constitutionally deficient system of care" here as Ms. Burke presented in her case. *See* LCvR 56.1(c) Statement(B), *supra.* But, here, Plaintiff had strengthened the evidence of a policy or custom. For instance, in the case at bar, Plaintiff discusses three inmates who all died in 2010 from cardiac arrest. *See* LCvR 56.1(c) Statement(B)(11-12, 17), *supra.* With minimally adequate care, each of these deaths could have been prevented. *Id.* These deaths, which preceded Ms. Salgado's, are specific evidence of a pattern and custom of dangerously deficient care for inmates with heart disease. Ms. Salgado's suffering and death, in June 2011, tends to prove these deficiencies were not alleviated by CHC in a timely manner, and that the failure to alleviate those deficiencies was a moving force behind her suffering and death. *See also* Allen (Verified) Report (Ex. 7) at 20-21. Plaintiff has also presented the "Gondles Report", which was not available to Ms. Burke. The Gondles Report provides additional evidence of known, systemic and continuing problems with the Jail's medical program. In addition, Plaintiff has presented evidence of CHC's failure to train and/or supervise Dr. Washburn and Nurse Metcalf. Indeed, when Dr. Washburn was hired as medical director, he had no experience in supervising nurses and was not even told what the medical director position was comprised of. He plainly failed to assure that Nurse Metcalf was providing appropriate care.

The Court should have little difficulty in affirming that the evidence here, which is virtually identical evidence presented in *Burke*, is sufficient to establish genuine

disputed facts as to the presence of an unconstitutional policy or custom which was a moving force behind Ms. Salgado's suffering and death.

II. CHC IS *NOT* ENTITLED TO SUMMARY JUDGMENT ON PLAINTIFF'S NEGLIGENCE CLAIM

"To establish deliberate indifference, a prisoner must demonstrate more than mere negligence…." *Alejo v. Gonzalez,* 203 F.3d 834, 2000 WL 64317 at *1 (10th Cir. 2000). As shown herein, CHC is not entitled to summary judgment on Plaintiff's claims that they were deliberately indifferent to Ms. Salgado's serious medical needs. Thus, it is axiomatic that CHC is *not* entitled to summary judgment on Plaintiff's negligence claim. Nevertheless, the CHC Defendants argue they are entitled to summary judgment on Plaintiff's negligence claim.

First, CHC claims, without citing any authority, that Dr. Allen, Plaintiff's correctional medicine expert, is not qualified to offer opinions regarding the standards of care in correctional health care nursing. This is a truly absurd assertion. Dr. Allen is a board certified internist who has worked in the field of correctional medicine for over seventeen (17) years, including three (3) years as "Medical Program Director" responsible for oversight of the medical care at all adult jails and prisons in Rhode Island. *See* Allen (Verified) Report (Ex.7) at 1. Dr. Allen co-founded the Center for Prisoner Health and Human Rights at Brown University. *Id.* He is currently a founding faculty member at the University of California-Riverside School of Medicine. *Id.* "A physician's area of expertise necessarily encompasses the standard of care applicable to nurses." *McDowell v. Brown*, 392 F.3d 1283, 1296 (11th Cir. 2004). Dr. Allen is eminently qualified to testify as to appropriateness of the correctional health care provided by nursing staff.

Second, Defendants state that Dr. Shah cannot testify concerning the standard of care in a correctional setting and that Dr. Allen's only standard of care opinion relates to Dr. Washburn's charting. Plaintiff has already fully addressed Dr. Shah's ability to testify as to the standard of care here in her Response to Glanz's *Daubert* Motion. *See* Dkt. #300. Importantly, Defendants fail to establish that there is any material difference between standards of care in a correctional setting versus the community at large. And, once again, Dr. Allen's opinions are ***not*** limited to Dr. Washburn's charting. *See, e.g.,* f.n. 11, *supra.* Further, and contrary to CHC's assertions, Dr. Allen offers opinions as to the poor quality of nursing care, particularly, the failure to monitor Ms. Salgado's condition. *See* Allen (Verified) Report (Ex. 7) at 20-21. Moreover, Plaintiff has offered significant evidence of Nurse Metcalf's many dismal failures to provide even basic care and supervision.

Additionally, Plaintiff has provided substantial evidence as to the proximate cause of Ms. Salgado's pain, suffering and death. *See, e.g., See, e.g.,* LCvR 56.1(c) Statement(A)(87, 90, 98-99), *supra.*

Lastly, the CHC Defendants assert that they are immune from tort liability under the Oklahoma Governmental Tort Claims Act ("GTCA"). *See* MSJ at 57. However, as private contractors, the CHC Defendants (and their employees) are not protected by the GTCA as a matter of Oklahoma law. *See, e.g., Sullins v. American Medical Response of Oklahoma, Inc.,* 23 P.3d 259, 264 (Okla. 2001); *Arnold v. Cornell Companies, Inc.,* 2008 WL 4816507 (W.D.Okla., Oct. 29, 2008).

III. THE STATE LAW CLAIMS ARE NOT BARRED BY THE STATUTE OF LIMITATIONS

The one-year statute of limitations that CHC relies on, 12 Okla. Stat. § 95(A)(11), is inapplicable to death claims brought by the administrator of an Estate. *See, e.g., Revilla v. Glanz,* No. 13-CV-315-JED-TLW, 2015 WL 6686734, at *1-2 (N.D. Okla. Oct. 29, 2015). Thus, Plaintiff's State law claims are **not** time-barred.

WHEREFORE, premises considered, Plaintiff respectfully requests that this Court deny CHC's Motion for Summary Judgment (Dkt. #244).

Respectfully,

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CERTIFICATE OF SERVICE

I hereby certify that on the 8th day of February 2016, I electronically transmitted the foregoing document to the Clerk of Court using the ECF System for filing and transmittal of a Notice of Electronic Filing to all ECF registrants who have appeared in this case.

/s/ Robert M. Blakemore