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

ROBBIE EMERY BURKE, Administratrix of the Estate of Terral Brooks Ellis II, Deceased, et al. Plaintiffs, v. OTTAWA COUNTY BOARD OF COUNTY COMMISSIONERS, et al., Defendants.	)	Case No.: 17-cv-00325-JED-FHM

PLAINTIFFS' RESPONSE IN OPPOSITION TO DEFENDANT FLOYD'S MOTION FOR SUMMARY JUDGMENT (DKT. 120)

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January 17, 2020

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COME NOW the Plaintiffs and respectfully submit their Response in Opposition to Defendant Jeremy Floyd's, in His Official Capacity as Ottawa County Sheriff, ("Sheriff Floyd" or "Defendant") Motion for Summary Judgment (Dkt. #120) as follows:

Introductory Statement

By October of 2015, Terral Ellis ("Mr. Ellis" or "Ellis") was determined to turn his life around for the benefit of his toddler son. As a first step, and with the counsel and guidance of his loving grandparents, Ellis had decided to voluntarily turn himself into the Ottawa County Jail ("Jail") on a pending charge. When Ellis arrived at the Jail on October 10, 2015, he was a healthy 26-year-old young man. *See* Video Clip 1 (Ex. 1) (https://vimeo.com/385605637/7cd4a08a77). Twelve days later, he would be dead. In those twelve days, Mr. Ellis encountered unspeakable mistreatment -- and nightmarish conditions of confinement -- tantamount to torture. Ellis's suffering and death were entirely preventable. The Jail staff's reckless -- and at times, depraved -- indifference to his serious medical needs is shocking, shameful and indefensible.

When Ellis started to develop symptoms of pneumonia, and began asking the detention staff for help, his pleas were met with ridicule and scorn. As the days went on, and his condition grew worse, he was branded as a malingerer and treated with utter contempt by the Jail staff. By the morning of October 22, Ellis was in the throes of respiratory distress, his legs were numb and his extremities were mottled. Beginning at around 8:27 and continuing to about 8:40 AM, Ellis can be heard -- on audio from the Jail's video surveillance system -- continually screaming, whimpering in pain and begging for help. *See* Video Clip 9 (Ex. 27) (https://vimeo.com/385606026/e8ce89fb7f).[1] He was in obvious distress and extreme pain. *Id.*

[1] Ellis is located in a holding cell just off camera, in the upper right hand corner of the upper right hand screen (and the upper left hand corner of the lower right hand screen). It is recommended that the Court use headphones -- or a large speaker -- when reviewing the video evidence as portions of the audio is difficult to discern on a regular computer audio system.

His screams are blood curdling: ***"D.O.!… Help!… Please! Help!… Ahhh!!! … HELP!!!!"*** *Id.* Ellis's frantic cries echoed hauntingly through the Jail. *Id.* When there were officers in the area, they vacillated between completely ignoring him -- to verbally refusing his cries for help -- to openly and cruelly mocking him. *Id.* No one was coming to save Terral Ellis. They couldn't be bothered.

By 10:45 AM on October 22, when the Jail's lone nurse, Thesea Horn, LPN, showed up, Ellis must have had a fleeting glimmer of hope that she would assess his serious condition and get him to the ER. Hope quickly turned to despair as Nurse Horn sadistically threatened to chain this gravely ill young man to a barbaric restraint device known as the "D-Ring" if he continued to complain about his medical condition:

> If we put you back in the pod and [you] start pissing in a cup again you're going [to] go to [the] fucking D-Ring cause there ain't [*sic*] a damn thing wrong with you … ***the very first time you [complain] 'oh I cant get up, I need help, oh I'm having seizures' you're going to that D-Ring and that's where you're going stay the whole time that you are here cause I'm sick and tired of fucking dealing with your ass! Ain't [sic] a damn thing wrong with you!"***

Video Clip 16 (Ex. 34) (https://vimeo.com/385606213/c240677c61). After threatening Ellis and providing no medical assessment or care whatsoever, Nurse Horn openly mocked him, ***"my back is broken, my legs are purple, blah, blah, blah, blah…"*** *Id.* These were some of the last words Mr. Ellis heard as he laid alone on a urine-soaked mat, his organs shutting down and death approaching. After Mr. Ellis was found unresponsive and cold to the touch at approximately 1:38 PM, Jail staff took measures to clean up the "crime scene" before EMS arrived. Inmate trustees were deployed to remove and clean the urine-soaked mat (crudely referred to as a "piss mat") that Ellis had been sleeping on. *See* Video Clip 18 (Ex. 38) (https://vimeo.com/385606266/2caf521ea7). By around 2:00 in the afternoon, Ellis had succumbed to septic shock, having never received the medical attention he so desperately and obviously needed.

There is no genuine dispute that Jail staff were deliberately indifferent to Mr. Ellis's serious medical needs. Sheriff Durborow admits that Nurse Horn ***"refused to do her job"*** and finds her treatment of Ellis to be ***"very disturbing."*** Durborow Depo. (Ex. 43) at 107:22 – 108:20. ***Sheriff Durborow believes that Nurse Horn***, the nurse who served under him at the Jail for many years, ***is responsible for Ellis's death.*** *Id.* at 118:5 – 119:3. Sheriff Durborow also concedes that his jailers failed to follow policy and could have "gotten [Ellis] out" of the Jail if they had appropriately responded to his complaints. *Id.* at 119:2-24; https://vimeo.com/385618162/e0007ff7f3.

Ellis's tragic death was a foreseeable result of the Jail's demonstrably unconstitutional medical delivery system. With no supervision, oversight or accountability, the Ottawa County Sheriff's Office ("OCSO") put the Jail's entire medical system in the hands of a single Licensed Practical Nurse ("LPN"), Nurse Horn. In essence, Nurse Horn *was* the Jail's medical system. For years, Nurse Horn exhibited utter indifference to the health and safety of the inmates, refusing to even regularly show up at the Jail, abdicating her nursing duties and responsibilities to the lay detention staff and paramedics. Nurse Horn was literally "phoning it in", carelessly rendering assessments and diagnoses beyond the scope of her licensure from a remote location. OCSO's medical policies were summarily ignored across the board, save one. The one policy that Nurse Horn did follow was the Jail Nurse Policy which provides: "Basically, a Correctional Facility Nurse does almost everything a trauma nurse does. ***It's just the type of patients that we deal with are different.*** [***N]ever let your guard down. [N]ever turn your back to them. [D]on't ever let them gain your trust."*** Jail Nurse Policy (Ex. 42) at 326 (emphasis added). By all appearances, this was Nurse Horn's overriding philosophy. In her view, inmates are "less than" and not worthy of trust or compassion. This attitude spread through the rest of the Jail staff like an infectious disease. Following Nurse Horn's lead, the detention staff refused to believe Ellis was

ill and suffering, even as he frantically begged for help. OCSO's medical delivery system was an abomination. And it was under this system that Mr. Ellis, just 26-years-old, unnecessarily died a most excruciating death.

Sheriff Floyd's Motion for Summary Judgment (Dkt. #120) should be denied.

LCvR 56.1(c) Statement

I. Response to Defendant's "LCvR 56.1(b) Statement"

A. Facts Specific to Mr. Ellis

- **Booking and the Early Days in D-Pod**

1. Defendant omits pertinent facts. On October 10, 2015, Mr. Ellis voluntarily turned himself in to the Ottawa County Jail on a warrant. *See, e.g.,* Video Clip 1 (Ex.1) (https://vimeo.com/385605637/7cd4a08a77); Bray Depo. (Ex. 2) at 254:17–255:11. As one may observe in the video of this event, Mr. Ellis arrived at the Jail with his grandfather and was cooperative and courteous. *Id.* As part of the booking process, the booking officer filled out a Medical Treatment/Injuries Questionnaire. The Medical Treatment/Injuries Questionnaire indicates that Ellis suffered from asthma, had previously been treated at Saint Francis and was prescribed albuterol. *See* Medical Questionnaire (Ex. 3) at 000018.

After book-in, Ellis was placed in "D-Pod". *See, e.g.,* Dkt. #135-4 at 1-2. D-Pod is a "dormitory style housing unit" at the Jail. *Id.* Ellis was housed in D-Pod with numerous other inmates, including an inmate named Michael Harrington. *See* Harrington Depo. (Ex. 4) at 34:12-15. When Harrington first encountered Mr. Ellis in "early October", Ellis seemed to be in good health and "good spirits". *Id.* at 11:18 – 12:9. After initially meeting Ellis in D-Pod, Harrington was moved to segregated housing for approximately six (6) days. *Id.* at 33:24 – 34:4, 35:3-6; *See also* Harrington Letter (Ex. 5). When Harrington was returned to D-Pod, he "found [Ellis] sick in bed" and observed that ***"something was extremely wrong*** with him…." Harrington Depo. (Ex. 4) at 35:20 – 38:17 (emphasis added).

- **October 17 through October 20, 2015**

2. Nurse Horn's "Progress Notes" are not credible and cannot be accepted at face value. The Assistant Jail Administrator, Charles Shoemaker ("Shoemaker"), testified that Nurse Horn's progress notes contain at least one outright lie (which is discussed in detail, *infra*). *See* Shoemaker Depo. (Ex. 6) at 85:5 – 87:6. More generally, courts are loath to accept self-serving accounts of a defendant as undisputed fact for the purposes of summary judgment, where, as here, the only other witness to the events in question is deceased. *See, e.g., Scott v. Henrich,* 39 F.3d 912, 915 (9th Cir.1994). However, even accepting Nurse Horn's progress notes as true, she had no contact with Ellis on October 17, 2015, despite receiving a report (over the phone) that Ellis was complaining of severe back pain. *See* Progress Notes (Ex. 7) at 000027. In addition to experiencing severe back pain, Mr. Ellis was not eating. *See* Harrington Depo. (Ex. 4) at 39:12 – 40:11; *See also* Harrington Letter (Ex. 5). According to inmate Harrington, the Jail staff "ignored the fact that [Ellis] wasn't eating." *Id.*

3. *See* LCvR 56.1(c) Statement(I)(A)(2). Nurse Horn did not take Ellis's vital signs when she saw him on October 19, 2015. *See* Horn Depo. (Ex. 8) at 123:9 – 124:4; Progress Notes (Ex. 7) at 000027-28. Rather, without gathering any objective data, Nurse Horn, who is a Licensed Practical Nurse, diagnosed Ellis with a broken rib. Progress Notes (Ex. 7) at 000027-28. [2] After Mr. Ellis's visit with Nurse Horn on October 19, he "complained to [Inmate Harrington] that it felt like [his condition] was getting worse, at which point [both Ellis and Harrington] continued to request medical attention" for Ellis. Harrington Depo. (Ex. 4) at 40:14 – 43:11. Nonetheless, the

[2] Plaintiffs' expert, Todd Wilcox, M.D., opines that Nurse Horn violated the standard of care by, *inter alia*: (A) failing to take Mr. Ellis's vital signs; (B) practicing outside the scope of her qualifications and training as an LPN by making a medical diagnosis; and (C) rendering an "inaccurate diagnosis [based on no objective data, which] led everyone [at the Jail] to label this patient as a malingerer and not take him seriously when he continued to have medical problems…." Wilcox (Verified) Report (Ex. 9) at 8.

Jail staff provided "[n]o reply" and the requests for medical attention were "ignored." *Id.* Over the next couple of days (approximately October 19-21), Ellis was ***"sweating profusely."*** *Id.* He had stopped eating or drinking on his own. *Id.* Inmate Harrington was ***"worried" about Ellis's "level of dehydration***…." *Id.* Ellis had become so weak that Inmate Harrington "literally had to hand feed and water him." *Id.* Inmate Harrington gave Ellis ***"cups to urinate in***, and then dump[ed] them out for him." *Id.* While Harrington and other inmates in D-Pod were helping Ellis, the Jail personnel were ***"absolutely not"*** doing anything to assist Mr. Ellis. *See* Harrington Depo. (Ex. 4) at 43:12-21. At one point, as Harrington was physically assisting Ellis to the "rec yard", he saw one of the Jail's detention officers, Johnny Bray. *Id.* at 44:14 – 46:11. Harrington pressed Officer Bray, "aren't you [going to] help him? He needs help. There's something wrong with him." *Id.* In reply, Bray became irritated, indicated that there was nothing he could do and accused Ellis of faking his illness to get released from the Jail. *Id.* Ellis prophetically inquired of Officer Bray: ***"What are you going to tell my 2-year-old son whenever I die?"*** *Id.* Unmoved, Officer Bray simply told Ellis to lie back down. *Id.* Hours later, Ellis earnestly stated to Harrington: "They're not going to help me, are they? ***I think I'm going to die."*** Harrington Letter (Ex. 5); *see also* Harrington Depo. (Ex. 4) at 46:12 – 47:16. Ellis said that he was experiencing the "worst pain of [his] life." Harrington Depo. (Ex. 4) at 46:12 – 47:16.

- **October 21, 2015**

4. Defendant omits pertinent facts. On October 21, 2015, at 4:10 PM, a detention officer, Curtis Lawson, is heard saying, "every time I'm an asshole to an inmate, they deserve it. I don't just go around treating people like shit, but you get what you get." Video Clip 2 (Ex. 10) (https://vimeo.com/385605653/65d6191479). Around this same time on October 21, Ellis began having what appeared to be a seizure. *See, e.g.*, Jail Log (Ex. 11) at 00746; Harrington Letter (Ex. 5). Ellis was "begging for his life" and "begging for help." Harrington Letter (Ex. 5); *see also*

Harrington Depo. (Ex. 4) at 48:14 – 49:18. Harrington and other inmates in D-Pod "started raising a hundred kinds of hell and protest as to why [the Jail staff] weren't giving Terral the medical attention that he needed." Harrington Depo. (Ex. 4) at 48:14 – 49:18. Only after the inmates vociferously advocated for Ellis did Officers Bray and Lawson respond. *Id.*; *see also* Lawson Incident Report (Ex. 12); Video Clip 3 (Ex. 13) (https://vimeo.com/385605662/5585059ad0). Upon arrival, Bray and Lawson ordered the D-Pod inmates, including Harrington, to the nearby rec yard. *Id.* As was common, Nurse Horn was offsite, but was contacted by the dispatcher. *See* Bray Depo. (Ex. 2) at 67:3 – 68:6. Nurse Horn advised the officers to call "EMS to come and check on the inmate." *Id.*[3] Officer Bray knew that the ***medical care provided at the Jail was "subpar"*** and that Ellis was complaining of a ***"serious medical condition."*** Bray Depo. (Ex. 2) at 30:20 – 31:11. Nevertheless, at approximately 4:33 PM, while awaiting the arrival of paramedics, Officers Bray and Lawson are heard sarcastically mocking Ellis and commenting on the poor quality of medical care at the Jail: "[I]t's awesome how a guy with no history of seizures suddenly has seizures" "Yeah, I think I feel one coming on Bray" "I feel one coming on too. I hear the medical around here is excellent… (laughs)" Video Clip 3 (Ex. 13) (https://vimeo.com/385605662/5585059ad0) at 16:33 – 17:02. Only in hindsight does Bray concede that his comments were "regrettable", "inappropriate" and "in bad taste…." Bray Depo. (Ex. 2) at 24:8-19, 88:25 – 89:12.

5-6. Defendant omits pertinent facts. Plaintiffs dispute any suggestion that Integris EMS took a full set of vital signs or otherwise provided appropriate treatment. Integris EMS was

[3] Dr. Wilcox opines that it was "inappropriate" for Nurse Horn to have EMS "come check out the patient to determine whether [Ellis] needed to go to the hospital" as this constitutes "a reversal in the medical licensure." Wilcox Depo. (Ex. 16) at 66:12 – 67:20. That is, despite the fact that paramedics have less medical training than a nurse, Nurse Horn was "relying upon them to assess the patient and make a determination about whether he needs additional care." *Id.* As discussed *infra*, this "inappropriate" practice was commonplace at the Jail.

dispatched to the Jail at 4:36 PM on October 21 – they were apparently notified that an "INMATE HAD SEIZURE AND IS COMPLAINING OF OTHER MEDICAL PROBLEMS." Miami Police Department Complaint Card (Ex. 14) at 000038. At 4:39 PM, Integris EMS arrived at the scene. *See* Integris EMS Records (10/21/15) (Ex. 15) at Plaintiffs_000013. Ellis purportedly informed Integris EMS that he: (A) had flank pain which grew worse upon palpitation; (B) had "two seizures"; (C) was "severely dehydrated"; and (D) had been urinating in a cup because he could not get up to go to the bathroom. *Id.* at Plaintiffs_000014 and 000018.[4] Harrington overheard one of the detention officers, believed to be Officer Bray, tell the Integris paramedics that ***Ellis was "faking"*** his illness, and that unless his condition was life threatening, ***"do not take him"*** to hospital. Harrington Depo. (Ex. 4) at 50:12 – 51:4; *see also* Harrington Letter (Ex. 5). Harrington further heard the officer, likely Bray, state to the Integris paramedics that the Jail would ***not "foot[] the bill"*** for Ellis's transport to the hospital. *Id.*[5] Under these circumstances, Integris EMS ultimately decided not to transport Ellis. *See, e.g.,* Integris EMS Records (10/21/15) (Ex. 15) at Plaintiffs_000013-14. Prior to leaving Ellis at the Jail, Integris took Ellis's blood pressure and determined that he "did not appear to be in" respiratory distress. *Id.* at Plaintiffs_000014. However, video does not show paramedic Jennifer Grimes using her stethoscope. *See* Video Clip 3 (Ex. 13) (https://vimeo.com/385605662/5585059ad0) at 13:30 – 28:45, *see also* Video Clip 4 (Ex.

[4] There are unexplained discrepancies between the Integris EMS "Comprehensive Report" and Integris EMS paramedic Jennifer Grimes' individual report. For instance, while the so-called "Comprehensive Report" states that Ellis's pain did not worsen with palpitation, Grimes' individual report states that his ribs were hurting "upon palpitation." *Compare* Integris EMS Records (10/21/15) (Ex. 15) at Plaintiffs_000014 and 18. The above summary combines facts taken from both reports, which must be read in the light most favorable to Plaintiffs.

[5] Officer Bray now claims that he did not believe Ellis was faking. Bray Depo. (Ex. 2) at 173:14 – 174:1.

17) (https://vimeo.com/385605789/20afd4c23d).[6] Further, Integris EMS did not take a full set of Ellis's vital signs; most importantly, Integris EMS failed to measure Ellis's pulse oximetry. *See* Integris EMS Records (10/21/15) (Ex. 15); Wilcox Depo. (Ex. 16) at 171:22 – 172:4.

As Dr. Wilcox[7] has opined, "[a] set of vital signs is absolutely essential even just to have a starting point to know what to do with the patient, and [the Integris EMS paramedics] didn't even do that." Wilcox Depo. (Ex. 16) at 89:4-22. Dr. Wilcox further opines that "[h]ad [the Integris EMS paramedics] completed a proper set of vital signs, it is likely that they would have seen an abnormality in the patient's pulse oximetry and that would have informed them and their medical control that [Ellis] needed additional workup." Wilcox (Verified) Report (Ex. 9) at 8-9. Per Dr. Wilcox, Integris EMS paramedics exhibited "phenomenal overreach of their training and medical authority" in making a medical determination that Ellis was "fine" to stay at the Jail based on a cursory and incomplete examination. *Id.* at 9.

Plaintiffs dispute the assertion that Ellis was moved to a holding cell (H-1) to "monitor him for any further symptoms." On the contrary, there is evidence that Ellis was moved to the segregated holding cell (H-1) because the other inmates in D-Pod were "making such a stink" about Ellis's mistreatment. *See* Harrington Depo. (Ex. 4) at 21:13 – 22:20; 51:5-15; Harrington

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[6] Integris EMS Paramedics can be seen, wearing pink-colored shirts, attending to Ellis in bottom right screen of Video Clip 3. Video Clip 4 is the same surveillance video footage from D-Pod as is included in Video Clip 3, but full screen.

[7] Dr. Wilcox is board certified in urgent care medicine. Wilcox Depo. (Ex. 16) at 12:11-15. He holds a B.S. in biological psychology from Duke University and graduated from Vanderbilt Medical School. *Id.* at 11:10-21. He actively practices in correctional healthcare as the Medical Director of the Salt Lake County (Utah) Jail System. *See* Wilcox (Verified) Report (Ex. 9) at 1. He is frequently called upon around the country as a consultant to assist correctional facilities in improving their delivery of care. *Id.* Dr. Wilcox has 24 years of experience in the design, administration, and delivery of correctional healthcare in various environments as well as the national standards that govern the field. *Id.* He has achieved both of the advanced levels of certification in correctional healthcare (CCHP-A and CCHP-P) from the National Commission on Correctional Health Care ("NCCHC"). *Id.*

Letter (Ex. 5). H-1 did not have a toilet or a sink. *See* Horn Depo. (Ex. 8) at 105:20 – 106:6; 139:16 – 140:9; Bray Depo. (Ex. 2) at 76:22 – 77:6. H-1 did, however, have a metal ring on the floor of the cell, the "D-ring", that was used to restrain inmates at times. Bray Depo. (Ex. 2) at 76:22 – 77:6. The "D-Ring" is further described *infra* (*See* LCvR 56.1(c) Statement(I)(A)(16)). H-1 is the only cell in the jail with a "D-ring". *Id.* at 163:4-13. It is certainly troubling and suspicious that OCSO would choose to place Ellis in H-1 (a segregated cell with no toilet or sink and the only cell with a "D-Ring"), after he had been complaining of serious medical needs. While in H-1, Ellis was forced to continue urinating in a cup. *See* Horn Depo. (Ex. 8) at 105:20 – 106:6; 139:16 – 140:9. This was particularly cruel as the cell directly adjacent to H-1, cell H-2, had both a toilet and a shower. *Id.* at 105:20 – 106:6. Nevertheless, it did not concern Nurse Horn that Ellis had been urinating in a cup as "[i]t wasn't the first time somebody had urinated in a cup in H1." *Id.* at 139:16-22. When asked where the urine from the cup would go, because there is no toilet in H-1, Nurse Horn answered: "I don't know. I guess they would take it to the toilet or there was a – there's a drain in there. It's a – it's a sewer drain. ***I guess it's used for pissing in the floor."*** *Id.* at 140:1-9.

While Jail staff was to check on Ellis in H-1 every 15 minutes as Defendant states, this did not happen. Indeed, OCSO's own investigator determined, by watching the surveillance video, that officers ***falsely reported*** they had checked on Ellis every 15 minutes, when in fact, they had not. *See* Derwin Depo. (Ex. 18) at 35:22 – 40:18, 44:12-16, 46:16 – 48:16; Derwin Supp. Report (Ex. 19).

7. Ellis did not refuse transport to the emergency room. *See* Video Clip 4 (Ex. 17) (https://vimeo.com/385605789/20afd4c23d); Bray Depo. (Ex. 2) at 97:5-11; Harding Depo. (Ex. 20) at 135:18 – 136:14, 197:19 – 198:14; Williams Depo. (Ex. 21) at 25:6-15; Grimes Depo. (Ex. 22) at 79:18-21; Shoemaker Depo. (Ex. 6) at 221:8 – 222:1-12.

8-9. Denied. *See* LCvR 56.1(c) Statement(I)(A)(5-6), *supra.*

10. The fact that Ellis was able to walk from cell H-1 to the bathroom at 8:18 PM on October 21 is immaterial. As Dr. Wilcox explains, "I would expect that a patient with evolving significant pneumonia would still be ambulatory, so [Ellis's ability to walk] doesn't strike me as abnormal at all." Wilcox Depo. (Ex. 16) at 73:18-24. Further, Ellis's complaint that his legs were "numb", as discussed below, would not "necessarily preclude the ability to walk." *Id.* at 72:2-4. Plaintiffs note that Defendant has not provided the video of Ellis purportedly walking without "difficulty" or "distress" and only provide the opinion of a single lay witness in support his assertion. As Dr. Wilcox observed, Ellis was walking "very guardedly." Wilcox Depo. (Ex. 16) at 72:23 – 73:24.

11. Defendant omits pertinent facts. At 9:34 PM, Ellis complained to Officers Lawson and Bray, who were at the booking desk, that his legs were numb. *See* Video Clip 5 (Ex. 23) (https://vimeo.com/385605868/4d749d5260). *See also* Bray Depo. (Ex. 2) at 154:17-22. In reply to Ellis's complaint, Lawson sarcastically commented: "He can't feel his legs now, Bray, he can't feel his legs!" *See* Video Clip 5 (Ex. 23) (https://vimeo.com/385605868/4d749d5260). Despite his lack of any medical training, Officer Bray told Mr. Ellis that he had no injuries to cause him to be unable to move his legs. *See* Bray Depo. (Ex. 23) at 202:12 – 204:9. At approximately 9:56 PM, Officer Bray can be heard mocking Ellis again, referring to him as ***"the zombie…."*** Video Clip 6 (Ex. 24) (https://vimeo.com/385605893/6bcbf61aa2)[8]. Still, Bray admits that Mr. Ellis's conditions, as reported to him, were ***getting worse.*** *Id.* at 201:25 – 202:8. Similarly, Officer Shoemaker, the Jail's Assistant Jail Administrator, admits that Ellis had been begging for help on October 21 and that his condition deteriorated the evening of October 21 into the morning of

[8] While drafting his incident report concerning Ellis's seizure activity, Bray can be heard asking, "What time did we go to D-Pod to check on the zombie?"

October 22. *See* Shoemaker Depo. (Ex. 6) at 78:15 – 79:17. Though Bray was "uncertain" whether or not he believed Ellis's complaints, he called Nurse Horn in any event. *See* Bray (Ex. 2) at 157:14-21. Despite being told by the paramedics to call them if Ellis's condition changed, it was Bray's understanding that as a detention worker he was forbidden from calling the paramedics, but was required to call Nurse Horn instead. *Id.* at 156:10-19. Bray called Nurse Horn, told her about Ellis's condition and that the paramedics said to call them back if Ellis's condition changed. *Id.* at 156:20-23, 199:13-23. Nurse Horn told Bray that she would be in the next day, which was consistent with her normal practice. *Id.* at 154:23 – 156:9. Despite Ellis's concerning change in condition, Nurse Horn did not call Integris EMS apparently because "EMS had already been to the jail earlier in the day and checked on the inmate." *Id.* at 155:11 – 156:6. Nurse Horn failed to document Bray's phone call from the night of October 21 in any of her progress notes, notwithstanding him telling her that Ellis was now unable to feel his legs. *Id.* at 199:13 – 200:1; *see also* Progress Notes (Ex. 7). At around 10:11 PM, Bray is heard taunting Ellis yet again: "Oh, you're paralyzed now? … Uh Huh, Ok … I ain't laughing at you…." Video Clip 7 (Ex. 25) (https://vimeo.com/385605995/115225a279). Ellis then asks Bray to call an ambulance, to which Bray sarcastically responds, "I'm gonna call her right now." *Id.*

- **October 22, 2015**

12-13. *See* LCvR 56.1(c) Statement(I)(A)(10), *supra.* From about 12:42 to 12:47 AM, there was an exchange between Ellis and Officer Mike Wiford, in which Ellis was apparently complaining that he felt as though he was bleeding internally and asked for help getting water. See Video Clip 8 (Ex. 26) (https://vimeo.com/385606006/0e9d85652b). Officer Wiford coldly responds, "No. … They're saying that ***there's nothing wrong with you***… This is the third thing that you've said you have that they're saying 'No' … So if you want to get a drink of water, get up…." *Id.*

14. Notably, Defendant ***admits*** that "between approximately 8:30 AM and 8:43 AM, ***Ellis repeatedly called out for help and requested jailers to call the E.R.*** [, but] Shoemaker told him that they were not calling the E.R." Dkt. #120 at 5 (emphasis added). However, Defendant has not provided the video (with audio) of these events and fails to provide additional material facts. Plaintiffs are providing that video for the Court's consideration. *See* Video Clip 9 (Ex. 27) (https://vimeo.com/385606026/e8ce89fb7f). From around 8:18 AM to 8:40 AM, Ellis can be heard continually screaming, whimpering in pain and begging for help. *Id.* The officers in the area, Officers Shoemaker and Travis Eads ("Eads"), and even the Jail's "lunch lady", Brenda Pierce ("Pierce"), vacillate between completely ignoring Ellis to verbally refusing his cries for help to openly and cruelly mocking him. *Id.* Following is a summary and transcription of some of the video/audio: Eads: "What, you fell?" Ellis: "[moaning]" … Ellis: "My legs!, ***Please!*** Please don't go anywhere!" Shoemaker: "We did this yesterday. ***You're not selling me.***" Ellis: "I just fell..." Shoemaker: "We're not calling the ER" [Shoemaker closes door] Ellis: "Please, dude, Wait, dude, ***I can't believe ya'll are doing this! Help! Help! Help! Somebody Help! Help! Help!...***" … Ellis (at 8:31 to 8:33 am): "Help me! Help! Help! Ahhhh! Ahhhh! Help me, Help!" …. Pierce: "If you can't breathe, how can you talk?!" Eads: "It's a miracle!" … Ellis (at 8:39:55): "Help! Help Me! Help!" *See* Video Clip 9 (Ex. 27) (https://vimeo.com/385606026/e8ce89fb7f). No help was ever provided. Amazingly, Officer Shoemaker testified he is not ashamed of the way he treated Ellis and believes he acted pursuant to his training at OCSO. Shoemaker Depo. (Ex. 6) at 51:8-21. As Officer Bray concedes, there is nothing more Ellis could have done to seek help from the Jail staff. Bray Depo. (Ex. 2) at 225:7-25.

At around 8:47 AM, Officer Travis Eads can be heard stating to OCSO Detective Rocky Ferdig: "This guy's been ***yelling help for about 30 [minutes]***. This guy in H-1. …[H]e got up, tried to stand up, and fell down." Video Clip 10 (Ex. 28)

(https://vimeo.com/385606113/1a39c0fca2); *See also* Shoemaker Depo. (Ex. 6) at 145:8 – 146:12. Neither officer provided any assistance to Ellis. *Id.* At approximately 8:49 AM, there was an exchange between an inmate and Officer Eads: Inmate: ***"I think [Ellis] died dude"*** Eads: ***"You think he died?"*** Inmate: "[inaudible] that'd be pretty bad" Eads: "[T]hat would be" Inmate: ***"He sounded so bad…."*** Video Clip 11 (Ex. 29) (https://vimeo.com/385606123/78556bcf05). Yet again, Officer Eads did nothing to assist Mr. Ellis. *Id.*

15. Defendant omits numerous material facts. As Defendant concedes, "at approximately 9:00 AM, Ellis asked jailer Eads for a drink of water, and Eads said he would get him some water… [but] Shoemaker told Eads that Ellis could get up and get it himself." Dkt. #120 at 5 (Fact #15). Shoemaker added, ***"Don't let [Ellis] try to fool you."*** Shoemaker Depo. (Ex. 6) at 126:24 – 128:15. Paradoxically, during his deposition, Officer Shoemaker testified that he did not "think that [Ellis] was faking." *Id.* at 128:22 – 129:3. Shoemaker further testified that he forbade Eads from giving Ellis water because he was "[i]nstructed per nurse [Horn] [to] make [Ellis] get up and get his own water…." *Id.* at 136:10-13. Shoemaker was also instructed by Nurse Horn to refrain from assisting Ellis to the bathroom, even if Ellis requested help. *Id.* at 143:22 – 144:1. At around 9:02 AM, Ellis again politely requested assistance from Officers Shoemaker and Eads; they provided none. *See* Video Clip 12 (Ex. 30) (https://vimeo.com/385606132/04a6a23110). At 9:08 AM, Officer Shoemaker shut Ellis's cell door without saying anything or doing anything to help him. *Id.* At no time is Ellis seen leaving the cell to get water and none was provided to him. *Id.* Shoemaker admits that there is no "penological purpose [in] mak[ing] a person who is in excruciating pain … get up to get [his] own water." Shoemaker Depo. (Ex. 6) at 81:15-20.

Defendant omits pertinent facts. Nurse Horn asserts, in her Progress Notes, that she checked on Ellis at 9:45 AM, found him "lying on the mat in H1" and that Ellis "voiced no" complaint. *See* Progress Notes (Ex. 7) at 000028. She additionally notes that Ellis stated he ate

breakfast that morning and requested to "go back to the pod…." *Id.* ***The 9:45 AM Progress Note is a complete fabrication.*** The video evidence establishes that Nurse Horn did not even arrive at the Jail until ***10:24 AM***. *See* Video Clip 15 (Ex. 31) (https://vimeo.com/385606205/46697ce776). While Nurse Horn now ***admits*** that she did not check on Ellis at 9:45 AM, and that ***she was not even at the Jail at 9:45*** AM, she claims that the Progress Note is based on information provided over the phone by detention staff. Horn Depo. (Ex. 8) at 165:7 – 166:15. During his deposition, Assistant Jail Administrator Shoemaker confirmed that Nurse ***Horn is "lying"*** (*i.e.*, Horn perjured herself). Shoemaker Depo. (Ex. 6) at 85:15 – 87:6. Contrary to the false impression Nurse Horn attempted to create with her fictitious 9:45 Progress Note and perjured testimony, the evidence is that Ellis consistently complained of a worsening condition and continually pleaded for help on the morning of October 22, 2015.

At approximately 10:00 AM, Ellis again began yelling from his cell to Officer Shoemaker (who was sitting at the desk): "DO! ... DO! My asthma!... DO! My asthma!... DO! My asthma! ***Asthma attack!…*** DO!" *See* Video Clip 13 (Ex. 32) (https://vimeo.com/385606173/986d03d2a6). Shoemaker ignored his cries for help. *Id.* at 10:01 AM, Ellis again pleaded with the detention staff: "Ahhh... DO!... DO! My asthma! I'm having an ***asthma attack! Help! Help!…*** I'm having an ***asthma attack! Help! … Help!… DO!… DO!… DO!… DO!… DO!"*** *Id.* Approximately three minutes later, Officer Eads went to Ellis's cell and asked, "What do you need?" *Id.* Ellis replied, "My asthma!" *Id.* Shoemaker asked whether Ellis had an inhaler to which Ellis responded that he did not. Shoemaker Depo. (Ex. 6) at 149:3 – 154:17. Shoemaker did not document Ellis's complaints of difficulty breathing and failed to provide any assistance. *Id.* At approximately 10:04 AM, Ellis can be heard moaning in pain and screaming, "Help!" Video Clip 13 (Ex. 32) (https://vimeo.com/385606173/986d03d2a6). In response to Ellis's screams for help, Shoemaker yells, ***"Dude, shut up!"*** *Id*; Derwin Depo. (Ex.

18) at 111:9-25. Neither Shoemaker, nor Eads, nor anyone else at the Jail, did anything to help Mr. Ellis. *Id.*

At 10:12 AM, Ellis again calls out, "DO!" *See* Video Clip 14 (Ex. 33) (https://vimeo.com/385606192/accf763ee3). Shoemaker cynically calls back, "Inmate!" *Id.* Ellis inquires, "Please…do I get albuterol or not? … ***I think I'm dying."*** *Id. See also* Shoemaker Depo. (Ex. 6) at 154:8-17. Shoemaker sardonically answers, ***"If only I'd heard that before."*** Video Clip 14 (Ex. 33) (https://vimeo.com/385606192/accf763ee3). After another inmate makes a joke about the "Boy Who Cried Wolf", ***Shoemaker laughs at Ellis.*** *Id.*

16. Defendant again omits material facts. Nurse Horn's interaction with Ellis -- on the morning of October 22 -- is a stunning and vile display of cruel and inhumane abuse. Dr. Wilcox describes Nurse Horn's conduct as ***"depraved indifference".*** Wilcox Depo. (Ex. 16) at 95:14 – 96:3. ***Nurse Horn's own counsel concedes*** that her behavior was ***"regrettable, unprofessional,*** and, certainly, not worthy of any accommodation…." Dkt. #131 at 13. At 10:42 AM, Ellis pleaded for help again, "DO! …. DO!" Video Clip 16 (Ex. 34) (https://vimeo.com/385606213/c240677c61). Nurse Horn and Assistant Jail Administrator Shoemaker can be seen conversing in the hallway before approaching Ellis's cell. *Id.* Ellis then begins begging the staff to look at his legs, complaining that his legs were turning "black". *Id.* Importantly, discoloration of the legs -- or "mottling" -- is "indicative of the presence of early sepsis…." Wilcox Depo. (Ex. 16) at 76:5 – 77:24. For no good reason, Ellis's complaints and pleas for help enraged Nurse Horn. Nurse Horn first screamed at Ellis: "***LISTEN TO ME AND SHUT UP!*** We've had EMS come over and check you out and they don't think there's nothin' [*sic*] wrong with you...." Video Clip 16 (Ex. 34) (https://vimeo.com/385606213/c240677c61). Ellis pleads: ***"Please! Look at my legs!"*** *Id.* Nurse Horn angrily refuses ***("No! No!")*** and then slams the cell door. *Id.* As Defendant admits, "Horn refused to look at his legs [and] yelled that they are not

black…." Dkt. #120 at 6 (Fact #16). Horn screamed at Ellis: ***"[Y]ou're fucking colorblind!"*** Video Clip 16 (Ex. 34) (https://vimeo.com/385606213/c240677c61). At approximately 10:44, Ellis politely pleaded with Officer Shoemaker, ***"I can't feel my legs sir."*** *Id.* Shoemaker responded by closing the cell door. *Id.* Nurse Horn then went on another tirade: "I just seen [*sic*] you move your legs … you moved your feet ... ***I'm tired of dealing with your dumb ass, you hear me?"*** *Id. See also* Horn Depo. (Ex. 8) at 127:9-17. Nurse Horn admittedly made no medical assessment of Mr. Ellis. *See* Horn Depo. (Ex. 8) at 138:5-18. And while Nurse Horn asserts that Mr. Ellis's legs were not black as he complained, when Ellis was found unresponsive in his cell hours later, mottling to his body and extremities was noted. *See, e.g.,* Progress Notes (Ex. 7) at 000029; *See also* ER Report (Ex. 35) at 000048.

As ***Defendant admits***, Nurse Horn next ***"threatened to punish Ellis by chaining him to the D-ring in the floor of the cell if he kept complaining about his medical condition."*** Dkt. #120 at 6 (Fact #16). Again, the "D-Ring" is a restraint device in the floor of cell H-1. Bray Depo. (Ex. 2) at 76:22 – 79:9. OCSO would handcuff an inmate to the "D-ring", resulting in that inmate being chained to the ring on the floor (in a cell with no water and no toilet), sometimes for hours. *Id.* Nurse Horn furiously screamed at Ellis: "If we put you back in the pod and start [you] pissing in a cup again you're going [to] go to ***[the] fucking D-Ring cause there ain't [sic] a damn thing wrong with you*** … the very first time you [complain] 'oh I cant get up, I need help, oh I'm having seizures' you're going to that D-Ring and that's where you're going stay the whole time that you are here cause ***I'm sick and tired of fucking dealing with your ass! Ain't [sic] a damn thing wrong with you!"*** Video Clip 16 (Ex. 34) (https://vimeo.com/385606213/c240677c61). While admitting her conduct was not

appropriate,[9] Nurse Horn testified: ***"Sometimes you have to threaten those inmates."*** Horn Depo. (Ex. 8) at 131:3 – 134:20. *See also id.* at 134:21 – 136:23, 137:1 – 138:25. After threatening Ellis and providing no medical assessment or care whatsoever, Nurse Horn walked in to the Jail Administrator's office and openly mocked him, ***"my back is broken, my legs are purple, blah, blah, blah, blah..."*** Video Clip 16 (Ex. 34) (https://vimeo.com/385606213/c240677c61) at 10:48 PM.

17. Admit.

18. Denied. *See, e.g., See* LCvR 56.1(c) Statement(I)(A)(3, 5-6, 11-13, 15), *supra.*

19. Defendant omits pertinent facts. Assistant Jail Administrator Shoemaker did not check on Ellis for at least an hour, despite falsely reporting he checked on him every fifteen minutes. *See, e.g.,* Derwin Supp. Report (Ex. 19); Derwin Depo. (Ex. 18) at 46:16 – 47:14. At around 1:03 PM, an inmate trustee is seen on video going to Ellis's cell door. Video Clip 17 (Ex. 36) (https://vimeo.com/385606254/dcd80149d7). About a minute later, the Jail's "lunch lady", Brenda Pierce, comes into view and starts a conversation with the trustee: Pierce: "I've never even looked in there [i.e., Ellis's cell]" Trustee: "Look in there … That shit is crazy…." Pierce: "Ok I'll look" Trustee: ***"LOOKS LIKE HE'S DYING…."*** *Id.* Ms. Pierce then briefly looked into Ellis's cell, only to leave the booking area without providing any assistance. *Id.* Ms. Pierce later drafted an incident report but failed to mention the trustee's statement that it appeared Ellis was dying. *See* Pierce Report (Ex. 37).

At around 1:38 PM, Shoemaker went to Ellis's cell and attempted to rouse him, but Ellis was ***unresponsive.*** Shoemaker Depo. (Ex. 6) at 167:3-14; *see also* Video Clip 18 (Ex. 38)

[9] Nurse Horn testified that she thinks the D-ring is "barbaric." Horn Depo. (Ex. 8) at 216:4-19. Yet, as shown, she did not hesitate to threaten to chain Ellis to the D-ring if he continued to report his medical conditions to Jail staff.

(https://vimeo.com/385606266/2caf521ea7); Shoemaker Report (10-22-15) (Ex. 39). As Shoemaker observed, Ellis's ***feet and hands were "discolored*** to a blue with red spots" and he was ***"cold to the touch."*** Shoemaker Report (10-22-15) (Ex. 39); Shoemaker Depo. (Ex. 6) at 117:12 – 118:19. At about 1:39 PM, Shoemaker left to retrieve Nurse Horn. *See* Video Clip 18 (Ex. 38) (https://vimeo.com/385606266/2caf521ea7). At around 1:40 PM, Shoemaker returned from Nurse Horn's office, followed by a very slowly moving Nurse Horn. *See* Video Clip 18 (Ex. 38) (https://vimeo.com/385606266/2caf521ea7). At 1:41 PM, Ellis is heard moaning in pain. *Id.* At approximately 1:42 PM, Nurse Horn left Ellis's cell, and, without any sense of urgency, walked back to her office, grabbed a blood pressure cuff, and slowly walked back. *Id.* According to Nurse Horn, when she entered Ellis's cell, she observed that Ellis: (A) was in respiratory distress, (B) had "garbled" speech, (C) was "cool to touch", (D) "responded in pain when touched on any part of body" and (D) had "mottled" extremities that were cold to touch. Progress Notes (Ex. 7) at 000029-30. Nurse Horn called for Quapaw EMS, who were dispatched at 1:49 PM. *See* Quapaw EMS Report (Ex. 40) at 000056.

20. Before Quapaw EMS arrived, in the middle of a medical emergency, inmate trustees were deployed to remove and clean the urine-soaked mat (crudely referred to as a "piss mat") that Ellis had been sleeping on. *See* Shoemaker Depo. (Ex. 6) at 181:15 – 183:22; Video Clip 18 (Ex. 38) (https://vimeo.com/385606266/2caf521ea7). Plaintiff disputes that Ellis was "awake and talking" for any significant period of time after Quapaw EMS arrived. Five minutes after Quapaw EMS first arrived in the booking area, the EMTs had to physically sit Ellis up. *See* Video Clip 18 (Ex. 38) (https://vimeo.com/385606266/2caf521ea7). Six minutes after Quapaw EMS arrived, two paramedics and a fireman can be seen carrying a stiff and unconscious Ellis out to the stretcher. *Id.* One of the paramedics slapped Ellis; Ellis did not respond. *Id.* Seven minutes after Quapaw EMS arrived, Ellis was taken out of the door from booking to the sally port; Ellis

does not move or say anything at any point that he is on the stretcher. *Id.* After Quapaw EMS left the booking area with Ellis, Nurse Horn and Assistant Jail Administrator Shoemaker began working on their incident reports together, with Nurse Horn largely instructing Shoemaker as to what he should report. *Id.* At one point, Nurse Horn suggested that Ellis possibly committed suicide. *Id. See also* Horn Depo. (Ex. 8) at 204:1 – 205:4. [10]

Ellis was unresponsive at the ER and later pronounced dead. *See* ER Report (Ex. 35). He was just 26-years-old. *See* ME Report (Ex. 41) at 000065. The Medical Examiner determined that Ellis's cause of death was sepsis/septic shock due to acute bronchopneumonia, and that "toxicology [was] noncontributory." *Id.* at 000065-66. The Medical Examiner further noted that Ellis was allegedly found with "a bed sheet tied loosely around his neck," (*Id.* at 000067) but also that the "neck [was]...free of mass and scar." *Id.* at 000069. As Dr. Wilcox explains, sepsis is "a final common pathway of many types of infections, and if you … diagnose [the underlying infection] properly and treat the infection adequately early enough, the patients never enter sepsis." Wilcox Depo. (Ex. 16) at 80:17 – 81:15. Dr. Wilcox opines that Ellis's death was "entirely preventable" as he was "young and otherwise healthy" and his "acute pneumonia … could easily have been diagnosed and treated." Wilcox (Verified) Report (Ex. 9) at 8. Dr. Wilcox notes that "it is so basic from a healthcare perspective to take care of an otherwise healthy young male who has a significant change in his health presentation" and that "[t]here were so many opportunities for so many

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[10] Shoemaker commented in his Report that there "was a blanket with a towel tied on the blanket that was sitting on [Ellis's] chest…." Shoemaker Report (10-22-15) (Ex. 39). In her Progress Notes, Nurse Horn claimed to have observed that Ellis's head and neck were "hyperextended" and that there were red marks on his neck which "may have been ligature marks". Progress Notes (Ex. 7) at 000029. Nurse Horn later reported to Quapaw EMS that "[a]t last checking patient was found with blanket wrapped around his neck but not tightly…." Quapaw EMS Report (Ex. 40) at 000059. The Medical Examiner found no "ligature marks" on Ellis's neck. *See* Horn Depo. (Ex. 8) at 206:24 – 207:1; ME Report (Ex. 41). Plaintiffs believe that, taken together, this is circumstantial evidence that Nurse Horn, with Shoemaker's assistance, attempted to stage Ellis's death as a suicide.

people [at the Jail] to intervene and none of them did." *Id.* at 9. Ultimately, Dr. Wilcox found that the "evidence of deliberate indifference to Mr. Ellis's serious medical needs is overwhelming and systemwide." *Id.* at 10.

B. The Jail's Medical Delivery System (Policy or Custom)

21. The booking process is largely irrelevant in this case. However, Dr. Wilcox found that "[t]he medical intake process in the Ottawa County jail is woefully inadequate." Wilcox (Verified) Report (Ex. 9) at 8. "It amounts to an officer asking a few brief questions with no specificity and it falls well below the standard of care." *Id.*

22. "[T]he existence of written policies of a defendant are of no moment in the face of evidence that such policies are neither followed nor enforced." *Ware v. Jackson County, Mo.,* 150 F.3d 873, 882 (8th Cir. 1998). While it is true that OCSO had a written Medical Services Policy providing that "inmates are entitled to health care comparable to that available to citizens in the surrounding community" (Dkt. #120 at 7 (Fact #22)), as a matter of practice, that policy was utterly disregarded and never complied with. According to Officer Bray, the medical care at the Jail "[w]ould not be what [he] would expect to find in a civilian world," and, based on his observations, was ***"subpar".*** Bray Depo. (Ex. 2) at 28:20 – 29:19, 33:16-21. The Jail's medical delivery system was ***"destined to fail."*** *Id.* at 148:18-22.

The written Medical Services Policy specifically required the medical care at the facility to be "delivered under the direction of a licensed physician." Shoemaker Depo. (Ex. 6) at 66:11-20; *see also* Dkt. #120-21 (Under Seal). However, from ***2005 to 2017***, the Jail was staffed with a ***single LPN, Nurse Horn.*** *See* Horn Depo. (Ex. 8) at 21:18 – 22:8. There was no physician providing care at the Jail. *See, e.g.* Bray Depo. (Ex. 2) at 222:24 – 223:25. And there was no physician directing the care provided at the Jail. *See, e.g.,* Horn Depo (Ex. 8) at 101:3 – 103:14. According to the Assistant Jail Administrator, all medical decisions at the Jail were made by Nurse Horn. Shoemaker

Depo. (Ex. 6) at 67:9 – 68:20. *See also* Harding Depo. (Ex. 20) at 38:16-25. Thus, admittedly, the ***policy was not being complied with.*** *Id.* Making matters worse, Nurse Horn was completely unsupervised and given unfettered discretion. Nurse Horn claims that her supervisor was the Jail Administrator, Jeff Harding. Horn Depo. (Ex. 8) at 20:24 – 21:17. During his deposition, however, the Jail Administrator testified that he was ***not*** Nurse Horn's supervisor. Harding Depo. (Ex. 20) at 39:17 – 40:1. Nurse Horn was never given a performance evaluation nor was she peer reviewed. Horn Depo. (Ex. 8) at 20:24 – 21:17.

While it is true, as Defendant states, that the written Medical Services Policy required the establishment of a "schedule for sick call" at the Jail (Dkt. #120 at 7 (Fact #22)), ***there was no scheduled sick call at the Jail.*** *See* Horn Depo. (Ex. 8) at 93:22 – 94:11. In fact, ***Nurse Horn did not even maintain a sick call list.*** *Id.* at 154:12-14. Indeed, Nurse Horn, despite being the sole nurse at the Jail, did not have a set schedule of when her shifts started and stopped. *Id.* at 143:15-17. Horn's daily shift was *supposed* to be approximately 9:00 AM. – 5:00 PM; but, in reality, Horn's hours were "[w]henever she wanted them to be." Shoemaker Depo. (Ex. 6) at 97:1 – 98:8. ***Nurse Horn was commonly not present at the Jail*** -- even during regular working hours -- when officers needed help with an inmate's medical condition. *See, e.g.,* Bray Depo. (Ex. 2) at 122:19 – 123:3; Shoemaker Depo. (Ex. 6) at 92:18-25. Stunningly, OCSO did not require Nurse Horn to track her hours until months after Ellis's death. Shoemaker Depo. (Ex. 6) at 95:7 – 96:6. Shoemaker complained -- first to the Jail Administrator and later to the Sheriff -- about Nurse Horn's habitual absences during working hours, but the problem continued to recur. *Id.* at 93:1 – 94:19.

As was the case with Mr. Ellis, it was Nurse Horn's practice to use paramedics/EMTs to medically assess inmates housed at the Jail. *See* Horn Depo. (Ex. 8) at 144:14-17. As Assistant Jail Administrator Shoemaker testified, because Nurse Horn was ***commonly absent from the Jail***

during working hours, when an inmate medical issue would arise, detention staff were forced to call EMS to assess the inmate. Shoemaker Depo. (Ex. 6) at 92:18-25. In fact, "more often than not" when detention staff reported a medical issue to Nurse Horn, she would rely on EMS to check out the inmate without ever conducting her own assessment. Bray Depo. (Ex. 2) at 112:11 – 113:18; 116:5-16.[11] Nurse Horn would use EMS to medically assess inmates despite the fact that paramedics/EMTs have less medical training than an LPN. *Id.* at 144:18 – 145:4. It is Dr. Wilcox's opinion that such a practice constitutes an inappropriate "reversal in the medical licensure." Wilcox Depo. (Ex. 16) at 66:12 – 67:20. Nurse Horn can provide ***no answer*** as to why she relied on EMS to make medical decisions despite their lesser training. Horn Depo. (Ex. 8) at 145:5-8. And even though Nurse Horn used EMS to provide medical assessments of the inmates, she ***never bothered to review the records generated by EMS***. *Id.* at 157:10-13. When Nurse Horn would instruct jailers to call EMS to come to the Jail for an inmate medical assessment, oftentimes EMS would decide not to transport the inmate to the hospital. Bray Depo. (Ex. 2) at 116:17-25. The Sheriff and Jail Administrator were aware that Nurse Horn was using paramedics/EMT's for medical decision-making purposes, but neither raised any concerns about this practice. Horn Depo. (Ex. 8) at 145:10-146:3. *See also* Shoemaker Depo. (Ex. 6) at 91:2-21.

With Nurse Horn out of the facility so often, the detention staff, who have no medical training, were put in the untenable position of attempting to provide medical supervision of the inmates. In this regard, OCSO written policy contemplates that the detention staff would "treat" inmate's medical or mental health conditions "as needed". Jail Nurse Policy (Ex. 42) at Plaintiffs_000326. In Nurse Horn's absence, Assistant Jail Administrator Shoemaker was having

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11 Other times when a medical request was made of Nurse Horn, she would feign her intent to assess the patient the inmate the following day, and never actually see the inmate. Bray Depo. (Ex. 2) at 34:21 – 35:8.

to perform many of her duties, such as "fill[ing] the med cart, always making sure that the inmates had the correct stuff to check their insulin, mak[ing] sure that [the inmates] had everything" they needed. Shoemaker Depo. (Ex. 6) at 94:20 – 95:5. As she admits, Nurse Horn would wait for the detention staff to call her when the officers believed an inmate had a serious illness. *See* Horn Depo (Ex. 8) at 72:14 – 73:15. Nurse Horn would then "make the decision whether to go in" to the Jail in order to address the inmate's medical issue. *Id.* In essence, Nurse Horn decided whether to show up at work and provide nursing services (which was, of course, her job) based on the assessments of non-medical detention staff. *Id.*

Simply put, the reality of the medical delivery system at the Jail was a far cry from the written Medical Services Policy. As summarized by Dr. Wilcox, ***the Jail "does not have a functioning medical system*** and the gaping holes in their overall system [were] directly contributory to [Ellis's] death." Wilcox (Verified) Report (Ex. 9) at 9.

23. While OCSO may have a written policy that gives inmates the ability "to make medical complaints for review by qualified medical personnel" (Dkt. #120 at 7 (Fact #23)), such complaints were clearly not being reviewed by any such medical professional and were not being addressed. *See, e.g.,* LCvR 56.1(c) Statement(I)(B)(22), *supra.* In particular, the "Non-Emergency & Medical Complaints" Policy provides that "[c]ases shall be referred according to the facility procedures to the appropriate hospital emergency room, to the regularly scheduled sick call visit by the facility physician." Dkt. #120-22 (Under Seal); *see also* Durborow Depo. (Ex. 43) at 70:14-25. But, because the ***Jail had no regularly scheduled sick call or a facility physician*** (*see* LCvR 56.1(c) Statement(I)(B)(22)), it is axiomatic that ***OCSO never even attempted to comply with this Policy.***

24. Once again, reality diverges sharply from the written version of OCSO's medical delivery system. *See, e.g.,* LCvR 56.1(c) Statement(I)(B)(22). It is true that OCSO had a contract

with a Physician's Assistant, Aleta Fox, under which Fox was supposed to be at the Jail "once a week" for "inmate medical exams." Jail Medical Treatment Contract (Ex. 44). However, contrary to the Jail's Medical Services Policy and the contract, Ms. Fox did not have a set period of time when she would be at the Jail, but would only come when and if Nurse Horn called her. *See* Horn Depo. (Ex. 8) at 24:10 – 25:2. Ms. Fox certainly did not conduct standard medical rounds at the Jail. *Id.* at 154:9-11. As an example of how sparingly the Jail would utilize Ms. Fox, Nurse Horn never called Ms. Fox pertaining to Mr. Ellis, despite his obvious and serious medical needs. *Id.* at 152:19-22. Further, the Jail Administrator and Sheriff were aware that Ms. Fox would only show up at the Jail when Horn felt the need to bring her in for additional triaging. *Id.* at 46:4-15.

25. While Plaintiffs admit that Nurse Horn was "responsible for the day-to-day medical care of the inmates", the remainder of Defendant's Fact No. 25 is contrary to the evidence. *See, e.g.,* LCvR 56.1(c) Statement(I)(B)(22-23), *supra.*

26. OCSO's Emergency Medical Care Policy defines an emergency situation to include "unconsciousness", "severe breathing difficulties", "sudden onset of bizarre behavior" and "health or life-threatening situation". Dkt. #120-24 (Under Seal) at 000282; Shoemaker Depo. (Ex. 6) at 80:3-14. While the written Policy allowed detention officers to directly "contact an ambulance" in an emergency situation if the nurse was not on the premises (*id.*), this is in direct conflict with the training provided by OCSO. Per OCSO training, detention officers were ***prohibited from sending an inmate to the emergency room unless Nurse Horn approved it.*** *See, e.g.,* Bray Depo. (Ex. 2) at 49:10 – 50:2, 50:10-17, 51:5-13. Nurse Horn testified that even when an inmate had a sudden onset of shortness of breath, the detention officer would call her and she would decide whether to send the inmate to the ER. Horn Depo (Ex. 8) at 80:6-23.

27. Yet again, the actual practice at the Jail was contrary to the written policy. OCSO's "Surveillance of Holding Cells" Policy provides that "[i]f the receiving Jailer suspects that an

inmate may … need … medical observation…", the receiving jailer may place the inmate in a segregated holding cell. Dkt. #120-13 (Under Seal) at 000388. As a matter of practice, however, Nurse Horn would decide whether to place an inmate in a holding cell for medical reasons, and either the Jail Administrator or Assistant Jail Administrator would decide whether to place the inmate in a holding cell for ***disciplinary reasons***. *See* Shoemaker Depo. (Ex. 6) at 139:6 – 140:2. There is evidence in this case that the Jail Administrator made the decision to place Mr. Ellis in the holding cell (H-1). *See, e.g.,* Bray Depo. (Ex. 2) at 75:15 – 76:6. According to Nurse Horn's testimony, she did not make the decision to transfer Ellis to H-1. Horn Depo. (Ex. 8) at 105:4-21. The inference to be drawn from this evidence is that Ellis was placed in H-1 for disciplinary reasons. In this regard, Shoemaker concedes that he decided to keep Ellis in H-1, not for medical observation, but because he needed some "cool down time…." Shoemaker Depo. (Ex. 6) at 116:22 – 117:11.

28. *See, e.g.,* LCvR 56.1(c) Statement(I)(B)(26), *supra.*

29-30. The training provided by OCSO was utterly insufficient. *See, e.g.,* Bray Depo. (Ex. 2) at 259:18-23. For instance, Officer Bray does not recall ever seeing the policy manual in the Jail. *Id.* at 282:12 – 284:5. During the brief time in which Bray was involved in on-the-job shadowing, neither he nor the person he was shadowing had a copy of the Policies and Procedures manual. *Id.* at 284:6-15. Furthermore, as shown above, there is significant evidence that the practices at the Jail were diametrically opposed to the Medical Services, Non-Emergency Care & Medical Complaints and Emergency Medical Care Policies. *See* LCvR 56.1(c) Statement(I)(B)(22-24, 26-27), *supra.* This evinces a total failure to train with respect to OCSO's medical policies.

31. Sheriff Durborow's lack of "interaction" with Ellis is irrelevant for the purposes of official capacity/municipal liability.

32. Part D of OCSO's Medical Services Policy required regular reviews/audits of the Jail's medical delivery system. *See* Dkt. #120-21 (Under Seal) at 000336; Durborow Depo. (Ex. 43) at 60:1 – 61:14; Harding Depo. (Ex. 20) at 109:10 – 111:14; Horn Depo. (Ex. 8) at 95:12-23, 97:13 – 98:10. More specifically, Part D required the Jail Administrator to "review annually statistics he/she ha[d] complied [*sic*] in concert with the facility nurse indicating the number of inmates receiving medical services by category of care." *Id.* The Policy further required the Jail Administrator and Nurse to review -- "[a]t least quarterly" -- the "effectiveness and efficiency of medical care", "changes implemented", "cost effectiveness of programs" and "any recommended changes." *Id.* These ***audits/reviews, as required under Part D of the Medical Services Policy, were <u>never</u> done.*** *See, e.g.,* Horn Depo. (Ex. 8) at 97:13 – 98:10; Shoemaker Depo. (Ex. 6) at 68:21 – 70:7. And Sheriff Durborow did nothing to ensure that this Policy was being complied with. *See* Durborow Depo. (Ex. 43) at 60:1 – 61:14.

33. There is ample evidence that Sheriff Durborow and the Jail Administrator were aware of numerous, and serious, problems with Nurse Horn's performance, specifically, and the Jail's medical delivery system, more generally. *See, e.g.,* LCvR 56.1(c) Statement(I)(B)(22, 24), *supra. See also* Bray Depo. (Ex. 2) at 248:3-18, 249:1-5. In addition to the evidence summarized above, Nurse Horn testified that she complained during staff meetings, which the Jail Administrator attended, regarding multiple and recurring problems with the Jail's medical system. *See* Horn Depo (Ex. 8) at 65:5 – 69:24. Specifically, Nurse Horn reported, *inter alia,* that detention officers were: (A) not timely providing medications to inmates; (B) not taking inmate diabetic inmates' blood sugar on time; (C) failing to conduct 15-minute checks; (D) failing to call her when an inmate was booked into the Jail with a medical condition; and (E) not timely notifying her when an inmate had a seizure. *Id.* Of course, Nurse Horn's complaints raised a much larger concern that lay detention officers were being expected to perform nursing functions.

34. The lack of prior known complaints specifically regarding Shoemaker is immaterial and provides no basis for summary judgment.

35. Plaintiffs need not show that Sheriff Durborow had prior knowledge of "jail staff interacting with … inmates in a manner similar to which staff members interacted with Ellis." Dkt. #120 at 10 (Fact #35). There is sufficient evidence, including circumstantial evidence, of OCSO's knowledge of dangerous deficiencies in the Jail's medical delivery system. *See, e.g.,* LCvR 56.1(c) Statement(I)(B)(22, 24, 33). Further, the Sheriff did nothing to monitor or investigate whether the Jail's medical delivery system was being implemented in compliance with OCSO policy; rather, he was merely "watching the money". *See, e.g.,* Durborow Depo. (Ex. 43) at 53:22 – 54:1, 60:1 – 61:14, 128:3 – 129:11, 133:5 – 134:15.

36. Plaintiffs' evidence regarding the "D-Ring" is discussed above. *See* LCvR 56.1(c) Statement(I)(A)(5-6, 16).

37. Denied. *See* LCvR 56.1(c) Statement(I)(B), *supra*, and LCvR 56.1(c) Statement(II), *infra.*

II. Additional Facts Precluding Summary Judgment

1. At all pertinent times, OCSO had a written Policy in place addressing the duties of the "Jail Nurse". *See* Jail Nurse Policy (Ex. 42) at Plaintiffs_000325-27. Importantly, the Jail Nurse Policy provides: "Basically, a Correctional Facility Nurse does almost everything a trauma nurse does. ***It's just the type of patients that we deal with are different. [N]ever let your guard down. [N]ever turn your back to them. [D]on't ever let them gain your trust."*** *Id.* at 326 (emphasis added). It was under this Policy that Nurse Horn assumed Mr. Ellis was malingering and treated him with utter contempt and depravity. The Jail Nurse Policy further states that it is the nurse's responsibility to provide "diagnostic… procedures…." *Id.* at 325. However, it is beyond the scope of a nurse's training to render a diagnosis. *See, e.g.,* Wilcox (Verified)

Report (Ex. 9) at 8. When asked in her deposition what she understood her scope of practice to be as an LPN, Nurse Horn replied: "That's hard to say working in a jail facility. ***I don't know how to answer that."*** Horn Depo (Ex. 8) at 43:16-20.

2. The Jail Log in this case reveals numerous, and disturbing, medical problems at the Jail, in addition to Ellis's. *See* Jail Log (Ex. 11). For instance, on October 13, 2015, an inmate named Debolt had a seizure. *Id.* 000728. Nurse Horn was not onsite, but advised the officers, over the phone, to call EMS. *Id.* EMS arrived, but opted not to take Debolt to the hospital. *Id.* At around 9:06 PM, inmate Debolt was release on an "OR" (i.e., "own recognizance") bond. *Id.*

3. On October 14, 2015 (which was a Thursday) at approximately 9:16 AM, it was documented that an inmate "Holderfield" was ***"not responding"*** but still breathing. Jail Log (Ex. 11) at 000729. Based on the documentation, Holderfield had refused breakfast that morning and the day before. *Id.* at 729, 729. As was her practice, Nurse Horn was absent from the Jail, but advised the officers, via telephone, to call EMS. *Id.* at 729. Similar to Ellis, EMS assessed Holderfield, but decided not to transport her to the hospital. *Id.*

4. At around 6:04 PM on October 20, 2015, Nurse Horn was called about an inmate with ***"chest pains".*** *See* Jail Log (Ex. 11) at 000744. Without assessing the inmate, Nurse Horn did not send him to the hospital, but advised the officers to simply have the inmate ***"sit and relax"***, concluding that it was "probably [an] anxiety attack." *Id.* (emphasis added). This is yet another example of Nurse Horn recklessly rendering a diagnosis (beyond the scope of her licensure), over the phone no less, and ignoring objective complaints of an emergent, and potentially life-threatening, condition.

5. On the afternoon of October 21, 2015, it was once again reported that inmate Holderfield was "breathing but ***unresponsive."*** Jail Log (Ex. 11) at 746. This is was an "emergency situation" as defined by OCSO's Emergency Medical Care Policy. *See* Dkt. #120-24

(Under Seal) at 000282; Shoemaker Depo. (Ex. 6) at 80:3-14. As shown *supra*, Nurse Horn was not at the facility on the afternoon of October 21. Yet, without assessing Holderfield, she advised the officers, over the phone, ***"to leave [Holderfield] in B Pod."*** Jail Log (Ex. 11) at 000746; Horn Depo. (Ex. 8) at 220:5 – 221:16. Nurse Horn has no explanation as to why she ordered that Holderfield was to stay in B Pod, and now acknowledges that EMS should have been called. Horn Depo. (Ex. 8) at 220:5 – 221:16. At 4:43 PM on October 21, while Ellis is being assessed by EMS, it was logged that Nurse Horn was called about an "unresponsive" female inmate (Ms. Holderfield) who was "cold to touch." Jail Log (Ex. 11) at 000747.

6. Less than two hours after Nurse Horn decided to leave inmate Holderfield at the Jail (on October 21), Ellis had his first seizure. Jail Log (Ex. 11) at 000746-47. Nurse Horn was still absent. *Id.* The events surrounding Ellis's seizures are summarized *supra.*

7. At 7:09 PM on October 21, 2015, Nurse Horn was called in reference to an inmate -- Jenkins -- with a recorded ***blood pressure of 184/120***, which is considered to be a hypertensive crisis. Jail Log (Ex. 11) at 000747; Horn Depo. (Ex. 8) at 222:20 – 224:1. Rather than send this inmate to the hospital, Nurse Horn advised the detention staff, over the phone, that that the inmate should ***"lay down [and] take it easy"***, with a plan to see him the next day. *Id.* In retrospect, Nurse Horn recognizes that Jenkins should have gone to the ER and she cannot explain why this did not happen. *Id.*

8. Just before 10:00 PM on October 22, 2015, Nurse Horn made the decision that an inmate with a reported history of "suicide tendency" was not "suicidal". Jail Log (Ex. 11) at 000749. Nurse Horn made this decision over the phone without assessing the inmate. *Id.*

9. The Ottawa County Sheriff is "ultimately responsible" for the well-being of inmates housed at the Jail. Durborow Depo. (Ex. 43) at 22:18 – 23:1. Sheriff Durborow admits that Nurse Horn ***"refused to do her job"*** and finds her treatment of Ellis to be ***"very***

disturbing." *Id.* at 107:22 – 108:20. ***Sheriff Durborow believes that Nurse Horn***, the nurse who served under him at the Jail for many years, ***is responsible for Ellis's death.*** *Id.* at 118:5 – 119:3. Sheriff Durborow also concedes that his jailers failed to follow policy and could have "gotten [Ellis] out" of the Jail if they had appropriately responded to his complaints. *Id.* at 119:2-24.

ARGUMENT

PROPOSITION: SHERIFF FLOYD, IN HIS OFFICIAL CAPACITY, IS *NOT* ENTITLED TO SUMMARY JUDGMENT ON PLAINTIFF'S CONSTITUTIONAL CLAIMS

Although "neither prison officials nor municipalities can absolutely guarantee the safety of their prisoners, [t]hey are ... responsible for taking reasonable measures to [e]nsure the safety of inmates." *Lopez v. LeMaster,* 172 F.3d 756, 759 (10th Cir.1999) (internal citation omitted). Sufficed to say, OCSO failed to take reasonable measures to ensure Ellis's safety. Plaintiffs' Constitutional claims -- of deliberate indifference to a serious medical need -- are brought against Sheriff Floyd in his official capacity. A claim against a state actor in his official capacity, such as Sheriff Floyd, "is essentially another way of pleading an action against the county or municipality" he represents and is considered under the standard applicable to § 1983 claims against municipalities or counties. *Porro v. Barnes,* 624 F.3d 1322, 1328 (10th Cir. 2010). *See also Kentucky v. Graham,* 473 U.S. 159, 166 (1985) ("[A]n official-capacity suit is, in all respects other than name, to be treated as a suit against the entity."). In *Monell v. New York City Dept. of Social Servs.,* 436 U.S. 658 (1977) and subsequent cases, the Supreme Court has consistently "required a plaintiff seeking to impose liability on a municipality under § 1983 to identify a municipal 'policy' or 'custom' that caused the plaintiff's injury." *Bd. of Cnty. Comm'rs of Bryan Cnty., Okl. v. Brown,* 520 U.S. 397, 403 (1997).[12] The evidence

[12] Because Plaintiffs' claims against the Sheriff in his official capacity are treated as claims against Ottawa County/OCSO, Plaintiffs need not establish that former Sheriff Durborow had

in this case establishes that the Jail had no "functioning medical system" and that "gaping holes in their overall system [were] directly contributory to [Ellis's] death." Wilcox (Verified) Report (Ex. 9) at 9. The evidence in this case easily meets the requirements of *Monell.* Sheriff Floyd is not entitled to summary judgment.

A. Sheriff Floyd Raises No Argument Concerning "Underlying" Violations of Mr. Ellis's Constitutional Rights

Usually, 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). And in most § 1983 cases involving a *Monell* theory, the "underlying constitutional violation" issue is vigorously disputed. Not here. Sheriff Floyd does not address the "underlying violation" issue in his Motion for Summary Judgment. *See* Dkt. #120. Thus, for the purposes of the Motion, it is essentially uncontested that the Sheriff's subordinate officers violated Mr. Ellis's Constitutional right to be free from deliberate indifference to his serious medical needs. Of course, any argument to the contrary would have been futile. Importantly, Former Sheriff Durborow admits that Nurse Horn "refused to do her job" and that she is responsible for Ellis's death. Durborow Depo. (Ex. 43) at 107:22 – 108:20; 118:5 – 119:3. Overall, Plaintiffs' evidence of underlying Constitutional violations is comprehensive, overwhelming and unassailable. *See* Introductory Statement; LCvR 56.1(c) Statement(I)(A), *supra.*. More than this, the evidence establishes that the denial of Ellis's serious medical needs produced "physical torture" and a

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any "personal participation" in the underlying violation of Ellis's Constitutional rights. *See, e.g., Essex v. Cty. of Livingston,* 518 F. App'x 351, 355 (6th Cir. 2013). And in any event, even with individual capacity supervisory liability claims, "personal participation" does not require "direct participation" in the violation of a plaintiff's rights. *Dodds v. Richardson,* 614 F.3d 1185, 1195 (10th Cir. 2010). As such, Defendant's argument concerning former Sheriff Durborow's "personal participation" (Dkt. #120 at 12) is misplaced. Defendant seems to concede this point. *Id.* ("Plaintiff's § 1983 claim against Defendant Floyd must be premised on the existence of some policy, practice, or custom in place under former Sheriff Durborow.").

"lingering death", "the evils of most immediate concern to the drafters of the [Eighth] Amendment." *Estelle v. Gamble,* 429 U.S. 97, 103 (1976)

B. There is Significant Evidence of an Unconstitutional Policy or Custom – Including a Failure to Train and Supervise – That is Causally Related to the Violation of Ellis's Constitutional Rights

County sheriffs may be held liable for the maintenance of an unconstitutional health care delivery system. In *Burke v. Regalado,* 935 F.3d 960, 999-1001 (10th Cir. 2019), the Tenth Circuit upheld a jury verdict against the Tulsa County Sheriff for his failure to supervise based on evidence that he maintained a policy or custom of insufficient medical resources and training, chronic delays in care and indifference toward inmate medical needs at the Tulsa County Jail. *See also 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."). As summarized herein, there is evidence that the Ottawa County Sheriff maintained such a system at the Jail. And there are numerous bases upon which to find the requisite "policy or custom".

First, and fundamentally, OCSO's written Jail Nurse Policy is unconstitutional in both concept and implementation and is causally linked to Ellis's suffering and death. It is well-established that a *Monell* plaintiff may establish the necessary policy or custom through evidence of a "formal regulation or policy statement…." *Bryson v. City of Oklahoma City,* 627 F.3d 784, 788 (10th Cir. 2010). It is rare, however, to find a written policy statement that causes a Constitutional deprivation. This is one of those rare cases. The Jail Nurse Policy arbitrarily, and perilously, draws distinctions in how a nurse would treat patients in the community and how a nurse must treat

inmates at the Jail: ***"[D]on't ever let [the inmates] gain your trust."*** Jail Nurse Policy (Ex. 42) at 326 (emphasis added). This a written policy statement that, in no uncertain terms, admonishes the Jail Nurse to always distrust the inmate patients. Based on the evidence in this case, this was the *only* medical policy that was followed at the Jail. It would appear that Nurse Horn adopted this policy statement as her overarching philosophy. From early on, Nurse Horn refused to believe Ellis's complaints of a serious medical need. Without ever conducting even a basic medical assessment, Nurse Horn baselessly labeled Ellis a malinger,[13] even as his condition worsened. Adding insult to injury, Nurse Horn instructed the detention staff to do the same. This policy of distrust spread through the entire Jail staff with disastrous consequences. In addition to Ellis's case, there were other inmates with objectively serious complaints, during the same time frame, who Nurse Horn chose not to believe despite the absence of any medical assessment or data. *See* LCvR 56.1(c) Statement(II)(4-5, 7-8). There is a direct link between the Jail Nurse Policy and the violation of Ellis's rights. On this basis alone, summary judgment should be denied.

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[13] *See, e.g., Burke,* 935 F.3d at 994 (10th Cir. 2019) (finding evidence of deliberate indifference where, "[d]espite his obvious need", jail nurses and detention staff "either dismissed Mr. Williams as a malingerer without undertaking any investigation into his condition or abdicated their gatekeeping roles by failing to relay the problem to medical staff."); *Walker v. Benjamin,* 293 F.3d 1030, 1040 (7th Cir. 2002) (in § 1983 case involving prisoner, reversing entry of summary judgment on qualified immunity grounds and stating, "[t]he fact that Nurse Dunbar and Dr. Benjamin may have based their refusal to treat Walker's pain on a good-faith belief that he was malingering, that he was not in pain but merely trying to get high with the narcotic painkiller, is an issue for the jury."); *Smith v. Campbell Cty., Kentucky,* No. CV 16-13-DLB-CJS, 2019 WL 1338895, at *14 (E.D. Ky. Mar. 25, 2019) ("[W]hen a doctor is faced with reports of a patient's worsening condition, his decision not to provide treatment based on a continued belief that the patient is malingering presents a triable issue of fact regarding deliberate indifference."); *Jordan v. Welborn,* No. 15-CV-00822-NJR, 2015 WL 4941783, at *2 (S.D. Ill. Aug. 19, 2015) ("Sgt. Welborn's apparently baseless belief that Plaintiff was faking disorientation and speech and mobility impairment could amount to deliberate indifference.").

Second, OCSO completely failed to supervise Nurse Horn. From 2005 to 2017, the Jail was staffed with a single LPN, Nurse Horn. With no oversight or accountability, Nurse Horn was given carte blanche to run the Jail's entire medical system, in violation of OCSO's own Medical Services policy. *See* LCvR 56.1(c) Statement(I)(B)(22). Nurse Horn was not even required by OCSO to regularly show up to the Jail, and she was frequently absent during regular working hours. *Id.* Indeed, it was her default practice to wait for the non-medical detention staff to call her with a medical issue before deciding whether to show up for work. *Id.* And even then, she would habitually remain offsite, attempting to "assess" inmates over the phone and relinquishing her nursing duties to the jailers -- who have no medical training -- and paramedics/EMTs, who have lesser medical training. *Id.* Simply put, the inmates at the Jail effectively had no access to medical care at the Jail. This "system" under Nurse Horn was a dangerously deficient. It was this "system" that failed Mr. Ellis. Sheriff Durborow and/or the Jail Administrator were aware of the problems, but never took any action to supervise Nurse Horn, in deliberate indifference to the consequences. *See, e.g.,* LCvR 56.1(c) Statement(I)(B)(22, 24, 33).

Third, as a matter of practice and custom, OCSO summarily ignored, and violated, its own medical policies that were necessary to inmate health and safety. *See, e.g.,* LCvR 56.1(c) Statement(I)(B)(22-24, 26-27, 32-33). In his Motion, the Sheriff attempts to avoid liability primarily based on the mere existence of written policies purportedly governing medical care at the Jail. *See, e.g.,* Dkt. #120 at 15-17. However, "the existence of written policies of a defendant are of no moment in the face of evidence that such policies are neither followed nor enforced." *Ware v. Jackson County, Mo.,* 150 F.3d 873, 882 (8th Cir. 1998). It is also well established that "[t]he knowing failure to enforce policies necessary to the safety of inmates may rise to the level of deliberate indifference." *Tafoya v. Salazar,* 516 F.3d 912, 919 (10th Cir. 2008) (citing *LaMarca v. Turner,* 995 F.2d 1526, 1536 (11th Cir.1993) (finding deliberate indifference where prison official "failed to ensure that his direct

subordinates followed the policies he established"), and *Goka v. Bobbitt,* 862 F.2d 646, 652 (7th Cir.1988) (holding that failure to enforce a policy where the policy is critical to inmate safety may rise to the level of deliberate indifference)). *See also Mata v. Saiz,* 427 F.3d 745, 758 (10th Cir. 2005) (finding that a "DOC protocol mandating that [defendant] treat severe chest pain as a cardiac symptom constitutes circumstantial evidence of her knowledge of the seriousness of such pain").

Here, the evidence establishes that, as a matter of routine Jail operations, ***none*** of the written medical policies -- as cited by the Sheriff in his Motion -- were followed or enforced. *See, e.g.,* LCvR 56.1(c) Statement(I)(B)(22-24, 26-27, 32-33). The following table summarizes this custom of policy violations.

Written Policy[14]	Actual Practice / Reality
"[I]nmates are entitled to health care comparable to that available to citizens in the surrounding community"	The Jail "does not have a functioning medical system and the gaping holes in their overall system [were] directly contributory to [Ellis's] death." Wilcox (Verified) Report (Ex. 9) at 9. The medical care at the Jail "[w]ould not be what [one] would expect to find in a civilian world," and, based on his observations, was "subpar". Bray Depo. (Ex. 2) at 28:20 – 29:19, 33:16-21. The Jail's medical delivery system was "destined to fail." *Id.* at 148:18-22.
The medical care at the facility is to be "delivered under the direction of a licensed physician."	From 2005 to 2017, the Jail was staffed with a single LPN, Nurse Horn. *See* Horn Depo. (Ex. 8) at 21:18 – 22:8. There was no physician providing care at the Jail. *See, e.g.* Bray Depo. (Ex. 2) at 222:24 – 223:25. And there was no physician directing the care provided at the Jail. *See, e.g.,* Horn Depo (Ex. 8) at 101:3 – 103:14. Medical decisions at the Jail were made by Nurse Horn. And, because of Nurse Horn's frequent absenteeism, medical supervision of the inmates was inappropriately relinquished to the detention staff and EMS. LCvR 56.1(c) Statement(I)(B)(22).

[14] For a more complete summary of the policies and policy violations, with citations to the record, *please see* LCvR 56.1(c) Statement(I)(B)(22-24, 26-27, 32-33).

The Medical Services Policy required the establishment of a "schedule for sick call" at the Jail.	There was no scheduled sick call at the Jail. *See* Horn Depo. (Ex. 8) at 93:22 – 94:11. In fact, Nurse Horn did not even maintain a sick call list. *Id.* at 154:12-14. Nurse Horn was habitually absent from the Jail and either attempted to assess patients over the phone, or inappropriately relied on detention staff and EMS to perform medical assessments.
The "Non-Emergency & Medical Complaints" Policy provides that "[c]ases shall be referred according to the facility procedures to the appropriate hospital emergency room, to the regularly scheduled sick call visit by the facility physician."	Because the Jail had no regularly scheduled sick call or a facility physician (see LCvR 56.1(c) Statement(I)(B)(22)), it is axiomatic that OCSO never even attempted to comply with this Policy.
OCSO had a contract with a Physician's Assistant, Aleta Fox, under which Fox was supposed to be at the Jail "once a week" for "inmate medical exams." Jail Medical Treatment Contract (Ex. 44).	Ms. Fox did not have a set period of time when she would be at the Jail, but would only come when and if Nurse Horn called her. *See* Horn Depo. (Ex. 8) at 24:10 – 25:2.
OCSO's Emergency Medical Care Policy allowed detention officers to directly "contact an ambulance" in an emergency situation if the nurse was not on the premises.	Per OCSO training, detention officers were prohibited from sending an inmate to the emergency room unless Nurse Horn approved it. *See, e.g.*, Bray Depo. (Ex. 2) at 49:10 – 50:2, 50:10-17, 51:5-13.
OCSO "Surveillance of Holding Cells" Policy provides that "[i]f the receiving Jailer suspects that an inmate may … need … medical observation…", the receiving jailer may place the inmate in a segregated holding cell.	Nurse Horn would decide whether to place an inmate in a holding cell for medical reasons, and either the Jail Administrator or Assistant Jail Administrator would decide whether to place the inmate in a holding cell for disciplinary reasons.
Part D of OCSO's Medical Services Policy required regular reviews/audits of the Jail's medical delivery system. More specifically, Part D required the Jail Administrator to "review annually statistics he/she has complied in concert with the facility nurse indicating the number of inmates receiving medical services by category of care." The Policy further required the Jail Administrator and Nurse to review -- "[a]t least quarterly" -- the "effectiveness and efficiency of medical care", "changes implemented", "cost effectiveness of programs" and "any recommended changes."	These audits/reviews, as required under Part D of the Medical Services Policy, were never done. *See, e.g.*, Horn Depo. (Ex. 8) at 97:13 – 98:10; Shoemaker Depo. (Ex. 6) at 68:21 – 70:7. And Sheriff Durborow did nothing to ensure that this Policy was being complied with. See Durborow Depo. (Ex. 43) at 60:1 – 61:14.

The medical delivery system proposed by OCSO's written medical policies is a utopian fantasy far removed from the abhorrent reality that Ellis, and the other inmates, encountered at the Jail. The ***habitual policy violations were the actual -- or "de facto" -- policies and customs*** in place at the Jail. *See, e.g., Henderson v. Glanz,* No. 12-CV-68-JED-FHM, 2014 WL 2815742, at *12 (N.D. Okla. June 23, 2014), *rev'd in part on other grounds, appeal dismissed in part for lack of interlocutory jurisdiction,* 813 F.3d 938 (10th Cir. 2015) (finding a triable issue of fact based in part upon a sheriff's "continued operation of … *de facto*" policies contrary to the facility's written policies). And these routine policy violations are causally related to Mr. Ellis's suffering and death. For instance, had there been regular sick call conducted by a physician, or even Ms. Fox, Mr. Ellis likely would have received an actual medical assessment and his pneumonia would have been identified and treated. Also, if the detention officers had been trained to call an ambulance in an emergency situation, Nurse Horn could have been bypassed and Mr. Ellis would have been sent to the hospital when his condition worsened.[15] These *de facto* policies provide another basis for *Monell* liability.

Fourth, there is evidence of "deliberate indifference" at the County level. The Sheriff argues that "Plaintiff cannot demonstrate that Sheriff Durborow was deliberately indifferent to a substantial risk that jailers or Nurse Horn might be likely to violate Ellis's constitutional right to medical care." Dkt. #120 at 16-17. This argument lacks merit. "Deliberate indifference … is defined differently for Eighth Amendment and municipal liability purposes." *Barney v. Pulsipher,* 143 F.3d 1299, 1308, n. 5 (10th Cir. 1998). Contrary to Sheriff Floyd's position, "[i]n the municipal liability context, deliberate indifference is an ***objective standard which is satisfied if the risk***

[15] For his part, Sheriff Floyd concedes that "[i]f [the written policies] … had been followed in this case, Ellis would not have been denied medical attention." Dkt. #120 at 16. But the Sheriff fails to address the evidence that Nurse Horn, Shoemaker, Bray and the other staff members were acting in accordance with the Jail's established practices, or de facto policies.

is so obvious that the official <u>should</u> have known of it." *Barney,* 143 F.3d at 1308, n. 5 (citing *Farmer v. Brennan,* 511 U.S. 825, 840–42 (1994)) (emphasis added).

In this case, there is evidence that the Sheriff and/or Jail Administrator knew or *should have* known, *inter alia,* that: (A) Nurse Horn was habitually absent during working hours; (B) untrained detention staff were being relied on to provide medical supervision in Nurse Horn's absence; (C) Ms. Fox would only show up at the Jail when Horn felt the need to bring her in for additional triaging; (D) Nurse Horn was improperly using paramedics/EMT's for medical decision-making purposes; (E) officers were failing to perform 15-minute wellness checks; (F) officers were failing to notify Nurse Horn when an inmate had a seizure; (G) there was no scheduled sick call at the Jail or even a sick call list; (F) Nurse Horn and the Jail Administrator failed to conduct regular medical audits/reviews as required by policy. *See* LCvR 56.1(c) Statement(I)(B)(22-24, 26-27, 32-33). In addition, based on the snapshot of other inmate cases provided in the Jail Log, it was obvious that the medical system was failing and was dangerously deficient. *See* LCvR 56.1(c) Statement(II)(B). At the very least, Sheriff Durborow must be charged with knowledge that his own written Jail Nurse Policy posed a threat to the health and safety of inmates like Ellis. Furthermore, OCSO's widespread and "knowing failure to enforce policies necessary to the safety of inmates" constitutes deliberate indifference at the County level. *See Tafoya,* 516 F.3d at 919 (10th Cir. 2008). Despite OCSO's knowledge of the substantial likelihood of constitutional violations, it took no remedial action. And Sheriff Durborow never looked at the health care delivery system at the Jail to determine whether the written policies were actually being followed. *See* LCvR 56.1(c) Statement(I)(B)(33, 35).

<u>Fifth,</u> there is sufficient evidence of a failure to train. The training provided by OCSO was utterly deficient. *See, e.g.,* Bray Depo. (Ex. 2) at 259:18-23. For example, Officer Bray does not recall ever seeing the policy manual in the Jail. *Id.* at 282:12 – 284:5. During the brief time in which

Bray was involved in on-the-job shadowing, neither he nor the person he was shadowing had a copy of the Policies and Procedures manual. *Id.* at 284:6-15. Furthermore, as throughout this Response, there is significant evidence that the practices at the Jail were diametrically opposed to the Medical Services, Non-Emergency Care & Medical Complaints and Emergency Medical Care Policies. *See*, *e.g.*, LCvR 56.1(c) Statement(I)(B)(22-24, 26-27), *supra.* This evinces a total failure to train with respect to OCSO's medical policies.

In sum, as was the case in *Burke,* a reasonable jury could find the Ottawa County Sheriff was responsible for an unconstitutional policy or custom of inadequate resources, chronic delays in care, and "lack of urgency surrounding jail medical care". *Burke,* 935 F.3d at 1001. And there is a causal nexus between Ellis's suffering and death and established policies and customs of the Ottawa County Sheriff 's Office.

For these reasons, Sheriff Floyd's Motion for Summary Judgment (Dkt. #120) should be denied.

Respectfully,

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CERTIFICATE OF SERVICE

I hereby certify that on the 17th day of January 2020, 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