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OPINION AND ORDER OF THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF OKLAHOMA (MARCH 1, 2018)

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF OKLAHOMA

FAYE STRAIN, AS GUARDIAN OF THOMAS BENJAMIN PRATT,

Plaintiff,

v.

VIC REGALADO, IN HIS OFFICIAL CAPACITY, BOARD OF TULSA COUNTY COMMISSIONERS OF TULSA COUNTY, ARMOR CORRECTIONAL HEALTH SERVICES, INC., CURTIS MCELROY, D.O., PATRICIA DEANE, LPN, and KATHY LOEHR, LPC,

Defendants.

Case No. 17-CV-0488-CVE-FHM

Before: Claire V. EAGAN,
United States District Judge.

Now before the court are motions to dismiss filed by all defendants: Armor Correctional Health Services (Armor) (Dkt. # 14); Patricia Deane, LPN (Dkt. # 15); Kathy Loehr, LPC (Dkt. # 16); Curtis McElroy, D.O.

(Dkt. # 17); and Vic Regalado and the Board of County Commissioners (BOCC) of Tulsa County (Dkt. # 21).

I.

Plaintiff Faye Strain is the duly appointed guardian, and mother, of Thomas Benjamin Pratt. Dkt. # 2, at 1. In her complaint (Dkt. #2), plaintiff alleges the following: on December 11, 2015, Pratt was booked into the David L. Moss Criminal Justice Center, often referred to as the Tulsa County Jail (the Jail). *Id.* at 5.

On December 12, 2015, at 7:39 a.m., Pratt submitted a medical sick call note requesting to speak to a nurse about "detox meds." *Id.* Later that day, at 12:10 p.m., Pratt submitted a second sick call note, stating,

> MY NAME IS TOMMY PRATT I CAME IN YESTERDAY AND STARTED HAVING WITHDRAWLS [sic] I NEED TO TRY AND GET SOME DETOX MEDS
>
> THANKYOU [sic]

Id. At 1:05 p.m., a nurse and employee of defendant Armor—a private corporation responsible, in part, for providing medical and mental health services to Pratt while he was in custody of the Tulsa County Sheriff's Office (TCSO)—conducted a drug and alcohol assessment of Pratt. *Id.* Pratt advised the nurse that he had a habit of drinking fifteen-to-twenty beers a day for at least the previous ten years. *Id.* The assessment tool indicates that Pratt was experiencing constant nausea, frequent dry heaves and vomiting, moderate tremors, anxiety, restlessness, drenching sweats, and severe, diffuse aching of the joints and muscles. *Id.* at 5-6. Accordingly, Pratt was placed on a "Librium protocol" (a sedative tranquilizer frequently used for patients

experiencing alcohol withdrawal) and "seizure precautions" were ordered. *Id.* at 6. At 1:48 p.m., Pratt was admitted to the Jail's medical unit, where a different nurse conducted a "mental health infirmary admission assessment." *Id.* The nurse noted that Pratt was nauseated, slumped over, anxious, fearful, and "unsteady on his feet," and that he was a "risk for injury" due to his detoxification and "high blood pressure." *Id.*

On December 13, 2015, Pratt was again placed on seizure precautions, which included an order that his vital signs be taken every eight hours. *Id.*[1]

On December 14, 2015, at approximately 2:08 a.m., defendant Patricia Deane, LPN, conducted another drug and alcohol assessment of Pratt. *Id.* The assessment tool indicated that he was experiencing constant nausea, frequent dry heaves and vomiting, severe tremors even with arms not extended, acute panic states as seen in severe delirium or acute schizophrenic reactions, restlessness, drenching sweats, continuous hallucinations, and disorientation for place or person. *Id.* at 6-7. Later that day, a nurse practitioner gave a phone order to start a Valium protocol. *Id.* at 7. At 3:44 p.m., an unidentified Armor employee took Pratt's vital signs and noted that he was "tearing up" his cell and stating that he was "locked in the store." *Id.*

In a note dated December 14, 2015, and placed in the Armor medical chart, defendant Curtis McElroy, D.O., stated,

> Pt seen and evaluated. Came in 12/11/15 with alcohol abuse and placed on Librium protocol for the alcohol withdrawal. Pt

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[1] This order, however, was not complied with. *Id.* at 8.

> switched to [V]alium and received first dose this morning. Pt reported to be found on floor pulling up tile with approximately 2 cm forehead laceration. Small, < 1 cm laceration left lateral elbow area and a laceration < 1cm on right mid right posterior forearm. Some scratches on dorsum of nose. No other facial injury. Pt awake, confused, talking about what movie are we watching tonight. No history of witnessed fall or pt inflicting injury to himself. Pool of blood under sink in cell.

Id. at 8-9.[2]

On December 15, 2015, defendant Kathy Loehr, LPC, conducted an initial mental health evaluation of Pratt. *Id.* Loehr observed that he was making slow, shaky movements, and presented with a wound on his forehead from an apparently unintentional, self-inflicted injury sustained on December 14. *Id.* at 11. Loehr was unable to complete her evaluation, however, because Pratt had difficulty answering questions. *Id.* Later that afternoon, at 3:40 p.m., McElroy logged a second note in the Armor medical chart, stating that Pratt was reported to "have been found underneath sink [in his cell] with laceration [on] mid-forehead." *Id.*

On December 16, 2016, at approximately 12:00 a.m., a nurse observed that Pratt "would not get up." *Id.* at 12. Just before 1:00 a.m., a detention officer noticed him lying on his bed and not moving; the

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[2] Also on December 14, 2015, a nurse reported that Pratt was angry, anxious, confused, reaching into space, had impaired short term memory, and needed assistance with activities of daily living. *Id.* at 10.

detention officer called for a nurse. *Id.* at 12. Upon entering Pratt's cell, the nurse found that he had no pulse or respiration and was completely unresponsive. *Id.* She initiated CPR and called a medical emergency at around 1:00 a.m. *Id.* Shortly thereafter, first responders arrived; Pratt was resuscitated at around 1:15 a.m. and was rushed to St. John Medical Center in Tulsa, Oklahoma. *Id.*

According to the Emergency Medical Services Authority (EMSA) report, Pratt had suffered a cardiac arrest. *Id.* The EMSA report also stated that: the Jail medical staff reported that Pratt hit his head "four days ago" and has been non-verbal and lethargic ever since; Pratt has been going through withdrawals and been on suicide watch; and he had a large hematoma to his forehead from his fall "four days ago." *Id.* at 12-13.

Pratt was admitted to the hospital, where he remained until January 1, 2016. *Id.* Upon discharge, he was diagnosed with cardiopulmonary arrest secondary to presumed seizure during incarceration, acute renal failure secondary to hypotension and rhabdomyolysis, Todd's paralysis, agitation, anoxic brain injury, AKI secondary to hypotension and rhabdomyolysis, hyponatremia, acute transaminitis, and acute head laceration. *Id.* at 13.

Before Pratt was admitted to the Jail on December 11, 2015, he had no history of seizure disorder, brain damage, or severe mood swings. *Id.* Since suffering cardiac arrest at the Jail, he has become permanently disabled. *Id.* He continues to suffer from severe seizure disorder, memory loss, extreme mood swings and anger, and communication deficits and delays. *Id.* He is now unable to work, and lives with his parents. *Id.* He

requires assistance with everyday life activities and is incapable of safely living on his own. *Id.*

Plaintiff alleges that, at the Jail, there are long-standing, systemic deficiencies in medical and mental health care services, about which Former Sheriff Stanley Glanz knew. *Id.* at 14. Plaintiff also alleges: in 2007, the National Commission on Correctional Health Care (NCCHC) audited the Jail and concluded that there were numerous deficiencies in the care provided to inmates, including failure to address health care needs in a timely manner. *Id.* In 2009, the Oklahoma State Department of Health cited TCSO for a violation of the Oklahoma Jail Standards in connection with the suicide death of a schizophrenic inmate. *Id.* at 15. In August 2009, the American Correctional Association conducted a mock audit of the Jail, which revealed that it was non-compliant with mandatory health standards. *Id.* In response to the audit, Elizabeth Gondles, Ph. D., produced a report to identify issues and suggest improvements. *Id.* The issues Gondles identified included: understaffing of medical personnel; deficiencies in doctor/PA coverage; lack of health services oversight and supervision; failure to provide new health staff with formal training; failure to provide timely health appraisals to inmates; and 313 health-related grievances within the twelve months before the report was written. *Id.* at 16. Gondles concluded that these issues were a result of the "lack of understanding of correctional healthcare issues by jail administration and contract oversight and monitoring of the private provider." *Id.* To address these issues, Gondles "strongly suggested" that the Jail establish a "central Office Bureau of Health Services," to be staffed by a "TCSO-employed Health Services

Director." *Id.* TCSO, however, did not implement Gondles's recommendations. *Id.*[3]

Plaintiff further alleges that, in 2010, the NCCHC conducted a second audit of the Jail's health system, after which the NCCHC placed the Jail on probation. *Id.* at 17. The NCCHC found numerous deficiencies with the Jail's health services program, including: the quality assurance multi-disciplinary committee does not identify problems, implement and monitor corrective action, "nor study its effectiveness;" there were several inmate deaths in the previous year; the clinical mortality reviews were poorly performed; the responsible physician does not document his review of the registered nurse's health assessment, or conduct clinical chart reviews to determine if clinically appropriate care is ordered and implemented by attending health staff; diagnostic tests and speciality consultations are not completed in a timely manner and are not ordered by the physician; if changes are indicated, the changes are not implemented; when a patient returns from an emergency room, the physician does not see the patient, review the discharge orders, or issue follow-up orders

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[3] Plaintiff's complaint alleges further that, on October 28, 2010, Assistant District Attorney Andrea Wyrick wrote an email to TSCO's Risk Manager voicing concerns about whether the "Jail's medical provider, [. . .] CHMO, a subsidiary of CHC, was complying with its contract." *Id.* In addition, plaintiff's complaint alleges that Ms. Wyrick stated, "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. . . . It is another issue to ignore any and all signs we receive of possible [medical] issues. . . . " *Id.* "CHMO," however, is not a defendant in this case, and plaintiff fails to explain what CHMO or CHC are. These facts lead the Court to believe that this portion of plaintiff's complaint is unrelated to these defendants.

as clinically needed; potentially suicidal inmates are not checked regularly, and follow-up with them has been poor; and training for custody staff has been limited. *Id.* Sheriff Glanz read only the first two or three pages of the report and is unaware of any policies or practices changing at the Jail in response to it. *Id.* at 18.

Additional historical allegations include: that over a period of many years, Tammy Harrington, R.N., former director of nursing at the Jail, observed and documented deficiencies in the delivery of health care services to inmates, including chronic failure to triage inmates' requests for medical and mental health assistance, chronic lack of supervision of clinical staff, and repeated failures of medical staff to alleviate known and significant deficiencies in the health services program. *Id.* On September 29, 2011, the United States Department of Homeland Security's Office of Civil Rights and Civil Liberties reported its findings in connection with an audit of the Jail's medical system pertaining to the United States Immigration and Customs Enforcement detainees, which found numerous deficiencies. *Id.* After the report was issued, Harrington did not observe any meaningful changes in health care policies or practices at the Jail. *Id.* On October 27, 2011, an inmate died at the Jail as a result of "inhumane treatment and medical neglect." *Id.* A federal jury has since entered a verdict holding Sheriff Regaldo liable in his official capacity for the unconstitutional treatment of this inmate. *Id.* at 19. In the wake of this inmate's death, Sherrif Glanz made no meaningful improvement to the Jail's medical system. *Id.* And, just months after this inmate died, another inmate died due to "deficient care." *Id.* On November 18, 2011, the Jail's retained medical auditor issued a

report to former 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. *Id.* The auditor noted six inmate deaths, finding deficiencies in the care provided to each. *Id.* As part of a 2012 corrective action review, the auditor found: delays for medical staff and providers to get access to inmates; no sense of urgency in attitude to see patients, or have patients seen by providers; failure to follow NCCHC guidelines to get patients to providers; and not enough training or supervision of nursing staff. *Id.* at 20. In November 2013, BOCC retained Armor as the new private medical provider for the Jail. *Id.*

On August 25, 2017, plaintiff filed her complaint (Dkt. # 2), alleging that: (1) all defendants, (including Sheriff Regalado in his official capacity, and ARMOR under a theory of municipal liability), pursuant to 42 U.S.C. § 1983, violated Pratt's Eighth Amendment right to be free from cruel and unusual punishment (count one); (2) defendants Armor, McElroy, Deane, and Loehr are liable in common-law negligence for failing to provide Pratt adequate care (count two); and (3) all defendants violated Pratt's right to be free from cruel and unusual punishment under Article II § 9 of the Constitution of the State of Oklahoma (count three). *Id.* at 20-26. Plaintiff seeks actual and punitive damages. *Id.* at 26.

II.

In considering a motion to dismiss under Federal Rule of Civil Procedure 12(b)(6), a court must determine whether the claimant has stated a claim upon which relief may be granted. A motion to dismiss is properly granted when a complaint provides no "more than labels

and conclusions, and a formulaic recitation of the elements of a cause of action." *Bell Atlantic Corp. v. Twombly*, 550 U.S. 544, 555 (2007). A complaint must contain enough "facts to state a claim to relief that is plausible on its face" and the factual allegations "must be enough to raise a right to relief above the speculative level." *Id.* (citations omitted). "Once a claim has been stated adequately, it may be supported by showing any set of facts consistent with the allegations in the complaint." *Id.* at 562. Although decided within an antitrust context, *Twombly* "expounded the pleading standard for all civil actions." *Ashcroft v. Iqbal*, 556 U.S. 662, 683 (2009). For the purpose of making the dismissal determination, a court must accept all the well-pleaded allegations of the complaint as true, even if doubtful in fact, and must construe the allegations in the light most favorable to a claimant. *Twombly*, 550 U.S. at 555; *Alvarado v. KOB-TV, L.L.C.*, 493 F.3d 1210, 1215 (10th Cir. 2007); *Moffett v. Halliburton Energy Servs., Inc.*, 291 F.3d 1227, 1231 (10th Cir. 2002). However, a court need not accept as true those allegations that are conclusory in nature. *Erikson v. Pawnee Cnty. Bd. of Cnty. Comm'rs*, 263 F.3d 1151, 1154-55 (10th Cir. 2001). "[C]onclusory allegations without supporting factual averments are insufficient to state a claim upon which relief can be based." *Hall v. Bellmon*, 935 F.2d 1106, 1109-10 (10th Cir. 1991).

In addition, where "a § 1983 plaintiff includes a government agency and a number of government actors sued in their individual capacities, it is particularly important . . . that the complaint make clear exactly <u>who</u> is alleged to have done <u>what</u> to <u>whom</u>, to provide each individual with fair notice [under *Twombly* and

Federal Rule of Civil Procedure 8(a)(2)] as to the basis of the claims against him or her, as distinguished from collective allegations against the state." *Bark v. Chacon*, 504 Fed. App'x 741, 745 (10th Cir. 2012)[4] (quoting *Robbins v. Oklahoma*, 519 F.3d 1242, 1249-50 (10th Cir. 2008)). "When a plaintiff instead uses 'either the collective term 'Defendants' or a list of defendants named individually but with no distinction as to what acts are attributable to whom, it is impossible for any of these individuals to ascertain what particular unconstitutional acts they are alleged to have committed.'" *Id.* (quoting *Robbins*, 519 F.3d at 1250).

III.

Count one of plaintiff's complaint alleges that all defendants deprived Pratt of his Eighth Amendment right to be free from cruel and unusual punishment, as their deliberate indifference to his medical needs caused the permanent disabilities from which he now suffers. Dkt. # 2, at 21. In their motions to dismiss, each defendant responds that plaintiff's complaint fails to state a claim for an Eighth Amendment violation. Dkts. ## 14, at 9; 15, at 9; 16, at 9; 17, at 9; 21, at 15.

"'Deliberate indifference to serious medical needs of prisoners' violates the Eighth Amendment.'" *Redmond v. Crowther*, ___ F.3d ___, ___, 2018 WL 798283, at *6 (10th Cir. Feb. 9, 2018) (quoting *Estelle v. Gamble*, 429 U.S. 97, 104-05 (1976)). "To establish an Eight Amendment claim based on inadequate medical care, the prisoner must prove both an objective component

[4] This and other cited unpublished decisions are not precedential, but may be cited for their persuasive value. *See* Fed. R. App. P. 32.1; 10th Cir. R. 32.1.

and a subjective component." *Id.* (citing *Self v. Crum*, 439 F.3d 1227, 1230-31 (10th Cir. 2006)). "The objective component requires showing the alleged injury is 'sufficiently serious.'" *Id.* (citing *Crum*, 439 F.3d at 1230). "A delay in medical care is only sufficiently serious if the plaintiff can show the delay resulted in substantial harm." *Id.* (citing *Mata v. Saiz*, 427 F.3d 745, 751 (10th Cir. 2005)). "A 'lifelong handicap, permanent loss, or considerable pain may satisfy the substantial harm requirement.'" *Id.* (quoting *Mata*, 427 F.3d at 751). "The subjective component requires showing the prison official 'knew [the inmate] faced a substantial risk of harm and disregarded that risk by failing to take reasonable measures to abate it.'" *Id.* at *7 (quoting *Martinez v. Beggs*, 563 F.3d 1082, 1088-89 (10th Cir. 2009)). "The subjective prong is met if prison officials intentionally deny[] or delay[] access to medical care or intentionally interfere[] with the treatment once prescribed." *Id.* (internal quotation omitted).

As an initial matter, count one of plaintiff's complaint is drafted in precisely the fashion *Robbins* proscribes; *i.e.* it is a § 1983 claim against a government agency and a number of individual government actors—referred to collectively as "defendants"—that fails to specify who is alleged to have done what to whom. Dkt. # 2, at 21-22. Under *Robbins*, therefore, count one of plaintiff's complaint fails to provide the individual defendants with fair notice as to the basis of the claim against them, to which they are entitled under Fed. R. Civ. P. 8(a)(2). Moreover, even assuming, *arguendo*, that count one of plaintiff's complaint does provide fair notice to defendants, it nevertheless fails to state a claim for an Eighth Amendment violation because it does not allege that any defendant disregarded a risk

to Pratt, intentionally denied or delayed his access to medical care, or interfered with his treatment once it was prescribed.[5]

Accordingly, plaintiff's Eighth Amendment claim (count one) must be dismissed as against all defendants.

IV.

Plaintiff's remaining claims for common-law negligence against Armor, McElroy, Deane, and Loehr (count two), and violation of Article II § 9 of the Constitution of the State of Oklahoma against all defendants (count three), arise under state law. Pursuant to 28 U.S.C. § 1367(a), federal courts may exercise supplemental jurisdiction over claims related to claims over which it has original jurisdiction. A district court may decline to exercise supplemental jurisdiction if it has dismissed all claims over which it has original jurisdiction. 28 U.S.C. § 1367(c)(3); *see Gaston v. Ploeger*, 297 F. App'x 738, 746 (10th Cir. 2008) (stating that § 1367(c)(3) expressly permits a district court to decline to exercise supplemental jurisdiction over remaining state law claims after granting summary judgment in favor of defendant on federal law claims). This Court does not have original jurisdiction over plaintiff's common-law negligence or Oklahoma constitutional claim because they arise under state law, and there is no evidence that diversity jurisdiction is present.

The decision to exercise supplemental jurisdiction is discretionary, but courts should consider "the nature and extent of pretrial proceedings, judicial economy,

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[5] Rather, plaintiff's complaint alleges only, in conclusory fashion, that defendants failed to "provide adequate medical care" to Pratt. *Id.* at 21.

convenience, and [whether] fairness would be served by retaining jurisdiction." *Anglemyer v. Hamilton Cnty. Hosp.*, 58 F.3d 533, 541 (10th Cir. 1995) (quoting *Thatcher Enters. v. Cache Cnty. Corp.*, 902 F.2d 1472, 1478 (10th Cir. 1990)). The Court finds that the extent of the pretrial proceedings does not outweigh the interests that would be served by having plaintiff's state law claims tried in a state court. Judicial economy would be served by having the Oklahoma courts resolve issues of Oklahoma law, and the parties have an interest in having their Oklahoma law disputes decided in a court intimately familiar with that law. Further, the Tenth Circuit has "repeatedly recognized that this is the preferred practice." *Gaston*, 297 F. App'x at 746; *see also Smith v. City of Enid*, 149 F.3d 1151, 1156 (10th Cir. 1998) ("When all federal claims have been dismissed, the court may, and usually should, decline to exercise jurisdiction over any remaining state law claims."). The Court, therefore, declines to exercise supplemental jurisdiction over plaintiff's remaining state law claims.

IT IS THEREFORE ORDERED, that all defendants' motions to dismiss—Armor Correctional Health Services (Dkt. # 14); Patricia Deane, LPN (Dkt. # 15); Kathy Loehr, LPC (Dkt. # 16); Curtis McElroy, D.O. (Dkt. # 17); and Vic Regalado and the Board of County Commissioners of Tulsa County (Dkt. # 21)—are granted.

DATED this 1st day of March, 2018.

/s/ Claire V. Eagan
United States District Judge

COMPLAINT
(AUGUST 25, 2017)

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

(1) FAYE STRAIN, AS GUARDIANS OF THOMAS BENJAMIN PRATT,

Plaintiff,

v.

(1) VIC REGALADO, IN HIS OFFICIAL CAPACITY, (2) BOARD OF COUNTY COMMISSIONERS OF TULSA COUNTY, (3) ARMOR CORRECTIONAL HEALTH SERVICES, INC., (4) CURTIS MCELROY, D.O., (5) PATRICIA DEANE, LPN, AND (6) KATHY LOEHR, LPC,

Defendants

Case No.: 17-cv-488-CVE-FHM

COMES NOW the Plaintiff Faye Strain ("Plaintiff") as guardian of Thomas Benjamin Pratt ("Mr. Pratt"), and for her Complaint against Defendants alleges and states as follows:

PARTIES

1. Plaintiff Faye Strain is the duly appointed guardian of Mr. Pratt. Plaintiff is also Mr. Pratt's mother.

2. Defendant Vic Regalado ("Sheriff Regalado" or "Regalado") is the current Sheriff of Tulsa County, Oklahoma, residing in Tulsa County, Oklahoma and acting under color of state law. Defendant Regalado is sued purely in his official capacity. It is well-established, as a matter of Tenth Circuit authority, that a § 1983 claim against a county sheriff in his official capacity "is the same as bringing a suit against the county." *Martinez v. Beggs*, 563 F.3d 1082, 1091 (10th Cir. 2009). *See also Porro v. Barnes*, 624 F.3d 1322, 1328 (10th Cir. 2010); *Bame v. Iron Cnty.*, 566 F. App'x 731, 737 (10th Cir. 2014). Furthermore, Rule 25(d) of the Federal Rules of Civil Procedure provides that "[a]n action does not abate when a public officer who is a party in an official capacity dies, resigns, or otherwise ceases to hold office while the action is pending", rather "[t]he officer's successor is automatically substituted as a party." As Tulsa County Sheriff, Regalado is, in essence, a governmental entity. As Tulsa Sheriff, in his official capacity, Sheriff Regalado is responsible for County/ Tulsa County Sheriff's Office ("TCSO") rules, regulations, policies, practices, procedures, and/or customs, including the policies, practices, procedures, and/or customs that violated Mr. Pratt's rights as set forth in this Complaint. Sheriff Regalado is the successor in office to former Sheriff Stanley Glanz ("Former Sheriff Glanz").

3. Defendant Board of County Commissioners of Tulsa County ("BOCC") is a statutorily-created governmental entity. 57 Okla Stat. § 41 provides that "[e]very county, by authority of the board of county commissioners and at the expense of the county, shall have a jail or access to a jail in another county for the safekeeping of prisoners lawfully committed." (emphasis added).

BOCC must discharge its responsibilities to the Tulsa County Jail in a constitutional manner. BOCC is properly sued under the provisions of the Oklahoma Governmental Tort Claims Act ("GTCA").

4. Defendant Armor Correctional Health Services, Inc. ("ARMOR") is a foreign corporation doing business in Tulsa County, Oklahoma and was at all times relevant hereto responsible, in part, for providing medical and mental health services and medication to Mr. Pratt while he was in the custody of TCSO. ARMOR was additionally responsible, in part, for creating and implementing policies, practices, and protocols that govern the provision of medical and mental health care to inmates at the Tulsa County Jail ("Jail"), and for training and supervising its employees. ARMOR was, at all times relevant hereto, endowed by Tulsa County with powers or functions governmental in nature. As such, ARMOR became an agency or instrumentality of the state and subject to its Constitutional limitations.

5. Defendant Curtis McElroy, D.O. ("Dr. McElroy") was at all time relevant hereto, an employee and/or agent of ARMOR/TCSO, who was, in part, responsible for overseeing Mr. Pratt's health and well-being, and assuring that Mr. Pratt's medical/mental health needs were met, during the time he was in the custody of TCSO. At all times pertinent, Dr. McElroy was acting within the scope of his employment and under color of State law. Dr. McElroy is being sued in his individual capacity.

6. Defendant Patricia Deane, LPN ("Nurse Deane"), was, at all times relevant hereto, an employee and/or agent of ARMOR/TCSO, who was, in part, responsible for overseeing Mr. Pratt's health and well-being, and assuring that Mr. Pratt's medical/mental health

needs were met, during the time he was in the custody of TCSO. At all times pertinent, Nurse Deane was acting within the scope of her employment and under color of State law. Nurse Deane is being sued in her individual capacity.

7. Defendant Kathy Loehr ("Ms. Loehr"), was, at all times relevant hereto, an employee and/or agent of ARMOR/TCSO, who was, in part, responsible for overseeing Mr. Pratt's health and well-being, and assuring that Mr. Pratt's medical/mental health needs were met, during the time he was in the custody of TCSO. At all times pertinent, Ms. Loehr was acting within the scope of her employment and under color of State law. Ms. Loehr is being sued in her individual capacity.

JURISDICTION AND VENUE

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

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

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

rights and the redress of deprivation of rights under color of law.

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

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

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

FACTUAL ALLEGATIONS

14. Mr. Pratt was booked into the Jail on December 11, 2015. Mr. Pratt was placed in a general population pod, J-16.

15. At 7:39am on December 12, 2015, Mr. Pratt submitted a medical sick call note, through the Jail's electronic kiosk system, requesting to speak to a nurse about "detox meds". This is clear evidence that by early in the morning of December 12, Mr. Pratt was going into alcohol withdrawal. In any event, this kiosk request was not responded to until two days later.

16. At 12:19pm on December 12, Mr. Pratt submitted a second kiosk request, as follows:

> MY NAME IS TOMMY PRATT I CAME IN YESTERDAY AND STARTED HAVING

WITHDRAWLS [sic] I NEED TO TRY AND GET SOME DETOX MEDS

THANKYOU

17. At approximately 1:05pm on December 12, 2015, Nurse Karen Canter, an employee of Defendant Armor and agent of the TCSO acting under color of state law and within the scope of her employment, conducted a drug and alcohol withdrawal assessment of Mr. Pratt. As part of this assessment, Mr. Pratt indicated that he had a serious alcohol problem. In particular, Mr. Pratt advised Nurse Canter that he had a habit of drinking 15-20 beers a day for "at least" the past ten (10) years. The assessment tool further indicates that Mr. Pratt was experiencing: "constant nausea, frequent dry heaves and vomiting", moderate tremors, anxiety, restlessness, "drenching sweats" and "severe diffuse aching of joints/muscles." On the basis of this assessment, Mr. Pratt was placed on a "Librium protocol" and "seizure precautions" were ordered.

18. Librium is a sedative tranquilizer frequently used for patients experiencing alcohol withdrawal.

19. At approximately 1:48pm on December 12, Mr. Pratt was admitted to the Jail's medical unit. Upon admission, Nurse Gracie Beardon, an employee of Defendant Armor and agent of the TCSO acting under color of state law and within the scope of her employment, conducted a "mental health infirmary admission assessment." Nurse Beardon noted that Mr. Pratt's admitting diagnosis was "Detox". Nurse Beardon additionally noted that, upon admission, Mr. Pratt was nauseated, slumped over, anxious, fearful and "unsteady on his feet". Nurse Beardon specifically acknowledged

that Mr. Pratt posed a "risk for injury" due to his detoxification and "high blood pressure".

20. On December 13, 2015, Mr. Pratt was placed on seizure precautions, which included an order that his vital signs be taken every eight (8) hours.

21. At approximately 2:08am on December 14, 2015, another drug and alcohol withdrawal assessment was conducted. This time, the assessment was done by Nurse Patricia Deane, an employee of Defendant Armor and agent of the TCSO acting under color of state law and within the scope of her employment. This December 14 drug-and-alcohol withdrawal assessment clearly indicated that Mr. Pratt's symptoms were worsening and becoming ever more severe. In this regard, the December 14 assessment tool indicates that Mr. Pratt was experiencing: "constant nausea, frequent dry heaves and vomiting", "severe" tremors "even with arms not extended", "acute panic states as seen in severe delirium or acute schizophrenic reactions", restlessness, "drenching sweats", "continuous hallucinations" and disorientation for "place/or person".

22. This assessment strongly suggested that Mr. Pratt was suffering from delirium tremens, a life-threatening condition related to alcohol withdrawal. To any moderately trained medical professional, it would be obvious that Mr. Pratt was suffering from delirium tremens. Nevertheless, despite the obvious severity and emergent nature of Mr. Pratt's deteriorating condition, he was not sent to a hospital or seen by a physician. Indeed, it does not seem that Nurse Deane even contacted a physician, despite the fact that the assessment tool itself mandated that she do so. Overall, there is no indication at this point that Mr. Pratt's detoxification was being supervised by a physician, as

required by Armor policy/National Commission on Correctional Healthcare ("NCCHC") standards. No vital signs were taken. No blood tests were performed.

23. Rather, at some unknown time on December 14, a Nurse Practitioner, Augustina Agadagba gave a "phone order" to "start valium protocol".

24. At approximately 3:44am on December 14, 2015, an unidentified Armor employee, acting within the scope of his/her employment and under color of state law, attempted to take Mr. Pratt's vital signs. This Armor employee noted that when he/she encountered Mr. Pratt he was "tearing up" his cell and deliriously stating that he was "locked in the store". Mr. Pratt was so disoriented and panicked that he could not sit still to have his vitals taken. Again, these were clear symptoms of delirium tremens, an emergent and life-threatening condition. It was apparent that Mr. Pratt's withdrawal-related psychosis was getting worse to the point that he posed an imminent threat of self-harm. Still, the Armor employee did nothing to assist Mr. Pratt. He was not taken to a hospital. He was not restrained. He did not see a physician or psychiatrist. He was not placed on suicide watch. No blood tests were performed. Rather, Mr. Pratt was left to his own devices, while in the throes of a dangerous withdrawal-related mental breakdown (likely, delirium tremens), alone in a cell.

25. Despite the fact that Mr. Pratt was to have his vital signs taken every eight (8) hours, the Armor employees responsible for this task never once recorded a complete set of vital signs for Mr. Pratt. No vital signs at all were recorded on December 14, 15 or 16. This failure not only violated policy and protocol, but substantively deprived Mr. Pratt's "caretakers" at the Jail of necessary information in monitoring his condition.

Indeed, frequent vital signs are essential in monitoring the health and assessing the needs of patients with delirium tremens. Amor's inability or refusal to take the minimal step of assessing vital signs is additional evidence of deliberate indifference to Mr. Pratt's serious medical needs.

26. There are two "Medical Sick Call Notes", dated December 14, 2015, in the "official" Armor medical chart, which were purportedly recorded by Dr. Cutis McElroy. Assuming that Dr. McElroy did see Mr. Pratt on December 14, as represented in the notes, the information in those notes provides additional evidence of deliberate indifference.

27. According to the "December 14" note, Dr. McElroy saw Mr. Pratt at around 10:30am. In the December 14 note, Dr. McElroy states:

> Pt seen and evaluated. Came in 12/11/15 with alcohol abuse and placed on Librium protocol for alcohol withdrawal. Pt switched to valium and received first dose this morning. Pt reported to be found on floor pulling up tile with approximately 2cm forehead laceration. Small, < 1cm laceration left lateral elbow area and a laceration < 1cm on right mid right posterior forearm. Some scratches on dorsum of nose. No other facial injury. Pt awake, confused, talking about what movie are we watching tonight. No history of witnessed fall or put inflicting injury to himself. Pool of blood under sink in cell.

(emphasis added). The information that Mr. Pratt, who was known to be detoxing, was found on the floor, with a "pool of blood" under the sink, and "pulling up tile"

after suffering some sort of head injury, would be information that even a layperson would recognize as an emergency medical situation. Further, there was additional information, in the medical record, from earlier that morning, that Mr. Pratt was continuously vomiting, hallucinating, suffering from severe tremors and was in an acute panic state. All of this evidence pointed to delirium tremens. Assuming Dr. McElroy did see Mr. Pratt at 10:30am on December 14, it was obvious that Mr. Pratt was experiencing life-threatening withdrawal (delirium tremens) and/or brain injury, and needed to be transferred immediately to a licensed acute care facility. Dr. McElroy's failure to send Mr. Pratt to a hospital evinces deliberate indifference to his serious and obvious medical and mental health needs. Indeed, Dr. McElroy's failure to send Mr. Pratt to the hospital under these conditions was a violation of the minimal standards of the National Commission on Correctional Healthcare ("NCCHC") (J-G-06), which TCSO and Armor have adopted as policy. In addition, Dr. McElroy did not provide Mr. Pratt with any neurological diagnostics or consult, despite the obvious need. And Dr. McElroy did not refer Mr. Pratt to a psychiatrist, despite the obvious need. He did not order vital signs be taken or that Mr. Pratt's blood be tested. These failures too are evidence of deliberate indifference to Mr. Pratt's serous medical and mental health needs.

28. Assuming that Dr. McElroy saw Mr. Pratt at 10:30am on December 14, 2015, there is no explanation as to why he waited over eight (8) hours after Nurse Deane's dire assessment, and nearly seven hours after the failed attempt to take Mr. Pratt's vital signs, to lay eyes on this patient. It is unconscionable that Mr. Pratt was left to suffer in his cell for this period of time

without even seeing a physician. Each passing hour was another lost opportunity to get Mr. Pratt to an emergency room to receive the level of care and assessment he obviously needed. With each passing hour without this ER-level care, Mr. Pratt was inching closer to a medical calamity that would alter the rest of his, and his family's, life.

29. Armor employee Nurse Margarita Brown encountered Mr. Pratt in the medical unit at around 4:07pm on December 14. Nurse Brown reported that Mr. Pratt was "angry", "anxious" and "confused"; and staring and "reaching into space." Nurse Brown further noted that Mr. Pratt lacked judgment and had "impaired short term memory." Lastly, Nurse Brown charted that Mr. Pratt needed assistance with "activities of daily living."

30. The failures of the medical staff, beginning with Nurse Deane's assessment and continuing through Dr. McElroy's dubious "evaluation" and Nurse Brown's observations, to send Mr. Pratt to an emergency room for medical intervention, or even order neurological testing or a psychiatric visit, constitutes deliberate indifference. And this deliberate indifference was a proximate cause of Mr. Pratt's unnecessary and prolonged pain and suffering; continuing and permanent disability; and medical expenses.

31. At approximately 8:49am on December 15, 2015, Kathy Loehr, a purported "Licensed Professional Counselor" or "LPC", conducted an initial mental health evaluation of Mr. Pratt. During the evaluation, Mr. Pratt reported that he was "detoxing from alcohol." Ms. Loehr observed that Mr. Pratt was "shaky" and had "difficulty following directions". Mr. Pratt was making "slow, shaky movements." Loehr charted that Pratt "present[ed]

with a wound on his forehead from a self inflicted injury yesterday" and that the wound "[a]ppear[ed] unintentional" as Pratt was "detoxing and did not appear oriented yesterday." Notably, Ms. Loehr was unable to complete her evaluation because Mr. Pratt had deteriorated to the point that he had "difficulty answering questions." Mr. Pratt was clearly still disoriented as he stated his mistaken belief that he was at a detox center and that it was Sunday (when, in fact, December 15, 2015 was a Tuesday). He appeared lethargic with poor eye contact. His memory, insight, judgment and concentration were all noted to be "poor".

32. Despite Mr. Pratt's obvious signs and symptoms of brain injury, coupled with his ongoing struggle with the effects of alcohol withdrawal, Ms. Loehr did not send Mr. Pratt to a hospital. Mr. Pratt was not seen by a physician. There is no indication that Ms. Loehr even contacted a physician. Instead, demonstrating disregard for the seriousness of the situation, Ms. Loehr educated Mr. Pratt "on getting clothes" and reportedly "encouraged vital signs to get medication." In other words, Ms. Loehr provided no care at all, and did nothing to assure that Mr. Pratt's emergent and life-threatening condition was appropriately addressed.

33. There is also a "Medical Sick Call" note, dated December 15, 2015, recorded by Dr. McElroy, in the version of Mr. Pratt's chart later sent to Saint John. According to the December 15 note, which is time stamped at 3:40pm, Mr. Pratt was reported to "have been found underneath sink [in his cell] with laceration [on] mid forehead." Taking the December 15 note at face value, coupled with the known history of Mr. Pratt's symptoms of delirium tremens and/or brain injury, Dr. McElroy should have, again, sent Mr. Pratt to a

hospital on December 15. His failure to due so was yet another instance of deliberate indifference to a serious medical need.

34. At approximately 12:00am on December 16, 2016, Nurse LeeAnn Bivins, an employee of Defendant Armor and agent of the TCSO acting under color of state law and within the scope of her employment, observed that Mr. Pratt "WOULD NOT GET UP . . . ." However, Nurse Bivins failed to check Mr. Pratt's vital signs, including his pulse and respiration.

35. Just before 1:00am on December 16, 2015, a TCSO Detention Officer ("D.O.") discovered Mr. Pratt "lying on [his] bed [and] not moving." The D.O. called for a nurse. Angela McCoy, a Licensed Practical Nurse (or "LPN"), an employee of Defendant Armor and agent of the TCSO acting under color of state law and within the scope of her employment, responded. Upon entering Mr. Pratt's cell, Nurse McCoy found that he had no pulse or respiration. He was completely unresponsive. She initiated CPR and called a "medical emergency" at around 1:00am. Shortly thereafter, first responders from the fire department and EMSA arrived, and continued CPR. Through these measures, Mr. Pratt was resuscitated at around 1:15am, and was rushed to Saint John Medical Center in Tulsa.

36. According to the EMSA Report, Mr. Pratt had suffered a cardiac arrest. In pertinent part, the narrative portion of the EMSA Report states: (A) "Jail Medical Staff report '[Mr. Pratt] hit his head 4 days ago, and has been non-verbal and lethargic ever since"; (B) "Staff reports [Pratt] has been going through withdrawals, and been on suicide watch as well"; (C) "[Pratt] has a large hematoma to his forehead, that staff reports '[i]s from his fall 4 days ago'".

37. Mr. Pratt was admitted to Saint John, where he remained until January 1, 2016. Upon discharge, Mr. Pratt was diagnosed with: (A) cardiopulmonary arrest (PEA) secondary to presumed seizure during incarceration; (B) acute renal failure: Secondary to hypotension and Rhabdomyolysis; (C) Todd's paralysis; (D) agitation; (E) anoxic brain injury; (F) AKI: Secondary to hypotension and rhabdomyolysis; (G) hyponatremia; (H) transaminitis: Acute; and (I) Head laceration: Acute.

38. Before Mr. Pratt was admitted to the Jail on December 11, 2015, he had no history of seizure disorder, brain damage or severe mood swings. Since suffering from untreated brain injury and delirium tremens which led to cardiac arrest/severe seizures at the Jail, Mr. Pratt is permanently disabled. He continues to suffer from severe seizure disorder, memory loss, extreme mood swings and anger and verbal/ communication delays/deficits. He is now unable to work and lives with his parents. He requires assistance with everyday life activities. He is incapable of safely living on his own. Mr. Pratt is just 36 years old. At the time of his incarceration, and resulting injuries, Mr. Pratt was 35.

39. Mr. Pratt is permanently disabled and has incurred and will continue to incur lost wages and medical expenses. In addition, Mr. Pratt has suffered and will continue to suffer physical and mental pain and anguish. These injuries and damages are a direct and proximate cause of Defendants' deliberate indifference and negligence as described supra.

40. The deliberate indifference to Mr. Pratt's serious medical needs, mental health and safety, as summarized *supra*, was in furtherance of and consistent with: a)

policies, customs, and/or practices which TCSO promulgated, created, implemented or possessed responsibility for the continued operation of; and b) policies, customs, and/or practices which ARMOR developed and/or had responsibility for implementing.

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

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

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

44. There is a long-standing failure to secure adequate mental health care, and to properly classify and protect inmates with obvious and serious mental health needs. For example, in 2009, TCSO was cited by the

Oklahoma State Department of Health for violation of the Oklahoma Jail Standards in connection with the suicide death of an inmate with schizophrenia.

45. In August of 2009, the American Correctional Association ("ACA") conducted a "mock audit" of the Jail. *See* Gondles Report 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 liaison. *See* Robinette Depo. 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. The Gondles Report was provided to the Jail Administrator, Michelle Robinette. *Id.* at 001; Robinette Depo. at 48:9-16. As part of her Report, Dr. Gondles identified numerous "issues" with the Jail's health care system, as implemented by the Jail's former medical provider, CHC. *See, e.g.,* Gondles Report 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. at 50:20-24.

46. 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 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 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.*

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

48. On October 28, 2010, Assistant District Attorney Andrea Wyrick wrote an email to Josh Turley, TCSO's "Risk Manager". *See* Wyrick Email. 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 . . . 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).

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

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

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

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

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

53. On September 29, 2011, the U.S. Department of Homeland Security's Office of Civil Rights and Civil Liberties ("CRCL") reported its findings in connection with an audit of the Jail's medical system – pertaining to U.S. Immigration and Customs Enforcement ("ICE") detainees-as follows: "CRCL found a prevailing attitude among clinic staff of indifference. . . . "; "Nurses are undertrained. Not documenting or evaluating patients properly."; "Found one case clearly demonstrates a lack of training, perforated appendix due to lack of training and supervision"; "Found two . . . detainees with clear mental/medical problems that have not seen a doctor."; "[Detainee] has not received his medication despite the fact that detainee stated was on meds at intake"; "TCSO medical clinic is using a homegrown system of records that 'fails to utilize what we have

learned in the past 20 years". "ICE-CRCL Report, 9/29/11 (emphasis added).

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

55. On the contrary, less than 30 days later the ICE-CRCL Report was issued, on October 27, 2011 another inmate, Elliott Earl Williams, died at the Jail as a result of the truly inhumane treatment and reckless medial neglect which defies any standard of human decency. A federal jury has since enter a verdict holding Sheriff Regaldo liable in his official capacity for the unconstitutional treatment of Mr. Williams.

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

57. On November 18, 2011 AMS-Roemer, the Jail's own retained medical auditor, issued its Report to Former 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." AMS-Roemer Report, 11/8/11 at CHM0171-72. AMS-Roemer specifically commented on no less than six (6) inmate deaths (including the death of Mr. Jernegan), finding deficiencies in the care provided to each. *Id.* at CHM0168-69; 0171

58. It is clear that Former Sheriff Glanz did little, if anything, to address the systemic problems identified in the November 2011 AMS-Roemer Report, as AMS

Roemer continued to find serious deficiencies in the delivery of care at the Jail. For instance, as part of a 2012 Corrective Action Review, AMS-Roemer found "[d]elays for medical staff and providers to get access to inmates," "[n]o sense of urgency attitude to see patients, or have patients seen by providers," failure to follow NCCHC guidelines "to get patients to providers," and "[n]ot enough training or supervision of nursing staff." Corrective Action Review at CHM1935 – 1938.

59. In November 2013, BOCC/TCSO/Former Sheriff Glanz retained ARMOR as the new private medical provider. However, this step has not alleviated the constitutional deficiencies with the medical system. Medical staff is still undertrained and inadequately supervised and inmates are still being denied timely and sufficient medical attention. Bad medical and mental health outcomes have persisted due to inadequate supervision and training of medical staff, and due to the contractual relationship between BOCC/TCSO/Former Sheriff Glanz and ARMOR (which provides financial disincentives the transfer of inmates in need of care from an outside facility). Former Sheriff Glanz and ARMOR have known of the deficiencies, and the substantial risks posed to inmates like Mr. Pratt, but have failed to take reasonable steps to alleviate the risks.

60. As alleged herein, there are deep-seated and well-known policies, practices and/or customs of systemic, dangerous and unconstitutional failures to provide adequate medical and mental health care to inmates at the Tulsa County Jail. This system of deficient care—which evinces fundamental failures to train and super-

vise medical and detention personnel—created substantial, known and obvious risks to the health and safety of inmates like Mr. Pratt. Still, Sheriff Glanz and ARMOR have failed to take reasonable steps to alleviate the substantial risks to inmate health and safety, in deliberate indifference to Mr. Pratt's physical health, mental health, and safety, in deliberate indifference to Plaintiff's serious medical needs.

CLAIMS FOR RELIEF
FIRST CLAIM FOR RELIEF

CRUEL AND UNUSUAL PUNISHMENT IN VIOLATION OF THE EIGHTH AND FOURTEENTH AMENDMENTS TO THE CONSTITUTION OF THE UNITED STATES
(42 U.S.C. § 1983)

A. Allegations Applicable to All Defendants

61. Plaintiff re-alleges and incorporate by reference paragraphs 1 to 60, as though fully set forth herein.

62. Defendants knew, or it was obvious, that Mr. Pratt was at significant risk of serious injury and harm as set forth herein.

63. Defendants failed to provide adequate medical care, mental health care and supervision to Mr. Pratt while he was in the Tulsa County Jail.

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

health and safety and resulted in his disability, and significant injuries as stated herein.

65. As a direct and proximate result of Defendants' conduct, Mr. Pratt experienced physical pain, severe emotional distress, mental anguish, and the damages alleged herein.

66. Mr. Pratt has incurred and will continue to incur medical expenses and lost wages as a proximate result of Defendants' deliberate indifference.

67. The aforementioned acts and/or omissions of the individually named Defendants were malicious, reckless and/or accomplished with a conscious disregard of Mr. Pratt's rights thereby entitling Plaintiff to an award of exemplary and punitive damages according to proof.

B. Official Capacity Liability (Sheriff Regalado)

68. Plaintiff re-alleges and incorporates by reference paragraphs 1 through 67 as though fully set forth herein.

69. The aforementioned acts and/or omissions of Defendants in being deliberately indifferent to Mr. Pratt's health and safety and violating Mr. Pratt's civil rights were the direct and proximate result of customs, practices, and policies for which TCSO promulgated, created, implemented and/or possessed responsibility.

70. Such policies, customs and/or practices are specifically set forth in paragraphs 40-60, supra.

71. TCSO, through its continued encouragement, ratification, approval and/or maintenance of the aforementioned policies, customs, and/or practices; in spite of their known and obvious inadequacies and dangers;

has been deliberately indifferent to inmates', including Mr. Pratt's, health and safety.

72. As a direct and proximate result of the aforementioned customs, policies, and/or practices, Mr. Pratt suffered injuries and damages as alleged herein.

C. Municipal Liability (ARMOR)

73. Plaintiff re-alleges and incorporates by reference paragraphs 1 through 72 as though fully set forth herein.

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

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

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

77. ARMOR was charged with implementing and assisting in developing the policies of TCSO with respect to the medical and mental health care of inmates at the Tulsa County Jail and have shared responsibility to adequately train and supervise their employees.

78. There is an affirmative causal link between the aforementioned deliberate indifference to Mr. Pratt's serious mental health needs, his safety, and the violations of his civil rights, and the above-described customs, policies, and/or practices carried out by ARMOR.

79. ARMOR knew (either through actual or constructive knowledge), or it was obvious, that these policies, practices and/or customs posed substantial risks to the health and safety of inmates like Mr. Pratt.

Nevertheless, ARMOR failed to take reasonable steps to alleviate those risks in deliberate indifference to inmates', including Mr. Pratt's, serious mental health needs.

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

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

SECOND CLAIM FOR RELIEF

NEGLIGENCE
(DEFENDANTS ARMOR, MCELROY, DEANE AND LOEHR)

82. Plaintiff re-alleges and incorporates by reference paragraphs 1 through 81 as though fully set forth herein.

83. ARMOR, McElroy, Deane and Loehr owed a duty to Mr. Pratt, and all other inmates in custody, to use reasonable care to provide inmates in need of medical attention with appropriate treatment.

84. ARMOR, McElroy, Deane and Loehr breached that duty by failing to provide Mr. Pratt with prompt and adequate medical and mental health care despite Mr. Pratt's obvious needs.

85. ARMOR, McElroy, Deane and Loehr's breaches of the duty of care include, inter alia: failure to treat Mr. Pratt's serious health condition properly; failure to conduct appropriate medical and mental health assessments; failure to create and implement appropriate medical and mental health treatment plans; failure to

promptly and adequately evaluate Mr. Pratt's health; failure to properly monitor Mr. Pratt's health; failure to provide access to medical and mental health personnel capable of evaluating and treating his serious health needs; failure to assure that Mr. Pratt received necessary emergency care; and a failure to take precautions to prevent Mr. Pratt from injury.

86. As a direct and proximate result of ARMOR's negligence, Mr. Pratt experienced physical pain, severe emotional distress, mental anguish, and the damages alleged herein.

87. As a direct and proximate result Defendants' negligence, Mr. Pratt has suffered, and will continue to suffer, real and actual damages, including medical expenses, mental and physical pain and suffering, emotional distress, lost wages and other damages in excess of $75,000.00.

88. ARMOR is vicariously liable for the negligence of its employees and agents.

89. ARMOR is also directly liable for its own negligence.

THIRD CLAIM FOR RELIEF

VIOLATION OF ARTICLE II § 9 OF THE CONSTITUTION OF THE STATE OF OKLAHOMA CRUEL AND UNUSUAL PUNISHMENT AND DELIBERATE INDIFFERENCE

90. Plaintiff re-alleges and incorporates by reference paragraphs 1 through 89, as though fully set forth herein.

91. Article II § 9 of the Oklahoma Constitution prohibits the infliction of cruel and unusual punishment. Under the Oklahoma Constitution's Due Process Clause,

Article II § 7, the right to be free from cruel and unusual punishment extends to pre-trial detainees, like Mr. Pratt, who have yet to be convicted of a crime (in addition to convicted prisoners who are clearly protected under Article II § 9).

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

93. As set forth herein, Defendants knew, or it was obvious, that Mr. Pratt was at significant risk of serious injury and harm as set forth herein.

94. Defendants failed to provide adequate medical care, mental health care and supervision to Mr. Pratt while he was in the Tulsa County Jail.

95. Defendants' acts and/or omission as alleged herein, including but not limited to their failure to provide Mr. Pratt with adequate medical and mental health supervision, assessment and treatment, and/or or to assure that Mr. Pratt receive adequate medical and mental health supervision, assessment and treatment, constitute deliberate indifference to Mr. Pratt's health and safety and resulted in his disability, and significant injuries as stated herein.

96. At all times relevant, the jail personnel described in this Complaint were acting within the scope of their employment and under the direct control of Defendant Glanz, the Sheriff of Tulsa County and/or ARMOR.

97. Defendants' failure to supervise and provide adequate mental health care and protection to Mr. Pratt was the direct and proximate cause of Mr. Pratt

injuries, physical pain, severe emotional distress, mental anguish, and all other damages alleged herein.

PRAYER FOR RELIEF

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

Respectfully submitted,

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