IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLORADO

Civil Action No: 16-cv-00629 WJM-STV

THE ESTATE OF JOHN PATRICK WALTER,
by and through its personal representative, DESIREE' Y. KLODNICKI,

Plaintiff,

v.

CORRECTIONAL HEALTHCARE COMPANIES, INC., et al.

Defendants.

PLAINTIFF'S RESPONSE TO FREMONT COUNTY DEFENDANTS' MOTION FOR SUMMARY JUDGMENT

Plaintiff, the Estate of John Patrick Walter, respectfully submits this response to Fremont County Defendants' Motion for Summary Judgment. The motion should be denied as to plaintiff's municipal liability claims against Fremont County itself. The motion should also be denied as to the following individual defendants: Sheriff James Beicker, Undersheriff Ty Martin, and Jail Commander John Rankin (collectively the "Command Staff Defendants").[1]

I. RESPONSE TO MOVANTS' STATEMENT OF MATERIAL FACTS[2]

SMF ¶ 1: Admitted, but object to the relevance of the alleged reasons for the arrest.

SMF ¶ 2: Admitted, but object to the relevance of the alleged reasons for the arrest.

SMF ¶¶ 3-11: Admitted.

[1] Plaintiff does not oppose dismissal of the remaining individual Fremont County defendants—Charlene Combs, Lee Cook, Justin Green, Dustin Mass, Greg Owen, Jordan Penn, Richard Solano, Michael Ulrich, Robert Miller, Sara Lightcap, Joshua Pohl, James Wheaton, and Randall Cullen.

[2] Plaintiff's admissions and denials are for purposes of this motion only.

SMF ¶ 12: Admitted in part. CHC employed PA Havens in April 2014 to work at the FCDC. However, he worked one hour per week, not four. *See* Dep. of K. Maestas (Ex. 1) at 54:15-18.

SMF ¶¶ 13-16: Admitted

SMF ¶ 17: Admitted. Object as to the relevance.

SMF ¶ 18: Admitted.

SMF ¶ 19: Admitted (as of the specific moment of her interaction on April 13th).

SMF ¶¶ 20-25: Admitted.

SMF ¶ 26: Admit that "Green was on duty when Mr. Walter was brought into [the jail]." The citation does not support the rest of this statement. Object to relevance of the alleged assault.

SMF ¶ 27: Denied. Mr. Walter was "calm" entering the jail on April 3rd and was not violent, aggressive, or verbally abusive. *See* Booking Rept. (Ex. 2); Dep. of J. Wheaton (Ex. 3) at 14:4-20:8. Any "cussing or screaming" would have been documented if it occurred, and Green may have confused Mr. Walter with another. *See* Dep. of J. Green (Ex. 4) at 42:16-44:17.

SMF ¶ 28: Denied. When Green, Cullen and Cook entered Mr. Walter's cell, Mr. Walter first "sat on the bunk." Only later did he stand up. *See* Green Dep. (Ex. 4) at 50:18-51:7.

SMF ¶ 29: Admitted.

SMF ¶ 30: Admitted.

SMF ¶ 31: Denied. Mr. Walter was not perceived to resist until cuffed. *Id*. at 52:2-15.

SMF ¶ 32: Denied that Mr. Walter "again" became combative. *See* Response to SMF ¶ 31. Admit Green claims Mr. Walter was "combative" after his wrists were secured behind his back.

SMF ¶ 33: Admit that a verbal command was given and that Green claims Mr. Walter grabbed Cook's hand after he was cuffed. *See* Green Dep. (Ex. 4) at 52:16-20.

SMF ¶ 34: Admit that Green tasered Mr. Walter's shoulder blade after he was cuffed with his hands behind his back. *Id.* at 52:21-53:12.

SMF ¶¶ 35-55: Admitted.

SMF ¶ 56: Admitted as to the first sentence. As to the second sentence: Admit only that Repshire provided Mr. Walter with methadone on April 16th. Mr. Walter was *never* provided with his critical "meds" or any substitute benzodiazepine. Maestas Dep. (Ex. 1) at 11:14-20.

SMF ¶ 57: Admitted.

SMF ¶ 58: Deny the first sentence. In a sworn interrogatory answer, Rankin did "not recall any communications" about Mr. Walter other than what was documented. *See* Rankin Answer to Interrogatory No. 2.B (Ex. 5) at pp. 4-5, 10. There is no documentation to support this claim. Admitted as to the second sentence: Rankin spoke with Undersheriff Martin about Mr. Walter.

SMF ¶ 59: Denied. *See* Response to SMF ¶ 58 & Ex. 5 at pp. 4-5, 10. There is no documentation to support the claim that Rankin "spoke to Nurse Maestas" at all about Mr. Walter. Furthermore, Nurse Maestas recalls no such conversation, *see* Maestas Dep. (Ex. 1) at 208:13-16, and thinks she would have remembered one if it occurred. *Id.* at 256:7-13. It is not credible to believe she would have forgotten a conversation with the jail's commander about an inmate who then died in the jail. Finally, the work schedules of Rankin and Maestas suggest that the alleged conversation did not occur. Maestas only worked on four days: April 3, 9, 12 and 20. *See id.* at 163:17-165:8. *See also* Calendar Page (Ex. 6). April 20th was the day of Mr. Walter's death, and Rankin was not at the jail that day until *after* he died. *See* Rankin Dep. (Ex. 7) at 72:3-6. Thus, he could not have spoken with her at any time between April 12th and after Mr. Walter died.

SMF ¶ 60: Denied. The claimed conversation between Beicker and Maestas could not have occurred based on Maestas's testimony that she was not at the jail at any time other than April 3, 9, 12 and 20 and Beicker's testimony that he was not at the jail at any time on Sunday, April 20. *See* Maestas Dep. (Ex. 1) at 163:17-165:8 & Ex. 6; Beicker Dep. (Ex. 8) at 51:5-7. Indeed, Maestas could not recall conversing with Beicker at any time about Mr. Walter. *See* Maestas Dep. (Ex. 1) at 207:25-208:9. She thinks she would have remembered any such conversation if it occurred. *Id.* at 256:7-13. It is not credible to believe she would forget speaking with the sheriff about an inmate who then died in the jail. Moreover, no documentation substantiates these claims.

SMF ¶ 61: Denied. *See* Response to SMF ¶ 60.

SMF ¶ 62: Denied. In an answer to an interrogatory asking Martin to identify everyone to whom he spoke about Mr. Walter during his confinement, the only "nurse" he identified was "Kathy Maestas," and he was "unsure" of the date. *See* Martin Answer to Interrogatory No. 2.B (Ex. 5) at p. 8. Based on Maestas's testimony that she was not at the jail at any time other than April 3, 9, 12 and 20 and Martin's testimony that he was not at the jail on Sunday, April 20 before Mr. Walter's death, the alleged conversation did not occur. *See* Maestas Dep. (Ex. 1) at 163:17-165:8 & Ex. 6; Martin Dep. (Ex. 9) at 30:10-18. Indeed, Maestas does not recall conversing with Martin about Mr. Walter. Maestas Dep. (Ex. 1) at 208:10-12, Ex. 1. She likely would have remembered such a conversation if it occurred. *See id.* at 256:7-13. It is not credible to believe she would forget a conversation with the undersheriff about an inmate who then died in the jail, and no documentation substantiates his claims. Even if he were to now claim that the "nurse" he spoke with was really Nurse Repshire, she recalls no such conversation either. *See* Repshire Dep. (Ex. 10) at 183:20-22. It is not credible to believe that she, too, would forget speaking to the undersheriff about an inmate who then died in the jail.

SMF ¶ 63: Denied. Based on Maestas's testimony that she was not at the jail other than on April 3, 9, 12 and 20 and Martin's testimony that he was not at the jail on Sunday, April 20 (before Mr. Walter's death), such a conversation did not occur. *See* Maestas Dep. (Ex. 1) at 163:17-165:8 & Ex. 6; Martin Dep. (Ex. 9) at 30:10-31:3. Furthermore, in her deposition, Maestas recalled no such conversation with Martin. *See* Ex. 1 at 208:10-12. She testified that she likely would have remembered any such conversation if it occurred. *Id.* at 256:7-13. It is not credible to believe she would forget having a conversation with the undersheriff about an inmate who then died in the jail. Moreover, no documentation substantiates these claims.

SMF ¶¶ 64-67: Admitted.

SMF ¶ 68: Admitted as to the first sentence. Denied as to the following two sentences. In his deposition, Sgt. Miller claimed that he and Rankin visited Maestas together in the "medical office"

for the purpose of discussing Mr. Walter. *See* Miller Dep. (Ex. 11) at 54:7-10. However, this could not have taken place between April 16 and April 20 because Nurse Maestas only worked on four days during Mr. Walter's confinement: April 3, 9, 12 and 20. *See* Maestas Dep. (Ex. 1) at 163:17-165:8 & Ex. 6. April 20th was the day of Mr. Walter's death, and Rankin was not at the jail that day until being called in *after* he died. *See* Rankin Dep. (Ex. 7) at 72:3-6. Thus, Rankin and Miller could not have visited Maestas together between April 16 and April 20. Moreover, Maestas recalled no such conversation, *see* Maestas Dep. (Ex. 1) at 208:13-19, and it is not credible to believe she would have forgotten it. Likewise, Nurse Repshire recalled no such conversation, *see* Repshire Dep. (Ex. 10) at 183:14-184:4, and there is no documentation to substantiate it.

SMF ¶ 69: Admitted.

SMF ¶ 70: Denied. Dr. Allen gave a "provisional" (not final) diagnosis based on a 10-minute interaction with Mr. Walter from outside his cell because she "really didn't have enough information to know that for sure." Def. Ex. Y; Allen Dep. (Ex. 12) at 144:18-25, 116:20-23.

SMF ¶ 71: Admitted.

SMF ¶ 72: Denied. Dr. Herr recalls no phone call relating to Mr. Walter. Herr Dep. (Ex. 13) at 180:3-181:21. He did not document the alleged call. *Id*. at 180:13-15. It was a basic practice of telephonic medicine to document telephone communications. *Id*. at 176:22-25. Dr. Herr was not even the on-call provider on April 19th. *See* Ex. 46. If Repshire called Dr. Herr, she gave him no pertinent information. *See* Repshire Dep. (Ex. 10) at 187:22-194:13.

SMF ¶¶ 73-76: Admitted.

II. STATEMENT OF ADDITIONAL DISPUTED FACTS

A. Background: The Fremont County Jail and CHC

1. As the Sheriff of Fremont County, James Beicker was a final policy-maker responsible for the Fremont County Jail. *See* Beicker Dep. (Ex. 8) at 15:17-20, 16:12-15, 19:16-19. Undersheriff Ty Martin and Jail Commander John Rankin were also County policymakers. *Id*. at 16:23-17:9.

2. Sheriff Beicker contracted with a for-profit company (CHC) to provide healthcare services at the jail. Def. Ex. F. He delegated his final policy-making authority (with respect to jail healthcare services) to CHC, which then became a policymaker for Fremont County with the power to make and change healthcare policies without his approval. Beicker Dep. (Ex. 8) at 288:10-289:2.

3. CHC was responsible for paying costs up to a set annual cap for inmate medications and hospital care. Def. Ex. F. at ¶¶ 1.2, 1.6, 1.15. Every dollar saved by CHC on such costs was an extra dollar of profit to it. Beicker Dep. (Ex. 8) at 306:17-307:22, 308:17-310:2.

4. The amounts CHC budgeted and spent on outside medical care and medications were "shockingly low" and inadequate for a jail of Fremont County's size. *See* Rept. of Jacqueline M. Moore, RN, Ph.D. (Ex. 14) at 5. *See also* Rept. of Michael Brasfield (Ex. 15) at 11-12 (CHC's budget was "grossly below" an amount that can provide adequate care for jail inmates).

5. In terms of medical personnel, CHC and the County grossly understaffed the jail. *See* Moore Rept. (Ex. 14) at 4. For 12-hours every day, there was no medical provider at all. A single LPN worked by herself from 7:00 a.m. to 7:00 p.m. A physician assistant visited the jail one hour per week. A psychiatrist visited the jail two hours every other week. That was it. This level of staffing, which left inmates without any care for 50% of the time and very limited care the other 50% was "grossly inadequate to provide for the expected medical needs of the jail's population." Moore Rept. (Ex. 14) at 4; *see also* Brasfield Rept. (Ex. 15) at 10-11.

6. LPN Kathleen Maestas was CHC's "Health Services Administrator" (HSA). Maestas Dep. (Ex. 1) at 11:5-13. She managed the other LPNs who worked at the jail. *Id.* at 49:3-23. She established the customs and practices at the jail for inmate medical care. Repshire Dep. (Ex. 10) at 17:12-18:19; Doughty Dep. (Ex. 16) at 22:1-20; Herr Dep. (Ex. 13) at 39:11-16.

7. Like all other HSAs working at CHC-run jails, Maestas would be well-aware of the CHC's budget for operations at the Fremont County Jail. *See* Dep. of CHC Dir. of Financial Planning J. Tikker (Ex. 17) at 9:12-16, 21:4-22, 26:25-27:7, 33:1-10, 35:18-36:1; Ex. 45.

8. Besides Maestas, only two other LPNs worked at the jail in April 2014: Monica Doughty (not a defendant) and Stephanie Repshire. Only one worked at a time—for 12-hours, by herself, with no overlap between them. *See* Repshire Dep. (Ex. 10) at 52:14-21.

9. Repshire was newly hired, untrained, unsupervised, and unfamiliar with CHC's policies, protocols, and procedures. *See* Moore Rept. (Ex. 14) at 10-11, 26-27; Rept. of Marc Stern, M.D. (Ex. 18) at 42. She admits her inexperience and lack of training and supervision. *See* Repshire Dep. (Ex. 10) at 39:20-40:2, 40:14-41:6, 47:16-19, 54:7-55:19, 63:1-5, 75:21-76:2, 76:23-77:2, 99:17-100:8. She did not know how to care for an inmate who, like Mr. Walter, might be suffering withdrawal symptoms from any substance. *Id*. at 104:9-106:9. Similarly, HSA Maestas had almost no knowledge, training, or experience on benzodiazepine ("benzo") withdrawal: she did not know the symptoms, how to monitor for it, or what might happen to a person suddenly discontinued from a benzo prescription. *See* Maestas Dep. (Ex. 1) at 154:8-156:12.

10. Because CHC had no on-site doctor or RN and its physician assistant came only one hour per week, the jail's LPNs practiced at the jail outside the scope of their licenses, unsupervised, in violation of Colorado law. *See* Moore Rept. (Ex. 14) at 19; Repshire Dep. (Ex. 10) at 35:17-37:2.

11. Dr. Herr was the Chief Medical Officer and a policymaker for CHC. Herr Dep. (Ex. 13) at 22:13-15. He was responsible for medical care at more than 200 jails. *Id*. at 19:9-12. He was based many miles from the Fremont County Jail and never once visited it. *Id*. at 16:25-17:3, 24:19-20.

12. As of April 2014, CHC had a set of written medical policies, protocols, and forms for inmate care. They were mandatory. Maestas Dep. (Ex. 1) at 57:21-58:16. Issued by Dr. Herr, *see* Herr Dep. (Ex. 13) at 21:3-12, they included mandates for intake medical screening and follow-up assessments; verification of meds; mental health screenings; emergency medical care; policies relating to substance withdrawal; health-care training for medical and corrections staff; protocols for when inmates show significant behavioral changes; protocols for benzodiazepine dependence and withdrawal; and multiple others. *See* Moore Rept. (Ex. 14) at 20-26; Ex. 19. The requirements

were in place to ensure inmates received at least minimally adequate treatment and reflected the standard of care. *See* Herr Dep. (Ex. 13) at 21:19-22:12.

13. The LPNs were untrained on most of the above requirements, did not know many of them existed, and routinely ignored them as of April 2014. *See generally* Repshire Dep. (Ex. 10) at 75:21-100:8, 101:24-104:8; Moore Rept. (Ex. 14) at 20-26. Their training was insufficient to enable them to follow the protocols. *See, e.g.*, Ex. 10 at 233:20-234:3. Even the most basic requirements, such as the mandatory intake health assessment, were not being done as a matter of custom at the jail. *See* Maestas Dep. (Ex. 1) at 90:4-8, 92:8-14, 92:22-93:1; Repshire Dep. (Ex. 10) at 81:15-82:16, 83:13-21, 84:24-86:8. Consistent with this custom, at least 16 separate policies, protocols, and forms were disregarded by the LPNs during Mr. Walter's confinement. *See* Moore Rept. (Ex. 14) at 20-26; Gendel Rept. (Ex. 20) at 8-12; Roy-Byrne Rept. (Ex. 24) at 6; Doughty Dep. (Ex. 16) at 132:22-133:16, 133:20-134:13, 135:19-136:16, 137:3-139:7, 141:9-146:5.

14. CHC conducted no medical audits of the Fremont County Jail in the three years before Mr. Walter's detention. *See* Maestas Dep. (Ex. 1) at 121:23-122:19. Such audits are "universally recognized as critical elements for constitutionally adequate health care delivery" in jails. Stern Rept. (Ex. 18) at 45. CHC's last audit of the jail's medical services in 2011 showed that its medical services "performed horribly" and "suffered from serious system flaws." *Id*. at 46.

15. Leading up to Mr. Walter's confinement, detention staff knew that HSA Maestas "regularly displayed an indifferent, abrasive and demeaning attitude towards inmates who had medical needs or were requesting medical aid or assistance." Decl. of Margaret Bradley (Ex. 21) at ¶ 3. A veteran of the jail's detention staff witnessed Maestas denying medications to inmates for illegitimate reasons and reported this and other observations to Commander Rankin and Sheriff Beicker. *Id*. at ¶¶ 4-8. Jail staff complained to LPN Doughty that Maestas was not meeting inmate medical needs, *see* Doughty Dep. (Ex. 16) at 26:24-27:2, and she told Sheriff Beicker and Undersheriff Martin that she feared Maestas would kill someone at the jail. *See id*. at 27:8-23. Deputy Lightcap[3] saw

[3] Ms. Lightcap since married and took the last name "Gonzales." Her deposition transcript uses her current last

Maestas ignore inmate medical needs and adopt "a dismissive attitude towards inmates who were attempting to express the need for medical care." Lightcap Dep. (Ex. 22) at 20:24-21:7. She complained to her superior who advised that it was generally known that Maestas had a dismissive attitude towards inmates who were expressing a need for medical care, and she heard the same concern from other deputies "across the board." *Id*. at 23:3-24:24. Sergeant Miller described Maestas as being short and abrasive with inmates who appeared to be making reasonable requests for medical care, not "really giv[ing] a damn" what inmates had to say, and "playing Russian roulette." R. Miller Dep. (Ex. 11) at 115:7-119:6. He complained to Commander Rankin about her conduct. *Id.* at 118:25-119:6. "It was known among the detention staff that the medical care available to inmates at the jail was a joke." Decl. of Christopher Wilson (Ex. 23) at ¶ 12.

16. As detailed in the reports of plaintiff's experts, Sheriff Beicker neglected his ultimate responsibility over the delivery of adequate health care services to inmates at the jail. Brasfield Rept. (Ex. 15) at 15-16. *See also* Stern Rept. (Ex. 18) at 24-28.

B. Benzodiazepine Withdrawal and its Dangers

17. Many people come to jail on prescription medications. *See* Herr Dep. (Ex. 13) at 48:13-20. These include benzodiazepines (or "benzos"). *Id*. at 47:16-48:12. "Commonly prescribed benzos include Xanax, Klonopin, Valium and Ativan." Moore Rept. (Ex. 14) at 2.

18. People on benzos—particularly in high doses over long periods of time—develop a physical dependence. *See* Rept. of Peter Roy-Byrne, M.D. (Ex. 24) at 3-5; Gendel Rept. (Ex. 20) at 4-5; Moore Rept. (Ex. 14) at 2-3. The sudden cessation of a person's benzo can lead to dangerous withdrawal. *See* Ex. 24 at 3-5; Ex. 20 at 4-5; Ex. 14 at 2-3; Ex. 18 at 23. Symptoms of benzo withdrawal include anxiety, insomnia, loss of appetite, cognitive impairment, tremors, mood swings, hallucinations, bizarre behavior, abnormal vital signs, seizures, cardiovascular problems, and ultimately death. *See* Ex. 24 at 4; Ex. 20 at 5; Ex. 14 at 2-3.

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name, "Gonzales," but this brief refers to her by her last name at the time of Mr. Walter's confinement: "Lightcap."

19. Benzo withdrawal is a significant risk in jails because a percentage of incoming jail inmates have been using benzos in the community and sudden discontinuance of the medication can result in serious withdrawal symptoms, including include the risk of death, if the withdrawal is severe and not properly addressed. Moore Rept. (Ex. 14) at 2.

20. Benzos should never be abruptly stopped—any discontinuance must occur by a slow taper over a long time with careful medical monitoring. Moore Rept. (Ex. 14) at 2; Roy-Byrne Rept. (Ex. 24) at 5; Stern Rept. (Ex. 18) at 20, 23. Severe benzo withdrawal mandates hospitalization for intensive care. Ex. 24 at 5. All reasonable jail medical personnel are well-aware of the foregoing. *See* Ex. 14 at 2-4, 16; Ex. 24 at 4-5, 12; Ex. 18 at 20; Doughty Dep. (Ex. 16) at 85:9-86:17.

21. CHC's Chief Medical Officer, Dr. Herr, was well-aware of the frequency with which benzo-dependent people enter jails and the dangers of severe benzo withdrawal. Herr Dep. (Ex. 13) at 46:15-56:9. He agrees that "[d]iscontinuing someone's benzo use without adequate monitoring and treatment may have catastrophic results." *Id.* at 60:13-17. He agrees that abrupt reduction in dose among chronic users can produce life threatening withdrawal (*id.* at 62:14-25), that "[p]atients should be tapered off benzodiazepines" since "abrupt discontinuance can lead to dangerous physical effects" (*id.* at 70:1-6), that with untreated withdrawal "a delirium may develop with hallucinations, changes in consciousness, profound agitation, autonomic instability, seizures and death" (*id.* at 73:13-18), and that "[p]atients showing signs of late, severe withdrawal should be hospitalized" in accordance with the standard of care. *Id.* at 73:19-74:1.

22. Dr. Herr issued a written benzodiazepine protocol for all CHC-run jails. *See* Ex. 25. The protocol ("CHC Protocol L-06") mandated specific steps to take when any person comes into the jail who has been using a benzo for over two weeks, including medication verification, continuation on the medication pending a provider's order otherwise, and implementing a dose tapering schedule if any reduction is anticipated. *See id.* The protocol also required nurses to carefully monitor for signs of benzo withdrawal and contact the provider if they observed any. *See*

id.; Moore Rept. (Ex. 14) at 25-26. Adherence to the protocol was particularly important for inmates on a relatively high dose for a long period of time. *See* Herr Dep. (Ex. 13) at 154:11-155:4.

23. Dr. Herr testified that it would be potentially dangerous and below the standard of care for a jail to have a blanket practice of discontinuing benzo medications cold-turkey. Herr Dep. (Ex. 13) at 166:21-167:17. He testified that such a policy would be unacceptable, inappropriate, and unsafe and that it should be stopped. *See id*. at 183:8-184:22.

C. The Jail's Policy and Custom of Cold-Turkeying Benzodiazepine-Dependent Inmates

24. Despite the well-known dangers of benzo withdrawal and the written protocol mandating tapering, we now know that, in truth, CHC had an *unwritten, across-the-board policy and practice of discontinuing inmates from their benzos—cold-turkey*. CHC's HSA at the Fremont County Jail detailed this policy in her deposition. She explained that CHC management directed that all inmates would be immediately discontinued from their benzo prescriptions upon entering the jail—with no tapering from the medication. *See* Maestas Dep. (Ex. 1) at 12:24-14:2, 14:11-15:25, 26:5-10, 32:5-35:20, 37:15-39:3, 40:9-13, 41:25-44:10. The policy was in place throughout her time at the jail; it applied to all benzos—no matter the dosage, the length of time the person had been taking the benzo, and the reason for the prescription (with the possible exception of seizure disorders). *Id*. at 15:8-25. It was communicated to Ms. Maestas from four of her CHC superiors that this policy came from Dr. Herr. *Id*. at 34:5-35:20. Under this policy, all new inmates were immediately discontinued from any benzo, "cold-turkey" without clinical reason. *Id*. at 32:16-18, 37:15-39:2, 41:25-44:10. The other LPNs at the jail were well-aware of this practice. *See* Doughty Dep. (Ex. 16) at 45:6-21. No benzo tapering occurred at the jail. *Id.* at 69:12-15, 79:19-21. *See also* Repshire Dep. (Ex. 10) at 115:12-19.

25. The policy was "grossly below the standard of care" and put all benzo-dependent inmates at substantial risk of serious harm. *See* Moore Rept. (Ex. 14) at 3-4, 8. The policy "invites the occurrence of a variety of adverse events related to benzodiazepine withdrawal, which can be fatal," and there is "no medical justification for such a policy" that "flaunts the seriousness of

benzodiazepine withdrawal or reflects indifference to the seriousness of the condition." Gendel Rept. (Ex. 20) at 8. Such a policy constituted "the most extreme form of medical malpractice." Roy-Byrne Rept. (Ex. 24) at 12. It was "medically dangerous," "whimsical, without rationale, and not necessary to further any penological need." Stern Rept. (Ex. 18) at 21.

D. Mr. Walter is Cold-Turkeyed From His Benzo Per Standard Policy and Practice

26. As of April 2014, Mr. Walter was under a long-standing prescription for Klonopin—a benzo known generically as "Clonazepam." Pursuant to his providers' prescriptions, Mr. Walter had been taking this benzo daily, in high doses, for years. *See* Gendel Rept. (Ex. 20) at 5; Roy-Byrne Rept. (Ex. 24) at 6, 12; Stern Rept. (Ex. 18) at 23; Moore Rept. (Ex. 14) at 6.

27. An abrupt discontinuation of Mr. Walter's Klonopin "would certainly evoke a withdrawal syndrome" which would be "serious, at a minimum." Gendel Rept. (Ex. 20) at 6. Cutting off Mr. Walter's benzo cold turkey would predictably cause "severe withdrawal" and result in a "potentially life-threatening withdrawal syndrome." Stern Rept. (Ex. 18) at 4, 20, 23.

28. Mr. Walter had his container of prescribed Klonopin when he entered the jail on April 3, 2014. It was properly labeled with his name, contents, provider information, and dosage and had the correct number of tablets remaining. Stern Rept. (Ex. 18) at 5 fn. 1; Roy-Byrne Rept. (Ex. 24) at 6; Moore Rept. (Ex. 14) at 6. The bottle was released to his family after his death. *See* Ex. 26.

29. Mr. Walter filled out a form at booking stating that he was taking Klonopin (among other medications). *See* Def. SMF ¶¶ 4-5. Mr. Walter's Klonopin (and other prescription bottles) were taken from him, sealed in a bag, and delivered to the jail's medical staff with the accompanying form stapled to it. Maestas Dep. (Ex. 1) at 142:14-144:14; Repshire Dep. (Ex. 10) at 68:15-71:15. Ms. Repshire reviewed and signed the form and understood that Mr. Walter was on prescribed Klonopin. Ex. 10 at 128:6-132:3, 132:20-23. The form then became the first document in his chart, which was available for all medical providers at the jail to see. *Id*. at 134:9-135:19.

30. When Mr. Walter entered the jail on April 3rd, the booking officer spent 45 minutes with him, verbally interacting with him and watching him shower and change into jail clothes. *See* Dep.

of J. Wheaton (Ex. 3) at 15:11-18:21. Mr. Walter was "calm" and uninjured except for some "scratches" and was not physically or mentally abnormal. *Id.* at 19:4-22:14; *see also* Ex. 2. Another officer who saw him when he was first admitted to the jail describes him as "completely normal in appearance," "not ill-appearing in any way," and "calm and mellow." C. Wilson Decl. (Ex. 23) ¶ 5. Mr. Walter gave his weight as "200 pounds." Ex. 27. Other inmates who saw Mr. Walter near the time of his admission to the jail describe him as "acting like any normal person," "lucid and coherent," "calm in demeanor" with "no apparent injuries," and weighing "about 200 pounds." Declaration of Quinn Smith (Ex. 28) ¶ 5; Declaration of Jason Vercillo (Ex. 29) ¶ 3.

31. From the point that Mr. Walter was first confined at the Fremont County Jail on April 3, 2014, until his death 17 days later on the evening of Easter Sunday, April 20th, he was not provided with even a single dose of any benzodiazepine. Maestas Dep. (Ex. 1) at 11:14-20. Instead, he was cut-off cold-turkey pursuant to CHC's unwritten "no benzos" policy. *Id.* at 41:25-44:8. CHC's HSA, Ms. Maestas, testified as follows:

> Q: So whether it was Mr. Walter or any other inmate, he would have been discontinued from the prescription Klonopin pursuant to the policy, correct?
>
> A: That is correct.
>
> Q: So in the case of Mr. Walter being discontinued from his Klonopin prescription with no tapering, was that done pursuant to the usual custom, practice and policy at CHC?
>
> A: That is correct.
>
> Q: In other words, he was not singled or treated differently because of who he was?
>
> A: That's correct.
>
> Q: And his – the order to discontinue his benzodiazepine with no tapering was given because that was the way things were done at the Fremont County Jail, correct?
>
> A: That was a policy, um, that we followed, yes.
>
> Q: And it was followed in the case of Mr. Walter?

A: That is correct.

Q: And that's why his benzo was discontinued with no tapering, correct?

A: That is correct.

Maestas Dep. (Ex. 1) 43:2-44:4 (objections to form omitted).

32. The abrupt cancelling of Mr. Walter's Klonopin was dangerous, reckless, utterly below the standard of care, without medical justification or rationale, and placed him at grave risk for serious withdrawal and potential death. *See* Ex. 24 at 6-7; Ex. 18 at 7-8; Ex. 14 at 7-8.

33. Mr. Walter received no medical screening at the time of his admission to the facility (or ever) in blatant violation of written policy and the standard of care. *See* Ex. 14 at 7; Ex. 20 at 10; Ex. 1 at 182:18-184:20. Maestas described this as a failure that occurred routinely; indeed, "the jail's nursing staff [was not] actually doing the intake screenings that [were] required by CHC policy" because they did not even have the forms on site. Ex. 1 at 184:21-185:7, 186:8-187:17.

34. Numerous other policies were violated at Mr. Walter's intake. His medications were not verified, and no one called his community provider or pharmacy to seek information about his medication history. *See* Ex. 14 at 7; Ex. 24 at 7. Maestas acknowledged these failures and admitted that they were "pretty significant." Ex. 1 at 178:4-180:13.

35. The written benzo "protocol" (L-06) was completely disregarded. Maestas Dep. (Ex. 1) at 194:10-196:21. This was a "significant failing on behalf of all the nurses who were working at the jail." *Id*. at 195:1-4. The failure to start the protocol left the nursing staff "in the dark about what to look for" given that none of the three LPNs "had any personal knowledge about how to monitor a person for benzodiazepine withdrawal." *Id*. at 196:4-197:12. The LPNs were not trained on the benzo protocol, and it was not being followed. *See* Doughty Dep. (Ex. 16) at 67:14-68:4, 69:24-71:10. Repshire did not even know there was a benzo protocol. *See* Ex. 10 at 125:2-126:3.

E. Mr. Walter in the T-Pod

36. As of April 5th, Mr. Walter was in a group of cells known as the "T-Pod" where he was

housed with other inmates. *See generally* Ex. 30; Vercillo Decl. (Ex. 29); Smith Decl. (Ex. 28).

37. In the T-Pod, Mr. Walter was "very concerned" that he was not getting his Klonopin. *See* Smith Decl. (Ex. 28) ¶ 6. Twice a day, a nurse would come to the pod with a detention deputy to deliver medications to the inmates. When they would come to the T-Pod, Mr. Walter "would tell them that he was not getting his Klonopin and that he desperately needed it." *Id*. Inmate Smith recalls Mr. Walter "begging them for the Klonopin." *Id*. Mr. Walter told the nurses "that he needed his Klonopin and that he would die if he didn't get it" and "said this repeatedly to them over the course of several days." *Id*. Inmate Vercillo recalls that "[w]henever one of the nurses would come by for med pass, Mr. Walter would tell [her] he was not getting his required medication." Vercillo Decl. (Ex. 29) ¶ 4. He was "quite vociferous" and his "concerns grew and grew." *Id*. He told the nurses words to the effect of, "I'm going to die without it!" *Id.*

38. In response to Mr. Walter's "urgently-expressed pleas," Maestas told him, "I'm not taking your shit. If you have a problem, kite it" and walked away. *Id.* ¶ 5.

39. Another inmate submitted two kites for Mr. Walter requesting his medication. *See* Vercillo Decl. (Ex. 29) ¶ 6; Smith Decl. (Ex. 28) ¶ 7. Maestas told the inmate he could not fill out kites for others, so he assisted Mr. Walter and saw him submit additional kites to the nurses on duty. *See* Ex. 29 ¶ 6. These kites have never been produced in discovery and were presumably destroyed.

40. After several days in the T-Pod, Mr. Walter's behavior changed. Smith Decl. (Ex. 28) ¶ 8. He "went from being totally normal to acting extremely strange." *Id.* He stopped sleeping, began "speaking gibberish," and stopped eating. *Id*. "He started to shake a lot." *Id*. This was all "very different from the way he had been behaving when he first came in." *Id*. Mr. Walter "kept getting weirder and weirder" with "loud nonsensical talking and jabbering" at night. *Id*. Inmate Smith told the detention deputies and Maestas and Repshire that Mr. Walter "needed to be in a hospital and not in jail." *Id*. Inmate Vercillo recalls Mr. Walter "behaving in a very bizarre way that was totally different than when he first came in." Vercillo Decl. (Ex. 29) ¶ 7. He was "up at all hours of the night," "barely sleeping at all," "not eating his meals," "pacing and sweating profusely,"

"mumbling and talking incoherently," "kick[ing] the door," "strip[ing] down to his underwear and pac[ing]," and "getting visibly weaker and more frail compared to when he first came in." *Id*.

41. On April 13th, Deputy Combs interacted with Mr. Walter. She found that he was "mentally confused" and "shaky" and that his eyes were "involuntarily pulsating or twitching." Deposition of C. Combs (Ex. 31) at 33:10-34:16. It was apparent to her that he was "mentally confused about what was happening around him." *Id*. at 34:12-16.

42. Mr. Walter received no medical evaluation at all until April 13th, when LPN Doughty checked his blood pressure and pulse "due to possible [withdrawal]." Def. Ex. J. This was one of only two times during his confinement that any vital sign was checked. His blood pressure was abnormally high. Doughty Dep. (Ex. 16) at 98:2-6. She ordered that his blood pressure be checked daily for the next five days. *Id*. at 98:23-99:4. However, his blood pressure was checked only one other time (on April 14th when it was still too high), and never again, in violation of the standard of care. Moore Rept. (Ex. 14) at 8-9; Roy-Byrne Rept. (Ex. 24) at 8.

43. On April 14th, a detention deputy interacted with Mr. Walter and found that he was "confused and shaking the entire time [the deputy] was speaking with him." Ex. 32. On this same date, detention records record a complaint from Mr. Walter's cell mates that he "kept him up all night by talking to the wall" and that he was speaking about things that were not happening. *Id.*

F. Reported Uses of Force Against Mr. Walter

44. On the morning of April 15th, detention deputies forcibly extracted Mr. Walter from the T-Pod. Groups of detention deputies tasered him (while handcuffed), used various pain-compliance force measures against him, took him to the ground, pepper-sprayed him in confined quarters without decontaminating him, and strapped him to a restraint chair. Additional uses of force occurred that same evening. These uses of force are briefly mentioned in the County Defendants' motion but are extensively detailed in the report of Katrina Cathcart, Ph.D., plaintiff's expert in the use of force in the correctional setting. *See generally* Cathcart Rept. (Ex. 33).

45. All force used on Mr. Walter occurred because of his untreated benzo withdrawal, which

caused him to lose touch with reality: when the force was used, Mr. Walter was not thinking straight and may have been delusional. *See* Wheaton Dep. (Ex. 3) at 125:12-23. Deputy Wheaton agreed that the actions of Mr. Walter which caused the uses of force "were not intentional actions but were caused by his deteriorated mental and emotional state." *Id*. at 137:23-138:4. It was clear that Mr. Walter was not in his right mind or did not understand what was going on when force was being used. *Id*. at 138:5-12. *See also* Miller Dep. (Ex. 11) at 81:20-24, 91:24-92:9; Owen Dep. (Ex. 34) at 80:2-13. He was "constantly talking to people who were not there," and there is "no reason to doubt that [he] may well have been delusional" during the uses of force. Ex. 34 at 81:3-16. *See also* Rankin Dep. (Ex. 7) at 158:11-15.

46. It was not reasonable for these officers to shock, spray, and use the other forms of force against a person they knew to be mentally incapable of understanding them or the world around him. *See* Cathcart Rept. (Ex. 33) at 6-7, 18, 28, 32; Brasfield Rept. (Ex. 15) at 18-19.

47. The force used against Mr. Walter was the result of the officers' lack of adequate training by the Fremont County Sheriff's Office as detailed by Ms. Cathcart after reviewing officer training records. *See generally* Ex. 33 at 5-33. Indeed, Sergeant Green admits that he and his deputies were untrained on using force against people who might be mentally impaired or having cognitive difficulties. Green Dep. (Ex. 4) at 76:20-24.

G. Mr. Walter's Transfer to the Windowed Holding Cell and his Subsequent Course

48. Early in the morning on Tuesday, April 15th, Mr. Walter was moved into a small holding cell in the jail's booking area known as Holding Cell 2; for the next *118 and ½ hours* (from 7:00 a.m. on April 15th until Mr. Walter's death at approximately 5:30 p.m. on April 20th), he was held nearly-continuously in this holding cell. J. Green Dep. (Ex. 4) at 87:19-88:1.

49. The holding cell has large windows through which anyone could easily observe Mr. Walter from the booking area. Rankin Dep. (Ex. 7) at 74:8-75:19; Martin Dep. (Ex. 9) at 24:9-25:3; Beicker Dep. (Ex. 8) at 36:19-38:13. *See also* Ex. 35.

50. Anyone could easily communicate with Mr. Walter while he was in the holding cell without opening the door. Green Dep. (Ex. 4) at 32:4-13.

51. The holding cell was no more than a one-minute walk from the administrative offices where the Command Staff Defendants were stationed. *See* Martin Dep. (Ex. 9) at 24:4-8; Beicker Dep. (Ex. 8) at 36:10-18; Rankin Dep. (Ex. 7) at 71:3-9. It was even closer to the medical office where the LPN on duty was stationed. *See* K. Maestas Dep. (Ex. 1) at 147:12-17.

52. Repshire was the only LPN on duty at the jail on April 16, 17, 18 and 19 and was there from 7:00 a.m. to 7:00 p.m. *See* Repshire Dep. (Ex. 10) at 223:8-224:2. Neither Maestas nor Doughty worked at the jail on these days. *See* Maestas Dep. (Ex. 1) at 164:14-165:8; Doughty Dep. (Ex. 16) at 92:11-20; 93:22-25. *See also* Ex. 6.

53. No medical person was at the jail *at all* to care for Mr. Walter for the 12-hour period of 7:00 p.m. to 7:00 a.m. during his confinement. *See* Wheaton Dep. (Ex. 3) at 122:5-8.

54. On the night of April 15, detention officers started an "Inmate Welfare Checklist" to document Mr. Walter's condition every half-hour. *See* Ex. 36. It was posted on the door of his cell, so anyone could see it. Rankin Dep. (Ex. 7) at 119:22-25; Lightcap Dep. (Ex. 22) at 85:6-13.

55. While Mr. Walter was in the holding cell, the collective jail staff observed a host of serious problems relating to his deteriorating mental and physical health. The signs and symptoms they observed are graphically described in their depositions and summarized in the reports of plaintiff's experts. Mr. Walter was barely eating; he was visibly diminishing in size from weight loss; he was not sleeping; he was delusional, talking nonsensically, and hallucinating; he was sick, pale, and weak; he was unresponsive to directives; he was unable to communicate his medical needs or fill out an inmate kite; he was disoriented as to time and place and confused; he was almost constantly naked inside his cell in full view of others; he was punching and kicking the walls of his cell; he was lying naked, shaking and/or convulsing, on the cold floor; he was badly bruised and also bleeding; and his cell smelled of urine. *See, e.g.*, Moore Rept. (Ex. 14) at 9-10; Stern Rept. (Ex. 18) at 19-20; Gendel Rept. (Ex. 20) at 6-7; Roy-Byrne Rept. (Ex. 24) at 9-12. *See also* Ex. 36.

56. Jail staff reported their concerns directly to the LPN on duty. By at least April 16 or 17, detention Deputy Wheaton was growing very concerned about Mr. Walter's deteriorating health Wheaton Dep. (Ex. 3) at 110:14-21. Wheaton felt that "he needed attention for both his mental condition and his physical condition." *Id*. at 107:17-20. He went directly to LPN Repshire to tell her that Mr. Walter was "deteriorating rapidly." *Id.* at 107:21-108:25. He made this report to Repshire in front of Mr. Walter's holding cell where she could see for herself. *Id*. at 108:18-25.

57. Similarly, it was obvious to Deputy Combs that Mr. Walter was deteriorating in the last days of his confinement—she observed him confused, behaving bizarrely, losing a lot of weight, shaking uncontrollably, not sleeping, refusing meals, naked for hours in full view, not making sense, badly bruised, unresponsive, having urinated in his surroundings, and progressively going downhill. *See* Combs Dep. (Ex. 31) at 63:1-65:3. Nurse Repshire was fully aware of Mr. Walter's condition, but Combs felt she just dismissed it. *See id*. at 65:11-66:18.

58. Deputy Wilson worked swing shift daily from April 16-19. Decl. of Christopher Wilson (Ex. 23) at ¶ 6. He saw Mr. Walter repeatedly during this four-day period. *Id*. Mr. Walter's appearance was "shocking" and "grew worse and worse with each passing day." *Id*. ¶ 7. He was "almost unrecognizable" from when he had been brought into the jail two weeks earlier. *Id*. "It was obvious that Mr. Walter had lost a massive amount of weight." *Id*. ¶ 8. He was naked, and his bones were jutting out beneath his skin; he was "pale and gaunt" and "looked very sick." *Id*. He was "weak and frail," "lying down on the floor of the cell," and "shaking." *Id*. "Mentally, he seemed to be in another world. Mr. Walter was obviously in need of medical attention." *Id*.

59. Deputy Lightcap worked daily from April 15-20. Lightcap Dep. (Ex. 22) at 37:17-38:13. She saw Mr. Walter during her shifts. *Id*. at 56:9-57:22; 84:6-15. It was obvious to her that he was going downhill; he was confused, behaving bizarrely, shaking uncontrollably, not eating, not sleeping, and not making sense. *Id*. at 128:7-22. During these five days, she could tell that Mr. Walter was not physically or mentally able to fill out a written inmate medical request form (or kite). *Id.* at 141:4-8. She felt he "needed to be" in a hospital, and it was obvious to her that he was

not fit to be confined in that cell. *Id*. at 134:9-25. She saw him hitting the door hard enough to hurt himself, staring vacantly for minutes on end, "chattering away to the wall," "shaking from head to toe almost as if he was freezing cold," "laying on [the] mat, shaking," "pacing in his cell with no apparent purpose," and telling non-existing people to leave his cell. *Id*. at 85:1-108:4. He was incapable of getting a cup of water. *Id.* at 162:11-16. Throughout, she was concerned that he was not being provided with adequate medical care and regularly heard the other members of the jail staff in connection with their duties saying they were concerned that Mr. Walter was not being provided with adequate medical care by nursing staff. *Id*. at 140:25-141:17. "It was known across – through all of us that he needed more help than he was receiving." *Id*. at 136:17-18. Deputies and supervisors were upset with medical staff for not attending to Mr. Walter's needs and not providing him with the care he obviously required. *Id.* at 142:11-143:13.

60. Deputy Pohl worked daily from April 15-20 during which he observed Mr. Walter. *See* Pohl Dep. (Ex. 37) at 14:7-15, 16:3-17:6, 28:13-20. Most of the detention staff who were working in the booking area indicated to him (or in his presence) that they were frustrated with the medical staff's lack of attention to Mr. Walter. *Id.* at 57:10-14. The deputies felt that Mr. Walter was getting worse and worse over time and that "the medical people at the jail were not being attentive to Mr. Walter's medical needs." *Id*. at 58:11-23. Pohl grew frustrated because Mr. Walter was *asking* for medical attention; Pohl brought these requests to the nurse who put it off and never came to see Mr. Walter. *Id*. at 58:24-59:18, 34:18-25, 35:9-23, 36:9-12, 37:9-21. Mr. Walter's requests for medical aid were made to Pohl on April 16 and/or 17. *Id*. at 54:25-55:5. Pohl told his superiors that Mr. Walter was asking for medical attention, that these requests had been relayed to medical, but that medical would not come—leaving Pohl frustrated. *Id*. at 71:18-73:10. He wanted his supervisors "to do something in order to gain medical attention for Mr. Walter." *Id.* at 73:5-10.

61. Corporal Owen went to his sergeant 4-5 times to report that he had been complaining to medical about addressing Mr. Walter's needs, which were not being met. *See* Miller Dep. (Ex. 11) at 44:7-46:9. Miller received reports from about 18 members of his detention staff expressing

concerns about Mr. Walter in the days leading up to his death. *Id*. at 51:17-52:3, 58:18-60:6.

62. The medical staff's conduct was grossly below the standards of care. *See generally* Repts. of Moore, Stern, Gendel and Roy-Byrne—Exs. 14, 18, 20 and 24.

H. The Command Staff Learns that Mr. Walter is Not Getting Needed Medical Attention

63. Jail Commander Rankin oversees and commands all aspects of confinement at the jail, as well as daily jail operations. Rankin Dep. (Ex. 7) at 8:16:22, 10:18-22, 19:23-25. For approximately one year before Mr. Walter's confinement, Rankin and HSA Maestas were romantically and sexually involved. *Id*. at 31:10-17, 34:5-24. This was well-known to the Sheriff, Undersheriff, all staff, and inmates. *Id*. at 44:19-46:21.

64. Commander Rankin was at the jail on April 15, 16 and 18 but not on April 17th or on the weekend of April 19-20 before Mr. Walter died. Rankin Dep. (Ex. 7) at 71:20-74:7.

65. On April 16 and 18, Commander Rankin regularly interacted with detention staff who were seeing what was happening to Mr. Walter inside the windowed holding cell. *Id*. at 81:13-21. Rankin knew "the entire staff who worked in the booking area were very concerned about Mr. Walter" and deeply worried about his medical condition. *Id*. at 89:12-20, 91:16-19, 96:21-97:1. Sergeants and corporals reported to him that Mr. Walter's medical condition was serious, including that he needed to be in a hospital. *Id*. at 89:24-91:11. Rankin also saw Mr. Walter inside the holding cell on several occasions. *Id*. at 81:22-25.

66. When Commander Rankin saw Mr. Walter for himself, he confirmed the reports he had been getting. *Id*. at 92:16-19. Like everyone else, he saw a host of highly concerning symptoms. He saw Mr. Walter in the holding cell confused, behaving bizarrely, and shaking uncontrollably. *Id.* at 82:17-83:3. He saw that Mr. Walter was pale and thin, unclothed in full view of anyone who looked in, and that he looked awful. *Id*. at 83:8-23. He noticed that Mr. Walter was talking to people who were not there and talking nonsensically. *Id*. at 83:24-84:11. He saw that Mr. Walter was yelling and screaming, unaware of his surroundings, disoriented, confused, and unable to fill out a medical request form or kite. *Id*. at 85:4-18, 86:24-87:4. He could see that Mr. Walter

appeared to be very ill. *Id*. at 85:19-21. He was aware that Mr. Walter had not been regularly sleeping or eating. *Id*. at 86:19-23. He knew that Mr. Walter's condition was deteriorating rapidly and getting worse and worse. *Id*. at 93:12-94:1. He knew that Mr. Walter was "getting weaker and weaker" and "losing a lot of weight." *Id*. at 95:5-8. It was apparent to Rankin that Mr. Walter was "in a medical crisis" and "in need of hospitalization." *Id*. at 87:5-12. *See also id.* at 102:2-9.

67. Commander Rankin knew that the sergeants themselves had attempted to address the issue directly with medical before coming to him. *Id*. at 97:10-14. The reports he received from those under his command occurred on April 16 and/or April 18. *Id*. at 97:21-98:1. It was likely both dates. *Id*. at 100:23-101:3. His own observations also occurred on those dates. *Id*. at 101:9-11.

68. Mr. Walter's medical issues were so dire that Commander Rankin discussed them with his boss, Undersheriff Martin. He conveyed to Martin what had been reported to him and what he, himself, had observed. *Id*. at 109:3-17. Rankin told Martin that detention staff members were frustrated about the lack of medical response and felt that Mr. Walter's medical needs were not being addressed. *Id*. at 109:22-25, 110:4-13. According to reports from Rankin, Martin learned that the detention staff were concerned that the medical staff did not appear to be doing anything for Mr. Walter. *See* Martin Dep. (Ex. 9) at 46:3-11.

69. Undersheriff Martin also learned from Rankin that Mr. Walter's condition appeared to be very serious and was deteriorating. *See* Martin Dep. (Ex. 9) at 43:2-12, 45:3-6. Martin received at least three reports from Rankin, which included descriptions about Mr. Walter's condition and the medical staff's lack of treatment. *See id.* at 48:18-49:8, 50:18-51:2.

70. Following their discussions, Rankin and Martin went to see Mr. Walter in his cell—this occurred on either April 16th or April 18th. Rankin Dep. (Ex. 7) at 110:14-17, 111:12-16.

71. Rankin also went to see Sheriff Beicker to make him fully aware of the situation with regard to Mr. Walter, including the frustrations that had been expressed to him with regard to medical staff's care of Mr. Walter. Rankin Dep. (Ex. 7) at 115:17-25. Rankin communicated to

Sheriff Beicker those things that had been communicated to him by his staff. *Id*. at 115:21-116:9. He only involved Beicker in serious situations. *Id*. at 68:19-23.

72. Sheriff Beicker admits receiving such reports from Rankin. He recalls Rankin informing him that Mr. Walter was not doing well and was "not responding to whatever medical care he was getting." Beicker Dep. (Ex. 8) at 57:20-25. He learned that Mr. Walter was deteriorating or going downhill, mentally confused, acting in a very unusual way, talking to people who were not there, and talking to himself in a very bizarre or unusual manner. *Id*. at 58:1-24. Rankin also reported to him that Mr. Walter was unable to sleep, shaking, not eating, losing unusual amounts of weight, thin or emaciated looking, and unaware of his surroundings. *See id*. at 59:18-20, 62:11-63:12. Beicker learned that the whole staff was concerned about Mr. Walter and felt like the medical staff was not doing enough for him. *Id*. at 60:11-18, 62:3-7.

73. Sheriff Beicker understood that the staff felt Mr. Walter was not getting the medical help he clearly needed. *Id*. at 61:10-14. The "general consensus" was that the medical staff was not providing him with all necessary care. *Id*. at 63:13-18. Commander Rankin came to Sheriff Beicker at least two to three times and told him that Mr. Walter was not improving and seemed to be deteriorating. *Id*. at 115:4-116:13.

74. Sheriff Beicker also received a report from a corporal who seemed extremely upset, concerned, and disturbed. *Id*. at 74:14-75:13. The corporal was bothered by Mr. Walter's continued deterioration. *Id*. at 76:2-10. He told Beicker that Mr. Walter was "not doing well" and that whatever the medical staff was doing was "not working." *Id*. at 76:16-18. Beicker learned that Mr. Walter remained mentally confused, weak, pale, and unwell and that he was still shaking, shuddering, and apparently hallucinating. *Id*. at 82:13-83:11.

75. Between April 16-18, Sheriff Beicker knew Mr. Walter was losing unusual amounts of weight, involuntarily shuddering or convulsing, talking to the walls, yelling with no apparent purpose, unaware of the presence of others, inappropriately naked, and mentally confused. *See* Beicker Dep. (Ex. 8) at 86:17-88:14. His also knew his detention staff was very frustrated because

they felt Mr. Walter was not getting needed medical help. *Id*. at 90:9-21. He knew that virtually the entire booking-area staff was concerned about Mr. Walter's deteriorating condition. *Id*. at 91:19-25. And he knew that essentially the entire jail staff was frustrated about the medical staff's lack of response to Mr. Walter. *Id*. at 92:1-4. Sheriff Beicker also "personally observed Mr. Walter on two or three occasions from the booking area" (Ex. 5 at 6), and therefore would have seen the same things the rest of the detention staff saw.

76. When asked whether there were other situations "on par with that of Mr. Walter with regard to the level of seriousness that was being expressed to [him] by staff about [Mr. Walter's] deteriorating condition and their frustration with medical staff," Sheriff Beicker acknowledged that there had been others and "probably many others." *Id*. at 103:25-104:10. Sheriff Beicker agreed that it was the custom of the jail not to transport inmates to the hospital even with the level of symptoms he knew Mr. Walter to be experiencing. *Id*. at 119:24-120:7.

77. The jail's staff was entirely correct about the seriousness of Mr. Walter's condition and the obviously inadequate medical attention. Throughout his time in the holding cell, the jail's medical staff was utterly neglecting him: he was not being medically monitored; no vital signs were being taken; protocols for assessing his medical condition and mental health were being ignored; other medications (not just his Klonopin, but also blood pressure meds and his prescribed Methadone) were withdrawn, missed, or not administered; no PA saw him; a psychiatrist (Dr. Allen) visited him for only 10-minutes and was grossly indifferent to his serious medical needs; and emergency care was not summoned. The medical staff was neglecting him—despite his objectively serious needs. *See generally* Repts. of Moore, Stern, Gendel and Roy-Byrne (Exs. 14, 18, 20 and 24). By at least April 15, Mr. Walter's Klonopin withdrawal was quite severe and growing increasingly more severe. Gendel Rept. (Ex. 20) at 19. He needed hospital treatment by at least April 15th, a need that grew "more urgent with each passing day and hour." *Id*.

I. Taking No Action, the Command Staff Defendants All Leave for the Weekend

78. Although Commander Rankin, Undersheriff Martin, and Sheriff Beicker all claim to have gone to the LPNs to seek information and/or assurances concerning Mr. Walter, the evidence shows this to be untrue. *See* Plaintiff's Response to Defs. SMF ¶¶ 58-59, 60-61, 62-63.

79. Despite knowing of Mr. Walter's condition and the near-universal frustrations of his staff concerning the obvious lack of medical care, Commander Rankin left the jail about 4:30 p.m. on Friday, April 18th. *See* Rankin Dep. (Ex. 7) at 124:18-125:8. He did not come back to the jail until after Mr. Walter died (on Sunday, April 20) and did not communicate with anyone about Mr. Walter after he left. *Id*. at 125:12-20. He had no reason to think the undersheriff or sheriff would be at the jail over the weekend, and he knew that not even a sergeant would be there. *Id*. at 126:12-127:4. Yet he did nothing to ensure that Mr. Walter received adequate medical care during that time. *Id*. at 127:12-17. He knew before he left the jail on April 18th that Mr. Walter did not appear to be in a condition to accurately communicate his medical needs. *Id*. at 148:19-25. And he knew that no nurse would even be on duty at all for at least 36 of the ensuing 60+ hours.

80. Undersheriff Martin departed the jail at the end of the day on Friday, April 18th, knowing that Mr. Walter would be without any medical provider for 12 hours out of every ensuing 24-hour period. *See* Martin Dep. (Ex. 9) at 79:25-80:14. There is no evidence that Undersheriff Martin took any action regarding Mr. Walter after he left for the weekend.

81. Sheriff Beicker acknowledges that he, too, would have left the jail after normal business hours on Friday, April 18th. Beicker Dep. (Ex. 8) at 93:3-8. He was not at the jail over the weekend. *Id*. at 93:9-11. He did nothing after leaving on April 18th to ensure that Mr. Walter received adequate medical care over the weekend. *Id*. at 113:15-25. He took no action despite knowing that there was no medical staff at the jail for at least 12 hours every day. *Id*. at 117:15-18.

82. Plaintiff's experts opine that the individual Command Staff Defendants—Rankin, Marin and Beicker—were in breach of the standards of care regarding Mr. Walter. *See, e.g*., Stern Rept. (Ex. 18) at 28-31; Brasfield Rept. (Ex. 15) at 7-8.

J. Mr. Walter's Continued Decline and the Jail's Policy Preventing Detention Staff from Securing Medical Care for Him

83. From the point the Command Staff Defendants left on Friday, April 18 until Mr. Walter's death approximately 49 hours later at 5:30 p.m. on Sunday, April 20, Mr. Walter's condition *continued* to deteriorate. Deputy Wilson describes his condition on April 19th as follows:

> By April 19th, Mr. Walter's condition was quite obviously dire – any person could see that. He was, by this time, covered with bruises. I could see bruises on his hands, feet, shins and torso. He was lying on the cell floor, simply shaking. He was emaciated and seemed to have no sense of his surroundings or the condition he was in.
>
> By the end of my shift on Saturday, April 19th, Mr. Walter was in such dire condition that I remarked to one of my fellow deputies, Charlene Combs, "I would not be surprised if he dies tonight." She agreed with me and told me that her superiors and pretty much everyone else working in the booking area were aware of Mr. Walter's situation. She also told me that the jail's nurse was aware of Mr. Walter's situation. Based on what I observed, and in light of the deterioration in Mr. Walter's condition with each passing day, he looked to me to be a dying man. Any person who saw Mr. Walter between April 16-19 (and particularly on April 19th) would have seen the same things I saw.

Ex. 23 ¶¶ 9-10.

84. An inmate being held across from Mr. Walter's cell on April 19th describes him as looking "like a living corpse," "malnourished," "violently shuddering," covered with marks and bruises, and "talking and mumbling almost nonstop." Decl. of J. Weber (Ex. 38) ¶ 3. "He was obviously physically and mentally ill, and anyone who looked at him for more than a minute would be able to see that." *Id*. Mr. Walter was "lying naked on the concrete floor . . . convulsing violently." *Id*. ¶ 7. "It was totally obvious to [him] that the man was in dire need of medical attention." *Id*. ¶ 4. The inmate told deputies, "He's going to die in here if you don't get him to a hospital." *Id*. ¶ 7.

85. Deputy Lightcap was so alarmed by Mr. Walter's condition on April 19th that she documented her observations. *See* Ex. 39. She described him being covered with "excessive bruises" "all over his body," his toe appeared to be broken, "[t]here seem[ed] to be more bruises showing up each day," and she saw his obvious "diminishing size." *Id.* His whole body was violently and involuntarily shaking, and she could see fresh blood among *many other* disturbing

observations as detailed in her deposition. *See* Lightcap Dep. (Ex. 22) at 110:18-129:6. He was in a "medical crisis" and needed to be in a hospital. *Id.* at 123:10-24, 134:9-25.

86. The Court need not guess what Mr. Walter's body looked like on April 19th because, following his death, photos were taken to show the excessive external injuries now covering his whole body. These photos were shown to Deputy Lightcap during her deposition, and she confirmed that they accurately depict the condition of his body as of 11:00 p.m. on April 19th—18 and ½ hours before he died. *See* Ex. 40; Lightcap Dep. (Ex. 22) at 140:7-17.

87. The Fremont County Sheriff's Office had a policy *prohibiting* detention staff from sending an inmate to the hospital or calling for outside aid based on their own judgment—without the pre-approval of the jail's medical staff. Wilson Decl. (Ex. 23) at ¶ 11. Multiple members of detention staff confirmed the existence of this policy. *See, e.g.*, Owen Dep. (Ex. 34) at 64:15-65:13; Combs Dep. (Ex. 31) at 21:1-16; Miller Dep. (Ex. 11) at 67:12-17; 69:10-13. Sheriff Beicker testified that it was his policy that no outside provider could be brought to the jail without the specific approval of CHC's HSA—Ms. Maestas. Beicker Dep. (Ex. 8) at 98:2-13. He also testified that no inmate could be taken to the hospital without Maestas's approval unless the person had "very obvious life threatening injuries" such as "bleeding and unresponsiveness." *Id.* at 98:14-99:14.

88. This policy was a moving force behind Mr. Walter not being sent to the hospital over the weekend of April 19-20. *See* Wilson Decl. (Ex. 23) ¶ 11. ("If we had been permitted to transport a person to the hospital based on our own judgments, I would have done so without hesitation" and "I would have called 911 and had Mr. Walter transported to a hospital immediately.").

89. On April 20th, Mr. Walter remained confined in the holding cell without any medical evaluation or care. Deputy Combs observed him that day. He was lying on the cold floor naked, shaking and quivering involuntarily from head to toe, and unresponsive to her. *See* Combs Dep. (Ex. 31) at 45:14-49:19. Corporal Owen saw Mr. Walter that day, lying naked under the sink on the cold floor shaking in a fetal-type position. *See* Owen Dep. (Ex. 34) at 68:24:69:17.

K. Mr. Walter's Death and Injuries

90. Mr. Walter died in his cell at approximately 5:30 p.m. on Sunday, April 20. Ex. 24 at 12. His body was autopsied by Dr. Emily Berry of the El Paso County Medical Examiner's Office. He weighed only 168 pounds—a loss of over 30 pounds during his 17 days in jail. *See* Ex. 41; Rept. of Frank Sheridan, M.D. (Ex. 42) at p. 4. He had numerous external injuries—extensive bruises, contusions and abrasions—covering nearly his whole body. *See* Ex. 40 & Ex. 41.

91. Mr. Walter also had extensive *internal* injuries. These included multiple *posterior* rib fractures—*i.e*., many broken ribs on the back of his body where his ribs attached to his spine. *See* Sheridan Rept. (Ex. 42) at p. 6. They occurred "at the strongest point in the rib-cage" and a "great deal of externally-applied force would have been necessary to cause these fractures." *Id.* The rib fractures could not have been self-inflicted, could not have been caused by resuscitative efforts, and were not caused after Mr. Walter's death. *Id.* They occurred "within a few days of death" and were "probably caused by another person or persons kicking or stomping on the subject." *Id*. Mr. Walter also had internal bleeding caused by someone beating, kicking, or stomping on him. *Id*.

92. Given that no other inmate had access to Mr. Walter during the last five and ½ days of his jail confinement, these significant internal injuries were caused by members of jail staff. No one has admitted using force sufficient to cause these injuries, but there is no question that they were inflicted by one or more jail staff members—and any force that caused these injuries was unquestionably excessive. *See* Cathcart Rept. (Ex. 33) at p. 33; Brasfield Rept. (Ex. 15) at p. 19.

93. After Mr. Walter died, Sheriff Beicker told Commander Rankin he felt the jail's nursing staff—Repshire and Maestas—were at fault for Mr. Walter's death. Rankin Dep. (Ex. 7) at 136:5-9. He told Rankin that he was very unhappy with the level of care provided by the nurses of the jail to Mr. Walter and that he felt that they neglected their duties to him. *Id*. at 136:10-14. Yet when presented with the obligation to intervene, he did nothing.

94. The post-death "investigation" was *extremely* deficient, as admitted by the undersheriff. *See generally* Martin Dep. (Ex. 9) at 121:13-130:2, 134:11-147:1, 150:7-156:5, 161:22-169:6. The

"investigation" was kept purely internal to the Fremont County Sheriff's Office; not a single person (outside of one T-Pod inmate) was interviewed, and no material evidence or information was gathered. *Id.* Undersheriff Martin "fully acknowledged" that the supposed investigation was "inadequate" and "not thorough." *Id.* at 162:17-163:11. Undersheriff Martin acknowledged that Mr. Walter's family was "owed a thorough investigation that they did not get" and that the investigation's utter inadequacy "deprived [them] of the right to the truth." *Id*. at 168:15-169:6.

95. Due to the inadequate investigation, the medical examiner was originally unable to determine the cause of Mr. Walter's death. Without a standard forensic death investigation, "there is no way that she could have arrived at a valid cause of death." Sheridan Rept. (Ex. 42) at 5.

96. Three years later, with information learned in this case, the original medical examiner appropriately amended the official autopsy report. She found that Mr. Walter died from "Acute Benzodiazepine Withdrawal." Ex. 43. Indeed, acute benzodiazepine withdrawal was the cause of Mr. Walter's death. Sheridan Rept. (Ex. 42) at 4. His death was "entirely preventable" and had he been treated appropriately in jail or "transported to the hospital and provided emergency medical care for his severe benzodiazepine withdrawal prior to his death," he would not have died and would have been spared from the pain and suffering he experienced. *Id*. at 5.

97. CHC's policies mandated full and thorough internal mortality reviews at the facility and corporate levels to determine the appropriateness of care provided (or not provided) to Mr. Walter during his confinement. Dep. of S. Thomas (Ex. 44) at 14:7-30:22. No such review was conducted in the case of Mr. Walter's death. *Id*. at 30:15-22, 41:24-42:12. CHC's corporate representative admits that these failures violated CHC policy. *Id*. at 36:20-24, 41:24-42:5.

98. Sheriff Beicker concluded that all Fremont County employees and personnel working at the jail acted in accordance with county policy with regard to Mr. Walter. Beicker Dep. (Ex. 8) at 342:24-343:4. He testified that he was "satisfied that [his] staff did what they should have done at the end of the day." *Id*. at 343:17-19. He testified that he therefore ratified their actions. *Id*. at 343:20-21. *See also* Brasfield Rept. (Ex. 15) at p. 21 (discussing same).

99. Mr. Walter was not the first inmate at the Fremont County Jail who was not taken to the hospital despite suffering from severe withdrawal symptoms. One detention deputy recalled approximately 10 other inmates who were suffering from significant alcohol withdrawal symptoms (including hallucinations, excessive sweating, and shaking) but who were kept in the holding cell without being taken to the hospital or receiving outside medical care. *See* Owen Dep. (Ex. 34) at 105:3-106:25. This was "standard practice at the jail." *Id*. at 107:21-108:10.

III. ARGUMENT

A. The Command Staff Defendants are Not Entitled to Qualified Immunity

To overcome a qualified immunity challenge at the summary judgment stage, plaintiff must show that (1) the defendants violated a constitutional right, and (2) the right was clearly established at the time of the incident. *Lundstrom v. Romero*, 616 F.3d 1108, 1118 (10th Cir. 2010). In deciding qualified immunity, the Court must view the facts in the light most favorable to the plaintiff and resolve all disputes and reasonable inferences in plaintiff's favor. *See Walton v. Gomez (In re Estate of Booker)*, 745 F.3d 405, 411 (10th Cir. 2014). The constitutional right implicated in this case is Mr. Walter's right to adequate medical care in jail. To state a claim under § 1983 for inadequate medical care, we must show that jail officials were deliberately indifferent to Mr. Walter's serious medical needs. *See Martinez v. Garden*, 430 F.3d 1302, 1304 (10th Cir. 2005).

"Deliberate indifference involves both an objective and a subjective component." *Sealock v. Colorado*, 218 F.3d 1205, 1209 (10th Cir. 2000).[4] The objective inquiry (which is uncontested here) asks whether "the deprivation alleged was, objectively, sufficiently serious." *Farmer v. Brennan*, 511 U.S. 825, 834 (1994). The subjective inquiry asks whether the defendant acted with "deliberate indifference" to "an excessive risk to inmate health or safety." *Id.* Deliberate

[4] Very recently, legal developments based on new Supreme Court precedent calls into serious doubt the continued use of a subjective standard in Fourteenth Amendment cases such as this one. We have discussed this at length in Section IV.B.1 of Plaintiff's Response to 'Motion for Summary Judgment on All Claims Against the Estate of Roy D. Havens' which is being simultaneously filed. The Court could dispense with the subjective inquiry here; however, there is more-than-sufficient evidence to overcome summary judgment even if the Court applies a subjective standard.

indifference lies "somewhere between the poles of negligence at one end and purpose or knowledge at the other." *Farmer*, 511 U.S. at 836. Under *Farmer*, the requisite state of mind is a "question of fact subject to demonstration in the usual ways, including inference from circumstantial evidence." *Gonzalez v. Martinez*, 403 F.3d 1179, 1183 (10th Cir. 2005).

1. The Command Staff Defendants Acted with Deliberate Indifference to Mr. Walter's Serious Medical Needs

It is beyond debate that Mr. Walter suffered from multiple serious medical conditions, and the Command Staff Defendants concede the seriousness of his medical needs. *See* ECF 167 at 18. Since the objective component of the inquiry is uncontested, the only question is whether the Command Staff Defendants were deliberately indifferent to Mr. Walter's serious medical needs. Viewing the facts in the light most favorable to the plaintiff, the answer to this question is clear.

Each of the Command Staff Defendants was personally aware of Mr. Walter's serious medical needs: their subordinates reported it to them, and they saw it themselves. They knew his condition was rapidly deteriorating and that he needed significant medical attention. Despite an obligation to ensure that his serious medical needs were met, they did next to nothing. Leaving him in the hands of LPNs, who were obviously ignoring his downhill slide—and leaving him with *no medical attention whatsoever* for 12 hours a day—was certain to put him at substantial risk of continuing harm and suffering. By failing to get him the help he needed, the Command Staff Defendants deliberately disregarded those risks. The record casts great doubt on the Command Staff Defendants' claims that they went to the LPNs *at all* and shows without doubt that they did nothing to secure further medical care for Mr. Walter *knowing* he was without adequate care.

2. The Law was Clearly Established in 2014: Unreasonable Reliance of Medical Providers is Not a Defense

The next question in the qualified immunity analysis is whether the law was clearly established. A jail official violates an inmate's clearly established constitutional rights "if he acts with deliberate indifference to [the] inmate's serious medical needs—if he 'knows of and disregards an excessive risk to inmate health or safety.'" *Garrett v. Stratman*, 254 F.3d 946, 949

(10th Cir. 2001) (quoting *Farmer*, 511 U.S. at 837)). *See also Mata v. Saiz*, 427 F.3d 745, 749 (10th Cir. 2005) (Freedom from "deliberate indifference to an inmate's serious medical need is a clearly established constitutional right[.]"); *Martin v. Board of County Commissioners*, 909 F.2d 402, 406 (10th Cir. 1990). The Command Staff Defendants do not challenge this clearly established precedent. Instead, they try to pass the buck to the to the corporate healthcare providers.

In support of qualified immunity, the Command Staff Defendants correctly cite the general rule that corrections officials can *ordinarily* rely on the judgment and advice of medical staff with respect to an inmate's treatment and care. However, it is equally clear that jail officials cannot escape liability for deliberate indifference on this basis *if* such reliance is not reasonable. As the Tenth Circuit explained 2009, "it has been clearly established for over a decade that *unreasonable reliance* on the advice of a medical professional will not excuse deliberate indifference to a prisoner's serious medical needs." *Weatherford ex rel. Thompson v. Taylor*, 347 F. App'x 400, 404 (10th Cir. 2009) (emphasis added). *See also Meyer v. Singh*, No. 10-cv-02302-PAB-KMT, 2011 U.S. Dist. LEXIS 61343, *40-41 (D. Colo. 2011) ("Where it is evident to a lay person that a prisoner is receiving inadequate or inappropriate treatment, non-medical prison officials still have an obligation to provide medical care."); *Fresquez v. Baldwin*, No. 08-cv-01233-CMA-CBS, 2009 U.S. Dist. LEXIS 71874, *5 (D. Colo. 2009) ("Although it is true that in the normal case non-medical jail staff may rely upon the medical judgments of the medical professionals, it is also true that this is not so in the unusual case where it would be evident to the layperson that a prisoner is receiving inadequate or inappropriate treatment.") (citations & internal quotations omitted).[5] Thus, it was well-settled in 2014 that jail officials could not *unreasonably* rely on medical staff or blindly defer to them if there was reason to believe they were not providing appropriate medical care.

[5] Other jurisdictions agree that unreasonable reliance on medical staff will not avoid a finding of deliberate indifference. *See McRaven v. Sanders*, 577 F.3d 974, 981 (8th Cir. 2009) (a "prison official may rely on a medical professional's opinion *if such reliance is reasonable*") (emphasis added); *Spruill v. Gillis*, 372 F.3d 218, 236 (3rd Cir. 2004) ("*absent a reason to believe (or actual knowledge) that prison doctors or their assistants are mistreating (or not treating) a prisoner*, a non-medical prison official . . . will not be chargeable with the Eighth Amendment scienter requirement of deliberate indifference") (emphasis added). Here, as discussed below, the Command Staff Defendants knew that the corporate medical providers were not providing adequate care. Indeed, this was obvious to all staff.

Here, virtually the entire detention staff recognized that the "treatment" being provided to Mr. Walter was inadequate. The inadequacy of care was obvious to them. They could see and appreciate his dire and deteriorating condition. As Mr. Walter's serious symptoms progressively worsened, new ones appeared and persisted. It was clear that Mr. Walter was in grave need of medical attention that he was not getting. Because it was obvious that Mr. Walter was not getting the medical care he needed, they reported their concerns to supervisors who saw the same things and, in turn, took their concerns higher. They reported what they and their subordinates saw of Mr. Walter's condition and the inadequacy of his care. Sheriff Beicker, Undersheriff Martin, and Commander Rankin all knew that nearly the entire staff was gravely concerned about Mr. Walter's worsening condition and the highly inadequate care from the part-time medical staff.

The Command Staff Defendants saw Mr. Walter's grave condition for themselves. It was clear to them that he was suffering from a profound medical crisis and was getting progressively worse. Even assuming that the Command Staff Defendants took their concerns to the nursing staff as they claim to have done (despite evidence to the contrary), it was not enough. Whatever bare minimal medical care he may have been receiving was plainly insufficient. Any lay person would have recognized that Mr. Walter needed to be hospitalized. Commander Rankin himself admits knowing that Mr. Walter needed to be in a hospital and was incapable of expressing his medical needs. Mr. Walter's dire symptoms cannot be ignored under the guise of "following protocols" and assurances by the nursing staff that they were doing "everything they could" for Mr. Walter. Any reliance on such assurances was unreasonable. They cannot escape liability by claiming to have relied on the nursing staff—even assuming this happened, which the record shows it did not.

3. The Command Staff Defendants' Supervisory Liability

In addition to their individual deliberate indifference, the Command Staff Defendants are personally liable under a supervisory liability theory. "[Section] 1983 allows a plaintiff to impose liability upon a defendant-supervisor who creates, promulgates, implements, or in some other way possesses responsibility for the continued operation of a policy the enforcement (by the defendant-

supervisor or her subordinates) of which 'subjects, or causes to be subjected' that plaintiff 'to the deprivation of any rights . . . secured by the Constitution[.]'" *Dodds v. Richardson*, 614 F.3d 1185, 1199 (10th Cir. 2010) (quoting 42 U.S.C. § 1983). In this case, the Command Staff Defendants, all of whom are policymakers, were personally responsible for implementing, enforcing, and participating in a policy that prohibited staff from taking measures to transport an inmate to the hospital—subjecting Mr. Walter to the deprivation of his right to adequate medical care.

B. The Evidence Supports Municipal Liability

In addition to the claims against the individual Command Staff Defendants, plaintiff asserts municipal liability claims against Fremont County itself. There are several ways in which the evidence supports municipal liability under § 1983. First, Fremont County has a non-delegable duty to provide adequate healthcare to its detainees. Because it cannot contract this duty away, the County is liable for any unconstitutional policies, practices, and customs of its corporate healthcare provider. Second, the County is liable for the acts and omissions of the Command Staff Defendants, each of whom is a policymaker. Third, the County is liable for its own unconstitutional policies, practices, and customs. Finally, the County is liable under the ratification doctrine.

1. Fremont County is Liable Under the Non-Delegable Duty Doctrine for the Unconstitutional Policies, Practices, and Customs of CHC

The County's obligation to provide medical care for those whom it is confining in jail is non-delegable: "Contracting out prison medical care does not relieve the [government] of its constitutional duty to provide adequate medical treatment to those in its custody, and it does not deprive [government] prisoners of the means to vindicate their [constitutional] rights." *West v. Atkins*, 487 U.S. 42, 56 (1988). Under the "non-delegable duty doctrine," when a county contracts out its obligation to provide medical care, the "county itself remains liable for any constitutional deprivations caused by the policies or customs of the [corporate medical services provider]." *Ancata v. Prison Health Servs*., Inc., 769 F.2d 700, 705 (11th Cir. 1985). *See also King v. Kramer*, 680 F.3d 1013, 1020 (7th Cir. 2012) (holding a county "cannot shield itself from § 1983 liability

by contracting out its duty to provide medical services" and noting that "[t]he underlying rationale is not based on respondent [sic] superior, but rather on the fact that the private company's policy becomes that of the County if the County delegates final decision-making authority to it").

The defense contends that "there is no such thing" as respondeat superior liability in cases under 42 U.S.C. § 1983. ECF 167 at 34. This is correct in the sense that a local government is not automatically liable for the acts of its employees—irrespective of any unconstitutional policy, custom, or practice. However, when a municipality delegates its policymaking authority to a third party, the third party's policies become those of the municipality. Consequently, if the third party's unconstitutional policies cause injury, then the municipality itself is liable under the non-delegable duty doctrine. *See Ancata*, 769 F.2d at 705; *Kramer*, 680 F.3d at 1020.

The non-delegable duty doctrine has been applied by this Court to find sufficient evidence of "indirect" municipal liability in a case involving same company involved in this case. *See McGill v. Corr. Healthcare Cos*., Inc., No. 13-cv-01080-RBJ, 2014 U.S. Dist. LEXIS 151929 (D. Colo. Oct. 24, 2014). In *McGill*, Jefferson County contracted with CHC to provide healthcare services at its jail. The plaintiff alleged that CHC had an unconstitutional practice of failing to adequately train its nursing staff, which resulted in their failure to call a doctor or ambulance when he presented with signs of a stroke. Although the sheriff, who was sued in his official capacity, admitted a non-delegable duty to provide medical care to inmates at the county jail, he argued that the plaintiff must come forward with specific facts showing that the municipality *itself* had a policy, practice, or custom of not providing emergent care to inmates. This Court disagreed:

> The Court . . . cannot absolve the County of indirect liability if a jury finds that CHC did in fact have a policy, custom, or practice in place that directly caused the alleged constitutional deprivation. Mr. McGill does not rely on a theory of respondeat superior liability, which would render the County automatically liable for the acts of its employees regardless of the existence of an unconstitutional policy, custom, or practice. See *Monell v. Dep't of Soc. Servs. Of City of New York*, 436 U.S. 658, 692-94, 98 S. Ct. 2018, 56 L. Ed. 2d 611 (1978). Instead, the plaintiff claims that CHC provided constitutionally inadequate training to its nurses that directly resulted in the nursing staff's failure to call a doctor or an ambulance when Mr. McGill presented with signs of a stroke. This theory alleges a policy, practice, or custom of CHC, which

> may be attributed to the County through the non-delegable duty doctrine. As such, the Court cannot dismiss Sheriff Mink from this action entirely, even though it dismissed the direct liability claim. Insofar as the defendant seeks summary judgment on indirect liability, the motion is denied.

Id. at *20-21. *See also Trujillo v. City & County of Denver*, No. 14-cv-02798-RBJ-MEH, 2016 U.S. Dist. LEXIS 175388, at *33-34 (D. Colo. Sept. 7, 2016) (recognizing the non-delegable duty doctrine when the government contracts with a private entity to provide jail healthcare services); *Anglin v. City of Aspen, Colo*., 552 F. Supp. 2d 1229, 1244 (D. Colo. 2008) ("[T]he State cannot, by choosing to delegate its constitutional duties to the professional judgment of others, thereby avoid all liability flowing from the attempted fulfillment of those duties under Section 1983.").[6]

In this case, CHC, the corporation to which Fremont County delegated its jail healthcare services, maintained multiple unconstitutional policies, practices, and customs. For example, as discussed in plaintiff's additional statement of disputed facts, CHC had a blanket policy of denying benzodiazepines to all arriving inmates—even to those who, like Mr. Walter, had a valid prescription—and making them go cold-turkey, despite the well-known risks of doing so. Such a policy is unconstitutional. *See Treadwell v. McHenry Cnty.*, 193 F. Supp. 3d 900 (N.D. Ill. 2016).

The *Treadwell* plaintiff was on the same prescription benzo as Mr. Walter. He was taken to jail, where he notified the staff about his Klonopin prescription. Like Fremont County, the

[6] The non-delegable duty doctrine is well-settled nationwide. *See, e.g., Leach v. Shelby Cnty. Sheriff*, 891 F.2d 1241, 1250 (6th Cir. 1989) (county "retains responsibility [for inmates' medical care] despite having contracted out the medical care of its prisoners"); *Simmons v. Corizon Health, Inc*., 122 F. Supp. 3d 255, 267 (M.D.N.C. 2015) ("[W]hen the County purportedly contracted out the performance of inmate medical care, at least some of Corizon's policies became 'that of the County,' and thus potential § 1983 liability is not based on respondeat superior."); *Scott v. Clarke*, 64 F. Supp. 3d 813, 819 (W.D. Va. 2014) (governments "may not insulate themselves from Eighth [or Fourteenth] Amendment claims premised upon allegations of deficient medical care by delegating responsibility for the provision of medical care to third parties."); *Kellogg v. Kitsap County*, No. C12-5717, 2013 U.S. Dist. LEXIS 71274, at *10-11 (W.D. Wash., May 20, 2013) (county "cannot shield itself from § 1983 liability by contracting out its duty to provide medical services. The underlying rationale is not based on respondeat superior, but rather on the fact that the [third party's] policy becomes that of the County if the County delegates final decision-making authority to it."); *Sullivant v. Spectrum Med. Servs*., No. 11-00119, 2013 U.S. Dist. LEXIS 9303, *21 (D. Mt. Jan. 23, 2013) (county "cannot shield itself from § 1983 liability by contracting out its duty to provide medical services."); *Wilson v. Douglas Cnty*., No. 8:03CV70, 2005 WL 3019486, at *1 n.1 (D. Neb. Nov. 10, 2005) (county may be liable "notwithstanding that the County contracted with Wexford, a private company, to provide medical services to inmates"); *Irby v. Erickson*, No. 03-C-1801, 2004 U.S. Dist. LEXIS 557, at *6 (N.D. Ill. Jan. 16, 2004) (contracting out prison medical care "does not relieve the county of its constitutional duty to provide adequate medical treatment to those in its custody.")

county contracted with a private corporation—Correct Care Solutions (CCS). Like CHC, CCS had a policy of discontinuing benzo prescriptions. *Id.* at 904. Unlike CHC, however, CCS provided the plaintiff with a substitute benzo and put him on a tapering schedule pursuant to a corporate protocol. *Id.* Despite the tapering with a substitute benzo, the plaintiff still suffered some withdrawal. *Id.* at 905-06. The U.S. District Court denied a summary judgment motion, ruling that "a reasonable jury could conclude that [plaintiff] suffered a painful and unnecessary withdrawal based on a blanket policy, rather than independent medical judgment." *Id.* at 909.[7]

After denying summary judgment to CCS, the court turned to the county's motion for summary judgment in which it argued that it could not be liable because it "had no role in CCS's medical policy decisions." *Id.* at 909. The court rejected this argument based on the non-delegable duty doctrine: the contract between CCS and the county gave CCS broad discretion to provide healthcare services, and no contractual provision required the county's approval before CCS could enact or change policies. "Accordingly, CCS's policy was "deemed by law to be the policy of the County," and it could not "'shield itself from § 1983 liability by contracting out its duty to provide medical services.'" *Id.* at 910 (quoting *King*, 680 F.3d at 1020).

In addition to its policy of "cold-turkeying" benzodiazepine dependent inmates, CHC also failed to provide constitutionally adequate training to its medical staff. For instance, during Mr. Walter's pretrial detention, CHC staffed the jail with a brand-new LPN, Stephanie Repshire. Despite her total lack of familiarity with CHC's medical policies, procedures, and protocols, CHC left her alone and unsupervised during her shifts—in violation of the Colorado Nurse Practice Act. Incredibly, she had no knowledge, training, or experience, or education on patients withdrawing from any kind of substance. By her own admission, as of April 2014, Ms. Repshire was not adequately trained in how to monitor and deal with a patient in Mr. Walter's condition. A reasonable jury could easily find CHC's lack of training to be constitutionally inadequate. *See,*

[7] CHC's policy here is far more constitutionally suspect than the CCS policy in *Treadwell* because it called for benzo cold-turkeying with no alternative medication or tapering. *See King v. Kramer*, 680 F.3d 1013, 1021 (7th Cir. 2012) (noting it would be unconstitutional policy to require benzo discontinuation without providing alternative treatment).

e.g., McGill, 2014 U.S. Dist. LEXIS at *20-21 (denying summary judgment where plaintiff had evidence that CHC failed to adequately train its nurses and finding that CHC's inadequate training could be attributed to the municipality through the non-delegable duty doctrine).

Another policy or custom attributed to Fremont County through the non-delegable duty doctrine is CHC's persistent pattern of failing to follow basic protocols designed to safeguard medically vulnerable inmates. This includes everything from required intake medical screenings and initial health assessments to mandatory 14-day mental health evaluations. The failure to follow these protocols during Mr. Walter's pretrial detention was not a random act or an isolated occurrence. Rather, CHC consciously disregarded these basic written protocols *as a matter of routine*. This persistent custom and practice was a moving force behind Mr. Walter's death.

In addition, CHC had a practice of budgeting and spending alarmingly insufficient amounts to meet inmates' medical needs. Based on the extraordinarily low amounts budgeted and spent on outside medical services, a reasonable jury could infer that CHC's refusal to hospitalize Mr. Walter was motivated by impermissible profit concerns. *See Ceparano v. Suffolk County, Dep't of Health*, S.C.C.F. Med. Unit, 485 Fed. Appx. 505, 508-09 & 509 n.7 (2d Cir. 2012) (reinstating claim of municipal liability based on county's "alleged policy of denying medical care to inmates at the SCCF in order to reduce costs."); *Fields v. Corizon Health, Inc*., 490 Fed. Appx. 174, 184 (11th Cir. 2012) (verdict upheld because "if the jury did ask itself why Prison Health delayed treatment for [plaintiff's] paralysis, it could have concluded that it delayed treatment to save costs."); *Zikianda v. County of Albany*, No. 1:12-CV-1194, 2015 U.S. Dist. LEXIS 122363, *148-49 (N.D.N.Y. Sept. 15, 2015) (evidence sufficient to show inadequate medical care was result of corporation's "money-saving measures"); *Stewart v. Wenerowicz*, 2015 U.S. Dist. LEXIS 114307, *49-50 (E.D. Pa. Aug. 27, 2015) (plausible Monell claim stated because corporate practices included "prioritizing financial considerations over the health and safety of inmates."); *Fields v. Prison Health Servs*., No. 2:09-cv-529-FtM-29DNF, 2011 U.S. Dist. LEXIS 99244 (M.D. Fla. Sept. 2, 2011) (finding sufficient evidence that company's cost containment practices for

emergency care caused constitutional violation); *Estate of Thomason v. County of Klamath*, No. 01-30004-CO, 2004 U.S. Dist. LEXIS 13985, at *59 (D. Or. July 16, 2004) (finding sufficient evidence of custom of withholding medication for budgetary reasons). Under the non-delegable duty doctrine, CHC's profit-driven practices became the practices of Fremont County itself.

2. The County is Liable for Unconstitutional Acts of the Command Staff

The rationale underpinning the non-delegable duty doctrine also applies when an individual municipal policymaker creates or participates in an unconstitutional policy or practice. This is because "[a]n unconstitutional deprivation is caused by a municipal 'policy' if it results from decisions of . . . an official whose acts may fairly be said to be those of the municipality itself." *Marshall v. Columbia Lea Reg'l Hosp.*, 345 F.3d 1157, 1177 (10th Cir. 2003) (citing *Bd. of County Comm'rs v. Brown*, 520 U.S. 397, 403 (1997)). In other words, "[a]n act committed by an official who has been delegated the power of 'establishing final policy' will also constitute a municipal policy." *Novitsky v. City of Aurora*, 491 F.3d 1244, 1259 (10th Cir. 2007) (quoting *Monell*, 436 U.S. at 690). *See also McGill*, 2014 U.S. Dist. LEXIS at *20. Because final policymaking authority resided in the Command Staff Defendants, their personal participation in the failure to secure needed medical care for Mr. Walter is imputed to Fremont County itself.

3. The County's Unconstitutional Policy of Not Taking Inmates to the Hospital

An official policy or custom need not come from a formal regulation or policy statement; it may also be based on an informal custom amounting to "a widespread practice that, although not authorized by written law or express municipal policy, is 'so permanent and well settled as to constitute a 'custom or usage' with the force of law.'" *City of St. Louis v. Praprotnik*, 485 U.S. 112, 127, 108 S. Ct. 915, 99 L. Ed. 2d 107 (1988) (quoting *Adickes v. S.H. Kress & Co.*, 398 U.S. 144, 167-68, 90 S. Ct. 1598, 26 L. Ed. 2d 142 (1970)). Here, Fremont County had a widespread practice of not securing emergency care for inmates without the pre-approval of the CHC medical staff. This policy was in effect even during the 12 hours a day when there was no medical provider

at the jail and was a moving force behind Mr. Water's lack of constitutionally adequate care.

Indeed, Fremont County staff have testified that they believed Mr. Walter needed to be hospitalized but that county policy precluded them from calling 911 or arranging for his hospital transport. Corrections officers have testified that they would have secured emergency medical care for Mr. Walter had the policy allowed them to do so. *See, e.g.*, Wilson Decl. ¶ 11 ("If we had been permitted to transport a person to the hospital based on our own judgments, I would have done so without hesitation," and "I would have called 911 and had Mr. Walter transported to a hospital immediately."). Given the absence of any medical providers at the jail for 12 hours a day, seven days a week, a reasonable jury could easily find such a policy to fall below minimal constitutional standards. *See Fields v. Corizon Health, Inc.*, 490 Fed. Appx. 174, *185 (11th Cir. 2012) ("A jury could therefore reasonably conclude that Prison Health's policy restricting the transportation to hospitals of inmates with serious medical needs was a direct cause of [plaintiff's] injuries.").

4. Ratification

Finally, municipal liability may also be based on "the ratification by [] final policymakers of the decisions—and the basis for them—of subordinates to whom authority was delegated subject to these policymakers' review and approval. *Brammer-Hoelter v. Twin Peaks Charter Acad.*, 602 F.3d 1175, 1189 (10th Cir. 2010). *See also St. Louis v. Praprotnik*, 485 U.S. 112, 127 (1988) ("If the authorized policymakers approve a subordinate's decision and the basis for it, their ratification would be chargeable to the municipality because their decision is final."). As noted above, Sheriff Beicker was a final policymaker for Fremont County. In that capacity, Sheriff Beicker ratified the failure to take Mr. Walter to the hospital as well as the underlying basis for the decision. This is clear based on both his direct personal participation in the unconstitutional activity and his after-the-fact ratification of the unconstitutional actions.

IV. CONCLUSION

Summary judgment to the Command Staff Defendants and the County should be denied.

Dated this 6th day of November, 2017.

Respectfully submitted,

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CERTIFICATE OF SERVICE

The undersigned certifies that on the date stated below this document was filed with the Clerk of the Court for the United States District Court for the District of Colorado, via the CM/ECF system, which will send notification of such filing to the following e-mail addresses:

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