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 JOINT MOTION FOR SUMMARY JUDGMENT ON ALL CLAIMS AGAINST STEPHANIE REPSHIRE AND SHARON ALLEN, M.D.

The Estate of John Patrick Walter respectfully responds in opposition to the joint motion for summary judgment filed by Stephanie Repshire and Sharon Allen, M.D.[1]

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

SMF ¶ 1: Admit that Mr. Walter was booked as a pretrial detainee at the FCDC. However, his booking occurred on April 3, 2014, not April 2, 2014. *See* Def. Ex. 1 (erroneously placing red box placed around arrest date; booking date below that).

[1] Defendants Repshire and Allen have filed a combined motion for summary judgment (ECF 170), which is separate and distinct from the one filed by the Estate of Roy D. Havens (ECF 172). The Havens Estate filed separately because it devotes much of its motion to rearguing a statute of limitations issue that this Court previously heard. But for the Estate's attempt to reargue this issue, the three defendants could have combined their motions into one—in which case plaintiff would have filed a single, combined response. Given the *substantial* factual overlap, this would have been far more efficient for the parties and the Court. Because of these separate filings, however, plaintiff must respond separately to each motion—despite substantial overlap in the facts—without knowing if the Court will even consider the Estate's re-argument at all. Plaintiff's responses to the separate motions are each within the 40-page limit of WJM Revised Practice Standards II.E.7.b.

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

SMF ¶ 2: Admit.

SMF ¶ 3: Deny. The cited testimony is pure speculation. Plaintiff requested this data in discovery, and the defendants claimed it was too burdensome to determine. *See* Ex. 47. Moreover, CHC's Chief Medical Officer agreed that "millions of adults in the United States are prescribed [benzodiazepines] annually" and that "[i]n connection with their normal operations, jails will admit and confine people who are under active benzo prescriptions." Herr Dep., (Ex. 1) 47:16-48:3. He further agreed that all reasonable jail medical providers must know that jails "commonly" confine people under prescription medications, including benzodiazepines. *Id.* at 48:13-49:1. Further, CHC's Health Services Administrator at the Fremont County Jail agreed that "*many* inmates had their benzos discontinued" there. Maestas Dep. (Ex. 5) at 35:16-20 (emphasis added).

SMF ¶ 4: Admit the first sentence. Deny the second. In a sworn interrogatory response, Repshire claimed she "completed extensive medical training" that "included education on benzodiazepine medications and withdrawal." Ex. 44 at 6. She also "affirmatively state[d] that she is familiar with the risks, signs and symptoms of benzodiazepine withdrawal from her education and practice as a nurse." *Id*. at 6-7. *See also* Resp. to SMF ¶ 5.

SMF ¶ 5: Deny. In her answer to the operative complaint, Repshire repeatedly admitted that she was "familiar with the risks, signs, symptoms of benzodiazepine withdrawal resulting from the discontinuation of benzodiazepine medications" at the time of Mr. Walter's confinement. ECF 134 ¶¶ 69, 71, 74. CHC's Chief Medical Officer agreed that "death is a well-recognized risk of acute benzo withdrawal" and that "all medical providers who work in the field of correctional medicine have an obligation to know about the symptoms, risks, and dangers associated with benzo withdrawal." Herr Dep. (Ex. 1) at 51:9-11, 55:16-20. *See also* Resp. to SMF ¶ 4.

SMF ¶ 6: Admit in part and deny in part. Admit that starting the benzodiazepine protocol was the responsibility of Nurse Maestas. Deny that it was not *also* Nurse Repshire's responsibility.

Nurse Maestas admitted that neither she nor Nurse Repshire started the protocol and agreed that this was a "significant" failure on the part "of *all the nurses* who were working at the jail." Maestas Dep (Ex. 5) at 194:19-195:4 (emphasis added).

SMF ¶ 7: Admit that Repshire may not have looked (or had a reason to look) at Mr. Walter's patient file on April 4, 2014. Deny to the extent the statement implies she would not have had a reason to look at Mr. Walter's patient file at subsequent points of his confinement, such as when he was begging for his medication and telling her that he would die without it. *See* Smith Decl. (Ex. 4) ¶ 6; Vercillo Decl. (Ex. 19) ¶ 4.

SMF ¶ 8: Admit that Repshire may not have reviewed Mr. Walter's patient file on April 4th. *But see also* Response to SMF ¶ 7.

SMF ¶ 9: Admit.

SMF ¶ 10: Deny. The order from P.A. Havens was in Mr. Walter's patient file. *See* Maestas Dep. (Ex. 5) at 200:8-12. *See also* Ex. 6, page L (Havens order) & Allen Dep. (Ex. 7) at 131:10-133:10 (confirming that order was part of the Mr. Walter's patient chart).

SMF ¶ 11: Admit.

SMF ¶ 12: Deny the first sentence. The assertion and the cited testimony are belied by Nurse Repshire's actual conduct: she disregarded protocols; failed to check Mr. Walter's vital signs; ignored his pleas for help and the concerns of the detention staff; and neglected his serious medical needs. *See* Smith Decl. (Ex. 4) ¶ 6; Vercillo Decl. (Ex. 19) ¶ 4; Moore Rept. (Ex. 2) at 17-19; Stern Rept., (Ex. 13) at 31-34; Gendel Rept., (Ex. 9) at 19. Admit the second sentence.

SMF ¶ 13: Admit the first sentence. Deny that she "referred Mr. Walter to the provider." She put a small sticky note on Mr. Walter's chart to flag it for P.A. Havens. Repshire Dep. (Ex 3) at 170:9-171:7. There is no evidence that P.A. Havens saw Mr. Walter.

SMF ¶ 14: Deny first two sentences, which are uncited.[3] Admit that Mr. Walter's file may have been on top of a stack.

SMF ¶ 15: Deny characterizations about bringing "Mr. Walter's medical condition to P.A. Havens' attention" and indicating that he "needed attention." Repshire merely put a small sticky note on Mr. Walter's chart for P.A. Havens. Repshire Dep. (Ex 3) at 170:9-171:7. She knew much more than what was in the chart as of April 17th. *See* Plaintiff's Stmt. of Add. Facts ¶¶ 46-63.

SMF ¶ 16: Admit in part. P.A. Havens wrote "I have no suggestions. May call Dr. Herr for more advice." Def. Ex. 8.

SMF ¶ 17: Deny. Dr. Herr does not recall being contacted by anyone relating to Mr. Walter or being involved in his care. *See* Herr Dep. (Ex. 1) at 180:3-181:21. He made no note or record of any kind in relation to Mr. Walter. *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 Nurse Repshire called him, she gave him no pertinent information. *See* Repshire Dep. (Ex. 3) at 187:22-194:13.

SMF ¶ 18: Denied. It was *obvious* that Mr. Walter needed to go to the hospital, yet Repshire made no such calls. *See* Plaintiff's Stmt. Add. Facts ¶¶ 46-77. And while she testified that she needed approval from Maestas to send Mr. Walter to the ER, *see id.* at 194:14-195:15, Maestas testified oppositely; any LPN could send anyone to the hospital at any time for any reason. Maestas Dep. (Ex. 5) at 65:5-66:15, 67:9-13.

SMF ¶ 19: Admit.

SMF ¶ 20: Admit.

SMF ¶ 21: Admit.

SMF ¶ 22: Admit.

[3] WJM Revised Practice Standard III.E.3 requires the movant to provide specific reference to admissible evidence in the record establishing each fact the moving party asserts.

SMF ¶ 23: Admit. However, this is *highly* misleading because very few deaths are the subject of "documented case studies." It is beyond dispute that "death is a well-recognized risk of acute benzo withdrawal." Herr Dep. (Ex. 1) at 51:9-11. *See also* Roy-Byrne Rept. (Ex. 8) at 3-5; Gendel Rept. (Ex. 9) at 4-5; Moore Rept. (Ex. 2) at 2-3; Stern Rept. (Ex. 13) at 23.

SMF ¶ 24: Deny. Dr. Allen did not gather enough info to make a differential diagnosis. *See* Roy-Byrne Rept. (Ex. 8) at 13. She only spent 10 minutes with Mr. Walter. Allen Dep. (Ex. 7) 116:20-23, 117:16-19. A differential diagnosis would have been documented, but Dr. Allen did not document one. *See* Gendel Rept. (Ex. 9) at 13.

SMF ¶ 25: Admit.

SMF ¶ 26: Admit the first sentence. Deny the second sentence to the extent it implies that P.A. Havens made any sort of informed "decision." P.A. Havens acted pursuant to an unwritten, across-the-board policy and practice of discontinuing inmates from their benzos—with no tapering from the medication. *See* Maestas Dep. (Ex. 5) 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. Under this policy, all new inmates were immediately discontinued from any benzo, "cold-turkey" without clinical reason. *Id*. at 32:16-18, 37:15-39:3, 41:25-44:10. No benzo tapering occurred at the jail. *See* Doughty Dep. (Ex. 10) at 69:12-15, 79:19-21. *See also* Repshire Dep. (Ex. 3) at 115:12-19. A reasonable jury could infer that Dr. Allen was aware of this policy and practice.

SMF ¶ 27: Admit.

SMF ¶ 28: Deny. Dr. Allen did not consult any medical literature when she evaluated Mr. Walter. *See* Allen Dep. (Ex. 7) at 154:15-18. Also, the DSM-5 does not support this assertion. *See* Def. Ex. 14; Response to SMF ¶¶ 29 & 30.

SMF ¶ 29: Admit the quote is accurate, though woefully incomplete and out of context. The DSM-5 takes pains to explain that withdrawal symptoms for benzos with long half-lives "may not develop for more than one week." Def. Ex. 14 at 559. Mr. Walter's medication, Klonopin, is a long-half-life benzodiazepine. *See* Roy-Byrne Rept. (Ex. 8) at 4-5; Gendel Rept. (Ex. 9) at 4.

SMF ¶ 30: Admit that the first sentence is an accurate quote from the DSM-5. The cited reference to the Gendel deposition transcript is a question or preface to a question by defense counsel and includes no witness testimony. Deny the last sentence. Dr. Allen viewed Mr. Walter at 8:30 a.m. on April 17th. This was the two-week anniversary of his April 3rd booking and the peak time for Klonopin withdrawal even according to the DSM-5. *See* Def. Ex. 14 at 559.

SMF ¶ 31: Admit.

SMF ¶ 32: Deny. The cited study does not support the contention regarding the number of like studies. Also, object to relevance: the cited study involves individuals on doses eight times lower than Mr. Walter's, among other things. *See* Rebuttal Rept. of Roy-Byrne (Ex. 45) at 2.

SMF ¶ 33: Deny. Dr. Allen did not consult any medical literature when evaluating Mr. Walter. Allen Dep. (Ex. 7) at 154:15-18. Had she consulted the DSM 5, she would have seen that peak time for Klonopin withdrawal would be about two weeks after cessation; and her visit to the jail was occurring on the 2-week anniversary of Mr. Walter's booking. *See* Def. Ex. 14 at 559.

SMF ¶ 34: Admit Dr. Allen has a general familiarity with DSM-5 criteria for bipolar disorder.

SMF ¶ 35: Deny. Mr. Walter's symptoms were consistent with benzodiazepine withdrawal. Had Dr. Allen spent more than 10 minutes assessing the situation, she would have recognized this. *See* Gendel Rept. (Ex. 9) at 12-15.

SMF ¶ 36: Deny. Misstates the evidence. Mr. Walter had withdrawal symptoms within the first 10 days of his detention. *See, e.g.*, Smith Decl. (Ex. 4) ¶ 8.

SMF ¶ 37: Deny. Dr. Allen did not gather enough info to make a differential diagnosis. *See* Roy-Byrne Rept. (Ex. 8) at 13. She only spent 10 minutes with Mr. Walter. Allen Dep. (Ex. 7) at 116:20-23, 117:16-19. A differential diagnosis would have been documented, but Dr. Allen did not document one. *See* Gendel Rept. (Ex. 9) at 13.

SMF ¶ 38: Admit.

SMF ¶ 39: Admit in part and deny in part. Admit that Dr. Allen gave a provisional diagnosis of bipolar disorder. Deny that she spoke with Nurse Maestas about Mr. Walter. When asked in an

interrogatory to "describe every communication [she] had with any other health care provider" about Mr. Walter, Dr. Allen did not recall "any communications not recorded in the medical records." *See* Ex. 44 at 8. There is no record of any conversation between Dr. Allen and Nurse Maestas. In fact, the purported conversation did not occur. Dr. Allen was only at the jail on April 17th. Allen Dep. (Ex. 7) at 109:12-110:1. Maestas did not work at the jail on April 17th and was not at the jail that day. *See* Maestas Dep. (Ex. 5) at 163:17-165:8, 165:25-166:3, 167:22-24. Nor does she recall a conversation with Dr. Allen. *See id.* at 166:5-15. It is not credible to believe she would have forgotten such a conversation, and a jury could infer that Dr. Allen is being untruthful about it taking place.

SMF ¶ 40: Deny. *See* Response to SMF ¶ 39. Moreover, when Maestas was asked whether she told Dr. Allen that Mr. Walter had not been taking Klonopin before he got into the jail, Maestas did not recall such a conversation and agreed she would have had no "basis or grounds to give her that information." Maestas Dep. (Ex. 5) at 167:13-21. There would be no basis to tell Dr. Allen that Mr. Walter was not compliant with his Klonopin because no one ever verified his medication compliance—in violation of policy. *Id*. at 178:4-179:6, 179:24-180:13.

SMF ¶ 41: Deny. The alleged conversation did not take place; Dr. Allen is not being truthful about it. *See* Response to SMF ¶¶ 39 & 40.

SMF ¶ 42: Admit. However, Dr. Gendel thinks Dr. Allen's actions (and provisional diagnosis) were highly inappropriate. *See* Gendel Rept. (Ex. 9) at 12-15.

SMF ¶ 43: Admit. However, Dr. Roy-Byrne thinks Dr. Allen's actions (and provisional diagnosis) were highly inappropriate. *See* Roy-Byrne Rept. (Ex. 8) at 10-11, 13-15.

SMF ¶ 44: Admit.

SMF ¶ 45: Admit that Dr. Greenblatt said these things.

SMF ¶ 46: Admit. Dr. Greenblatt has done more lab research on benzodiazepines. However, Dr. Gendel also testified (in the same answer cited by defendants) that he has "a great deal more clinical experience" than Dr. Greenblatt. *See* Def. Ex. 16 at 77:17-78:7.

SMF ¶ 47: Admit.

SMF ¶ 48: Admit.

SMF ¶ 49: Admit.

II. STATEMENT OF ADDITIONAL DISPUTED FACTS

A. Background

1. Fremont County contracted with Correctional Healthcare Companies, Inc. (CHC) to provide healthcare services at the Fremont County Jail. *See* Jail Services Contract (Ex. 11).

2. Under the contract with CHC, LPN Stephanie Repshire and Dr. Sharon Allen provided correctional medical care. *See* Movants' Amended Answer (ECF 134) ¶¶ 22, 24.

3. When Repshire worked at the jail, she worked as the only LPN on duty for 12-hour shifts, from 7:00 a.m. to 7:00 p.m., by herself, with no overlapping shifts with any other LPN. *See* Repshire Dep. (Ex. 3) at 42:2-13, 52:14-21. There was no medical provider for the other 12 hours each day—between 7:00 p.m. and 7:00 a.m. Dep. of J. Wheaton (Ex. 12) at 122:5-8.

4. Dr. Allen visited the jail two hours every other week. *See* Allen Dep. (Ex. 7) at 15:11-24.

B. The Dangers of Benzodiazepine Withdrawal and Movants' Knowledge Thereof

5. Many people who go to jail are on prescriptions medications, including medications known as benzodiazepines or "benzos." *See* Herr Dep. (Ex. 1) at 47:16-48:20. "Commonly prescribed benzos include Xanax, Klonopin, Valium and Ativan." Moore Rept. (Ex. 2) at 2.

6. People who have been taking benzos—particularly in high doses over longer periods of time—can become physically dependent. *See* Roy-Byrne Rept. (Ex. 8) at 3-5; Gendel Rept. (Ex. 9) at 4-5; Moore Rept. (Ex. 2) at 2-3.

7. The sudden cessation of a person's benzo can lead to dangerous withdrawal. *See* Ex. 8 at 3-5; Ex. 9 at 4-5; Ex. 2 at 2-3; Stern Rept. (Ex. 13) at 23. Symptoms of benzo withdrawal include

anxiety, insomnia, loss of appetite, cognitive impairment, tremors, mood swings, hallucinations, bizarre behavior, abnormal vital signs, seizures, and death. *See* Ex. 8 at 4; Ex. 9 at 5; Ex. 2 at 2-3.

8. CHC's Chief Medical Officer agrees that "all reasonable medical professionals working in correctional medicine should know that among the people who might be admitted and confined in the jail are people who are physically dependent on benzos." Herr. Dep. (Ex. 1) at 48:21-49:6. Benzo withdrawal is a significant risk in jails because a percentage of incoming jail inmates will have been using benzos in the community, and the sudden discontinuance of the benzo can result in life-threatening withdrawal symptoms. Moore Rept. (Ex. 2) at 2.

9. CHC's Chief Medical Officer, Dr. Herr, agrees that benzo withdrawal "can be life-threatening." Herr Dep. (Ex. 1) at 62:14-25, 73:13-18. He agrees that patients showing signs of late, severe withdrawal should be hospitalized and that the standard of care in the correctional setting requires such hospitalization. *Id.* at 73:19-74:1. And he agrees that discontinuing someone's benzo use without tapering and without adequate monitoring and treatment is dangerous and can lead to "catastrophic results." *See id.* at 60:13-17, 70:1-6.

10. Dr. Herr testified that it would be inappropriate and outside the standard of care for any jail to have a blanket practice of suddenly discontinuing benzos for incoming inmates. Herr Dep. (Ex. 1) at 166:21-167:17. He testified that such a practice would be unsafe and should be stopped. *Id.* at 183:8-184:22.

11. Benzos should never be abruptly discontinued—any discontinuance must occur by slow tapering with careful monitoring. *See* Moore Rept. (Ex. 2) at 2; Roy-Byrne Rept. (Ex. 8) at 5; Stern Rept. (Ex. 13) at 20, 23. Severe benzo withdrawal requires hospitalization for intensive care. *See* Ex. 8 at 5; Herr Dep. (Ex. 1) at 73:19-74:1. All reasonable jail medical personnel are aware of the foregoing. *See* Ex. 2 at 2-4. *See also* Herr Dep. at 55:16-20 (agreeing that "all medical providers who work in the field of correctional medicine have an obligation to know about the symptoms, risks, and dangers associated with benzo withdrawal").

12. Defendants Repshire and Allen were fully aware of the signs and symptoms of benzo withdrawal at the time of Mr. Walter's confinement. *See* Movants' Amended Answer (ECF 134) ¶ 69 (Repshire) and ¶¶ 71 & 74 (Repshire & Allen). *See also* Ex. 44 at 6-7 (interrogatory answers).

C. Mr. Walter Enters Jail and is Cut-off "Cold-Turkey" from His Benzo Prescription

13. As of April 2014, Mr. Walter was under a long-standing prescription for Klonopin—a well-known 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. 9) at 5; Roy-Byrne Rept. (Ex. 8) at 6, 12; Stern Rept. (Ex. 13) at 20, 23; Moore Rept. (Ex. 2) at 6.

14. Given the dose and duration of Mr. Walter's benzo prescription, an abrupt discontinuation "would certainly evoke a withdrawal syndrome" which would be "serious, at a minimum." Gendel Rept. (Ex. 9) at 6. Cutting him off cold turkey would predictably result in a "potentially life-threatening withdrawal syndrome." Stern Rept. (Ex. 13) at 20, 23. *See also* Ex. 8 at 7.

15. Mr. Walter had his container of prescribed Klonopin when he entered the jail on April 3, 2014; it was properly labeled with his name, prescribing provider's information, contents and dose quantity and frequency, and had the correct number of tablets remaining in the bottle. *See* Stern Rept. (Ex. 13) at 5; Roy-Byrne Rept. (Ex. 8) at 6; Moore Rept. (Ex. 2) at 6. *See also* Ex. 14 (photos of bottle released after Mr. Walter's death). Mr. Walter also completed a booking form stating that he was on Klonopin and provided the name and location of his prescribing provider. *See* Ex. 15.

16. Mr. Walter's Klonopin (and other prescription bottles) were sealed in a bag and delivered to the jail's medical staff with the accompanying form stapled to it. *See* Maestas Dep. (Ex. 5) at 142:14-144:14; Repshire Dep. (Ex. 3) at 68:15-71:15.

17. Defendant Repshire signed the bottom of Mr. Walter's intake form where he had indicated he was taking Klonopin; she did this on April 4th—the day after his booking. *See* Repshire Dep. (Ex. 3) at 130:18-131:2. Repshire reviewed the form and understood that Mr. Walter was on a

Klonopin prescription. *See id*. at 131:19-132:3. She also knew that he had brought his Klonopin medication with him to the jail. *Id*. at 132:20-23.

18. The form became the first document in Mr. Walter's chart and was available for all medical providers at the jail to see. *See* Repshire Dep. (Ex. 3) at 134:19-135:19.

19. Although Defendant Repshire knew that Mr. Walter had entered the jail with a benzo prescription, neither she nor anyone else verified his medications, called his provider or pharmacy, or otherwise sought information about his medication history—in violation of policy and the standard of care. *See* Moore Rept. (Ex. 2) at 7; Roy-Byrne Rept. (Ex. 8) at 7; Maestas Dep. (Ex. 5) at 178:4-179:6, 179:24-180:13.

20. In addition, Mr. Walter received no medical screening at the time of his admission to the facility (or ever), which was also a violation of written policy and the standard of care. *See* Ex. 2 at 7; Gendel Rept. (Ex. 9) at 10; Maestas Dep. (Ex. 5) at 182:18-184:20.

21. Moreover, despite the well-known risks of benzo withdrawal, P.A. Havens ordered an abrupt discontinuance of Mr. Walter's Klonopin prescription with no tapering. *See* Maestas Dep. (Ex. 5) at 152:18-153:2; Herr Dep. (Ex. 1) at 192:2-194:15.

22. 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 a single dose of any benzo. *See* Maestas Dep. (Ex. 5) at 11:14-20. The decision to discontinue his prescription was not the result of an individualized or clinical assessment. Instead, he was cut-off, cold-turkey, pursuant to CHC's unwritten "no benzo" policy. *Id.* at 41:25-44:10.

23. CHC's HSA at the Fremont County Jail detailed this "no benzo" policy in her deposition. She explained that CHC management directed the discontinuance of all inmates from their benzo prescriptions upon entering the jail—cold-turkey and with no tapering from the medication. *See* Maestas Dep. (Ex. 5) at 12:24-14:2, 14:11-15:25, 26:5-11, 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.[4]

24. The other LPNs at the jail were well-aware of this policy. *See* Doughty Dep. (Ex. 10) at 45:6-21. No benzo tapering occurred at the jail. *Id.* at 69:12-15, 79:19-21. *See* Repshire Dep. (Ex. 3) at 115:12-19. A reasonable jury could infer that Dr. Allen was also familiar with the "no benzo" policy and practice at the jail.

25. The sudden discontinuation of Mr. Walter's Klonopin placed him at grave risk for serious withdrawal and potential death. *See* Roy-Byrne Rept. (Ex. 8) at 6-7; Stern Rept. (Ex. 13) at 7-8; Moore Rept. (Ex. 2) at 7-8; Gendel Rept. (Ex. 9) at 17. Forcing him into cold turkey withdrawal was "patently dangerous and likely to lead to life-threatening withdrawal given the high dose he was on and prolonged time he had been on it." Stern Rept. (Ex. 13) at 8.

26. A written benzodiazepine protocol was in place for all CHC-run jails. *See* Ex. 21. Among other things the protocol (known as "CHC Protocol L-06") required that the nurses carefully monitor for symptoms of benzo withdrawal, including abnormal vital signs, and contact the provider if they became aware of any. *Id*; Moore Rept. (Ex. 2) at 8, 25.

27. However, no monitoring took place. The written benzo "protocol" (L-06) was completely disregarded. Maestas Dep. (Ex. 5) 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 (emphasis added).

D. Mr. Walter in the T-Pod

28. From near the time of his admission to the jail until April 15th, Mr. Walter was in a group

[4] The unwritten "no-benzo" policy was in place at the Fremont County Jail even though it violated *written* CHC Policy D-02, which mandates that "[p]atients entering the facility on prescription medication *continue to receive the medication in a timely fashion as prescribed*, or acceptable alternate medications are provided as clinically indicated . . . ." Ex. 22 at 2-4 (emphasis added). Under Policy D-02, no medication discontinuance is allowed unless information is gathered indicating why it was prescribed, the dosages and times of administration, when it was last taken, and the prescribing clinician and pharmacy. *Id*. Under the policy, a patient who enters the jail on an established and verified regimen of medications "shall be continued on this regimen until seen by the responsible physician." *Id*. None of these things were done in the case of Mr. Walter. *See* Moore Rept. (Ex. 2) at 7; Stern Rept. (Ex. 13) at 6-8; Maestas Dep. (Ex. 5) at 177:4-179:3.

of cells known as the "T-Pod." Rankin Dep. (Ex. 23) at 75:20-76:3. In the T-Pod, he was housed with other inmates. *See* Vercillo Decl. (Ex. 19) at ¶ 3; Smith Decl. (Ex. 4) at ¶ 4.

29. When Mr. Walter first entered the T-Pod, he was speaking and acting normally. *See* Smith Decl. (Ex. 4) at ¶ 5; Vercillo Decl. (Ex. 19) at ¶ 3. His fellow inmates described him as weighing about 200 pounds, calm, lucid and coherent, healthy-looking, and uninjured. *Id.* Others who saw him near that time provided similar descriptions of his appearance and demeanor. *See* Decl. of C. Wilson (Ex. 20) ¶ 5; Wheaton Dep. (Ex. 16) at 15:11-18:21, 19:4-22:14. *See also* Booking Rept. (Ex. 17); Ex. 18 (indicating Mr. Walter's weight at "200 lbs." near time of booking).

30. Although Mr. Walter was initially acting normally in the T-Pod, inmates recall him being "very concerned" that he was not getting his Klonopin. Smith Decl. (Ex. 4) ¶ 6. Twice a day, the nurse on duty would come to the pod to deliver medications to the inmates. *Id*. This included "Nurse Stephanie [Repshire]." *Id*. Inmate Smith testified: "When Nurse Stephanie [Repshire] and Nurse Kathy[Maestas] would come by the T-Pod to deliver medications, Mr. Walter would tell them that he was not getting his Klonopin and that he desperately needed it. I recall him begging them for the Klonopin. I recall him telling [Nurse Kathy] and Nurse Stephanie . . . that he needed his Klonopin and would die if he didn't get it. He said this repeatedly to them over the course of several days." *Id*.

31. Inmate Vercillo also recalls Mr. Walter telling the nurses that he was "going to die" without his medication. Vercillo Decl. (Ex. 19) ¶ 4. "Whenever one of the nurses would come by for med pass, Mr. Walter would tell the nurse he was not getting his required medication." *Id.* He was "quite vociferous," and his "concerns grew and grew." *Id*. Mr. Walter told the nurses words to the effect of, "I'm going to die without it!" *Id.* Mr. Walter made these requests regularly. *Id*.

32. There is no evidence that Defendant Repshire took any action in response to Mr. Walter's pleas for his medication or his concerns that he would die without it. In fact, she did not relay his

concerns to any other medical provider, and she has no recollection of ever discussing Mr. Walter's Klonopin with anyone. *See* Repshire Dep. (Ex. 3) 147:6-148:5.

33. Another inmate submitted two kites on behalf of Mr. Walter requesting medication and helped him submit others. Vercillo Decl. (Ex. 19) ¶ 6. *See also* Smith Decl. (Ex. 4) ¶ 7. These kites were never produced in discovery and have presumably been destroyed; however, a reasonable jury could infer that Defendant Repshire was aware of them and ignored them.

34. Mr. Walter's initially-normal behavior and appearance changed dramatically following the discontinuance of his Klonopin. He "went from being totally normal to acting extremely strange." Smith Decl. (Ex. 4) ¶ 8. He stopped sleeping and began "speaking gibberish" and talking to people who were not there." *Id*. He stopped eating regularly. *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." *Id*. His "behavior became worse, and he continued to deteriorate mentally." *Id*.

35. Inmate Vercillo recalls Mr. Walter in the T-Pod "behaving in a very bizarre way that was totally different than when he first came in." Vercillo Decl. (Ex. 19) ¶ 7. He was "up at all hours of the night," "barely sleeping," "not eating," "pacing and sweating profusely," "mumbling and talking incoherently," "kick[ing] the door," removing his clothes, and "getting visibly weaker and more frail compared to when he first came in." *Id*.

36. While in the T-Pod, Inmate Smith informed Defendant Repshire (among others) that Mr. Walter needed psychiatric help and needed to be in a hospital and not in jail. Smith Decl. (Ex. 4) ¶ 8. There is no evidence that Repshire took any responsive action.

37. On April 13th, Detention Deputy Combs interacted with Mr. Walter. She was concerned that he was mentally confused and shaky and that his eyes were "involuntarily pulsating or twitching." Dep. of C. Combs (Ex. 24) at 33:10-34:16.

38. From the moment he entered the jail until at least April 13th, the record is devoid of Mr. Walter receiving any kind of medical evaluation at all. *See generally* Ex. 6.

39. On April 13th, LPN Doughty checked Mr. Walter's blood pressure and pulse "due to possible [withdrawal]." *See* Ex. 25. This was the first of only two times during his confinement that his vital signs were checked. His blood pressure was abnormally high. *See* Doughty Dep. (Ex. 10) at 98:2-6. She ordered daily blood pressure checks for the next five days. *Id*. at 98:23-99:4. Defendant Repshire was aware of order. *See* Ex. 3 at 211:16-19. However, his blood pressure was checked only one other time (on April 14th when it was still high) and never again, in violation of the standard of care. *See* Moore Rept. (Ex. 2) at 8-9; Roy-Byrne Rept. (Ex. 8) at 8. Repshire never took a single vital sign. Repshire Dep. (Ex. 3) at 201:15-202:11, 66:17-67:2.

40. On April 14th another detention officer, Corporal Mass, interacted with Mr. Walter and found that he was "confused and shaking the entire time [he] was speaking with him." *See* Ex. 26. On this same date, detention records show a complaint from Mr. Walter's cellmates that he "kept him up all night by talking to the wall" and that he was speaking nonsensically. *Id.*

41. On April 15th, officers removed Mr. Walter from the T-Pod and used force against him in the form of tasering, pepper-spraying, and using other types of painful force. *See* Cathcart Rept. (Ex. 27) at 6-7, 18, 28, 32; Brasfield Rept. (Ex. 28) at 18-19. Mr. Walter was likely delusional and not in his right mind when they were using this force on him. *See* Wheaton Dep. (Ex. 16) at 125:12-23, 137:23-138:12; Owen Dep. (Ex. 29) at 80:2-80:13, 81:3-16.

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

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

43. The holding cell has large windows through which anyone could easily observe Mr. Walter. *See* Rankin Dep. (Ex. 23) at 74:8-75:19; Martin Dep. (Ex. 31) at 24:9-25:3; Beicker Dep. (Ex. 32) at 36:19-38:13. *See also* photographs (Ex. 33). One could also communicate with him without opening the door. *See* Green Dep. (Ex. 30) at 32:4-13.

44. Detention officers posted an "Inmate Welfare Checklist" on the door of the holding cell to document Mr. Walter's condition every half-hour. *See* Ex. 34. It was visible for anyone to see. Lightcap Dep. (Ex. 35) at 85:6-13; Rankin Dep. (Ex. 23) at 119:22-25.

45. The holding cell was an approximately 30-second walk from the medical office where the nurses were stationed. *See* Maestas Dep. (Ex. 5) at 147:12-17.

46. By the time Mr. Walter was moved to the holding cell on April 15th, his withdrawal symptoms were severe: "The standard of care required that Mr. Walter be transferred to a hospital for treatment by at least April 15th. The need for hospital treatment grew more urgent with each passing day and hour." *See* Gendel Rept. (Ex. 9) at 19. The failure to transport Mr. Walter to the hospital was particularly shocking because the Fremont County Jail "was totally ill-suited to address his serious medical needs." *Id*.

47. Defendant Repshire was the only LPN on duty at the jail on April 16, 17, 18 and 19—from 7:00 a.m. to 7:00 p.m. Repshire Dep. (Ex. 3) at 223:8-224:2. She would have been able to observe the same things the detention staff observed during this period.

48. By April 16 or 17, Deputy Wheaton was growing very concerned about Mr. Walter's deteriorating health. Wheaton Dep. (Ex. 12) at 110:14-21. He felt that Mr. Walter needed attention for both his mental condition and his physical condition. *Id*. at 107:17-20. He went to Defendant Repshire to tell her that Mr. Walter was deteriorating rapidly. *Id.* at 107:21-108:25. He said this to her just outside of Mr. Walter's cell where she could see him for herself. *Id*. at 108:18-25.

49. Similarly, it was obvious to Deputy Combs that Mr. Walter was deteriorating in the holding

cell—she observed him confused, behaving bizarrely, shaking uncontrollably, not sleeping, not eating, losing a lot of weight, naked for hours in full view, not making sense, not being responsive, having urinated in his surroundings, and really going downhill. *See* Combs Dep. (Ex. 24) at 63:1-65:3. Combs saw Defendant Repshire walk right past Mr. Walter, fully aware of his condition, but she seemed to just dismiss it. *Id*. at 65:11-66:18.

50. While in the holding cell, Mr. Walter was *asking* for medical attention from the medical staff; Mr. Walter made these requests to Deputy Pohl on two or three occasions. Dep. of J. Pohl (Ex. 36) at 34:18-25, 35:9-23. Mr. Walter's requests to Pohl were made on April 16th or 17th or both. *Id*. at 54:25-55:5.

51. Deputy Pohl took Mr. Walter's requests to Defendant Repshire. *Id.* at 36:9-17. However, based on his observations, she never came to see Mr. Walter. *See id*. at 59:11-16. This left Pohl feeling frustrated and helpless. *Id*. at 59:11-18, 60:8-11. He knew she was stationed 30 seconds away from Mr. Walter's cell, and he could think of no security reason why she could not evaluate him. *Id*. at 60:15-24. Pohl explained: "Their job is to take care of the inmates . . . . they were not very far away from him." *Id*. at 73:16-25. *See also id.* at 74:1-5. Pohl told his supervisors that he was frustrated that medical would not come to see Mr. Walter in response to his requests for medical attention. *See id*. at 71:18-72:23.

52. Deputy Lightcap worked daily from April 15-20. Lightcap Dep. (Ex. 35) 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. Based on her observations, Mr. Walter belonged in a hospital and was not fit to be confined in that cell. *Id*. at 134:9-25.

53. On April 16-17, Deputy Lightcap saw him hitting the door with a closed fist 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 physically incapable of getting a cup of water. *Id.* at 162:11-16. She was concerned that he was not being provided with adequate medical care and regularly heard other members of the jail staff express the same concern. *Id*. at 140:25-141:17. The detention staff felt that Mr. Walter was not getting the medical care he needed. *Id*. at 136:17-18, 142:11-143:13.

54. The detention deputies were not alone in their concern for Mr. Walter: Commander Rankin agreed that "the entire staff who worked in the booking area" were "deeply worried about his medical condition." Rankin Dep. (Ex. 23) at 89:12-20, 91:16-19, 93:12-94:1, 96:21-97:1. 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. 37) at 44:7-46:9. Sergeant Miller received reports from approximately 18 members of his staff expressing concerns about Mr. Walter. *Id*. at 51:17-52:3, 58:18-60:6.

55. On April 16 and 18, Jail Commander Rankin regularly interacted with detention staff who were seeing what was happening to Mr. Walter inside the windowed holding cell. Rankin Dep. (Ex. 23) at 81:13-21. 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.

56. When Commander Rankin saw Mr. Walter for himself, he confirmed the reports he had been getting. *Id*. at 92:16-19. He saw that Mr. Walter was confused, behaving bizarrely, and shaking uncontrollably. *Id.* at 82:17-83:3. He was pale and thin, naked, and looked awful. *Id*. at 83:8-23. He was talking to people who were not there and talking nonsensically. *Id*. at 83:24-84:11. Mr. Walter was yelling and screaming, unaware of his surroundings, disoriented, and unable to fill out a simple medical request form. *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 rapidly deteriorating. *Id*. at 93:12-94:1, 98:8-21. 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 him, even as a lay person, 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.

57. Rankin received reports from his sergeants that they had already attempted to address Mr. Walter's needs with the medical staff (including Ms. Repshire) and that they had grown frustrated by the lack of attention paid to Mr. Walter in response to their reports. *Id*. at 97:10-20. The reports he received from those under his command occurred on April 16 and/or April 18 (*see id*. at 97:21-98:1, 100:23-101:3), which were days when Repshire was the only LPN on duty. *See* Repshire Dep. (Ex. 3) at 223:8-224:2.

58. Rankin sought out Repshire directly to address Mr. Walter's needs. Rankin Dep. (Ex. 23) at 103:5-20. He told her that his staff was deeply concerned about Mr. Walter. *Id*. at 103:15-23. Rankin tried to make Repshire fully aware of the situation. *Id*. at 108:1-4.

59. Commander Rankin also went to his boss, Undersheriff Martin, to convey what had been reported to him and what he, himself, had observed. *Id*. at 109:3-17. He told Martin that detention staff members were worried about the apparent lack of medical response and "felt that Mr. Walter's serious medical needs were not being addressed by the nursing staff." *Id*. at 109:22-25, 110:4-13. Again, the only member of nursing staff on duty during this period was Defendant Repshire. *See* Repshire Dep. (Ex. 3) at 223:8-224:2.

60. Undersheriff Martin recalls learning from Rankin that Mr. Walter's condition appeared very serious and was deteriorating. Martin Dep. (Ex. 31) at 43:2-12, 45:3-6. He also recalls Rankin reporting "that he and his staff were concerned that the medical staff did not appear to be doing anything for Mr. Walter." *Id*. at 46:3-11. Martin received at least three reports from Rankin, including descriptions about his condition and the medical staff's lack of treatment. *Id*. at 48:18-49:8, 50:18-51:2.

61. Following reports from Commander Rankin, Martin went to one of the nurses, who he says was not Nurse Maestas or Nurse Doughty. *Id*. at 51:18-54:22, 57:16-20. The only other possible nurse was Nurse Repshire, and she was the only nurse on duty between April 16-19. Repshire Dep. (Ex. 3) at 223:8-224:2. Undersheriff Martin claims that this nurse (i.e., Repshire) told him she was fully aware of Mr. Walter's situation and claimed that he was being regularly monitored. Martin Dep. (Ex. 31) at 54:23-55:5. Of course, this was not true: Mr. Walter's benzo withdrawal was not being monitored at all by the nursing staff. *See* Maestas Dep. (Ex. 5) at 194:10-196:21. The nurse (i.e., Repshire) even told Martin that "they were checking his vitals." Martin Dep. (Ex. 31) at 52:8-10. This was also false. *See* Repshire Dep. (Ex. 3) at 201:15-202:11, 66:17-67:2.

62. Commander Rankin also went to Sheriff Beicker to make him aware of the situation, including the detention staff's frustrations regarding the medical staff care of Mr. Walter. Rankin Dep. (Ex. 32) at 115:17-25. Rankin only involved Beicker in serious situations. *Id*. at 68:19-23.

63. Commander Rankin informed Sheriff Beicker that Mr. Walter was not doing well and was not responding to whatever medical care he was getting. Beicker Dep. (Ex. 32) at 57:20-25. Among other things, Beicker learned from Rankin that Mr. Walter was deteriorating, mentally confused, inappropriately naked, acting unusually, talking to people who were not there and to himself, not sleeping, shaking, involuntarily shuddering or convulsing, losing unusual amounts of weight, and thin or emaciated. *See id*. at 58:1-24, 59:18-20, 62:11-63:12, 86:17-88:4. Rankin also told Beicker that the whole detention staff was concerned that the nurses were not doing enough for Mr. Walter. *Id*. at 60:11-18, 61:10-14, 62:2-7, 63:13-18, 90:9-21, 91:19-92:4. These reports were likely made to him by at least April 16th. *Id.* at 74:2-13.

64. Sheriff Beicker also received a report from a corporal, who was upset, concerned, and disturbed. *See* Beicker Dep. (Ex. 32) 74:14-75:13. The corporal was bothered by Mr. Walter's continued deterioration. *Id*. at 76:2-10. He reported that whatever the medical staff was doing was "not working." *Id*. at 76:17-18.

65. On April 17th, Mr. Walter was seen by Defendant Sharon Allen, M.D., who came to the jail for two hours every other week. *See* Allen Dep. (Ex. 7) at 15:11-24, 109:12-18. This was Mr. Walter's first and only visit by a medical doctor. Her visit lasted only "about 10 minutes." *Id.* at 116:20-23, 117:16-23, 109:12-22.

66. When Dr. Allen saw Mr. Walter, he was naked, disoriented and confused, and believed he was in a hospital rather than in a jail. *Id*. at 120:11-21, 135:23-24, 137:13-138:1. He did not know which month it was; he guessed it was February, even though it was mid-April. *Id*. at 120:17-19, 141:19-24. He did not know what year it was, making several unsuccessful guesses. *Id*. at 141:25-142:6. Dr. Allen thought Mr. Walter might be hallucinating. *Id*. at 142:8-10. She could see that his hands were tremoring during the encounter. *Id*. at 143:10-11. And she knew that Mr. Walter had not been sleeping. *Id*. at 144:15-17.

67. Dr. Allen also knew that Mr. Walter's mental state rendered him incapable of reporting accurate symptoms of what he was experiencing. *Id*. at 151:14-152:5. The "magnitude of his decompensation" made him "completely unpredictable at that point." *Id*. at 152:3-5. Mr. Walter could not be an accurate historian in his condition. *Id*. at 138:21-24.

68. Although Mr. Walter could not answer many questions, Dr. Allen admits he told her that he takes Klonopin. *Id*. at 121:9-19. Dr. Allen testified that she asked Mr. Walter more questions about his Klonopin, such as how much Klonopin he took, when he last took it, his dosage, and how long he had been taking it. *Id*. at 139:9-13. However, Mr. Walter was unable to answer these questions due to his decompensated mental condition. *Id*. at 139:14-19.

69. Despite being aware that Mr. Walter had a prescription for Klonopin and had been deprived of his medication at the jail, Dr. Allen did nothing whatsoever to treat his withdrawal symptoms; instead she prescribed him medication for bipolar disorder (even though he had no history of bipolar disorder), and she left the jail without further evaluation or treatment. *See* Stern Rept. (Ex. 13) at 13-14; Roy-Byrne Rept. (Ex. 8) at 10-11; Gendel Rept. (Ex. 9) at 13-15.[5]

[5] Additional facts pertaining to Defendant Allen's conduct and her purported reasons for not treating Mr. Walter's

70. With his benzo withdrawal still untreated, Mr. Walter's condition continued to deteriorate. Deputy Wilson was working the swing shift daily from April 16-19. Decl. of Christopher Wilson (Ex. 20) at ¶¶ 1-6. He saw Mr. Walter repeatedly during this four-day period. *Id*. ¶ 6. Mr. Walter was "almost unrecognizable" from when he had been brought into the jail two weeks earlier. *Id*. It was obvious to him that Mr. Walter had lost a massive amount of weight. *Id*. ¶ 8. Mr. Walter 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*.

71. Deputy Wilson describes Mr. Walter's 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.

Wilson Decl. (Ex. 20) ¶¶ 9-10 (emphasis added). The "nurse" was Repshire. *See* Repshire Dep. (Ex. 3) at 223:8-224:2.

72. An inmate who was being held across from Mr. Walter's holding cell on April 19th describes him as looking "like a living corpse," "malnourished," "violently shuddering," covered

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Klonopin withdrawal are discussed *infra*, in Section F.

with marks and bruises, and "talking and mumbling almost nonstop" as well as many other disturbing observations. Decl. of Joseph 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.*

73. Deputy Lightcap was so disturbed by Mr. Walter's condition on April 19th that she contemporaneously documented her observations. *See* Ex. 39. She described him as being covered with "excessive bruises" "all over his body," his toe appeared to be broken, "[t]here seemed 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. *See* Lightcap Dep. (Ex. 35) 110:18-129:6. It was apparent to her that Mr. Walter was in a medical crisis and needed to be in a hospital. *Id.* at 123:10-24, 134:9-25.

74. Following Mr. Walter's death, photographs were taken of him showing the excessive external injuries covering his body. These photos were shown to Deputy Lightcap during her deposition and she confirmed that the photographs accurately show the condition of Mr. Walter's body on the night of April 19th. *See* Photographs (Ex. 40); Lightcap Dep. (Ex. 35) at 140:7-17.

75. Although Repshire worked full shifts on April 16, 17, 18 and 19, she did not take a single vital sign of Mr. Walter during that time—or, indeed, ever. Repshire Dep. (Ex. 3) at 201:15-202:11, 66:17-67:2.

76. Defendant Repshire claims to have had a telephone conversation about Mr. Walter with Dr. Herr on April 19th. However, the evidence casts doubt on her claim, *see* Resp. to SMF ¶ 17, and a reasonable jury could determine that the call did not take place. If the conversation did occur, Repshire gave Dr. Herr no pertinent information. *Id.*

77. On April 20th, Deputy Combs observed Mr. Walter in the holding cell. He was lying on the floor naked, shaking and quivering involuntarily from head to toe, and unresponsive to her. *See* Combs Dep. (Ex. 24) at 45:14-49:19. Corporal Owen also saw him that day—lying naked under the sink, shaking, in a fetal-like position. *See* Owen Dep. (Ex. 29) at 68:24-69:17.

78. Mr. Walter died in his cell at approximately 5:30 p.m. on Sunday, April 20. *See* Gendel Rept. (Ex. 9) at 7. He weighed only 168 pounds at autopsy—a loss of over 30 pounds during his 17 days in jail. *See* Ex. 41; Rept. of Frank Sheridan, M.D. (Ex. 42) at 4. He had numerous external injuries—extensive bruises, contusions and abrasions—covering nearly his whole body. *See* Ex. 40 (autopsy photos) & Ex. 41 (autopsy report).

79. Mr. Walter also had extensive *internal* injuries—most notably, multiple broken ribs on the backside of his body. *See* Sheridan Rept. (Ex. 42) at p. 6. The fractures occurred "at the strongest point in the rib-cage," where the ribs attach to the spine, and a "great deal of externally-applied force would have been necessary to cause these fractures." *Id.* They were not self-inflicted or caused by resuscitative efforts. *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*.

80. Mr. Walter died from "Acute Benzodiazepine Withdrawal." *See* Ex. 43. *See also* 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.

81. Multiple policies, protocols, and procedures were disregarded by the nursing staff during Mr. Walter's confinement. *See* Moore Rept. (Ex. 2) at 20-26; Gendel Rept. (Ex. 9) at 8-12; Roy-Byrne Rept. (Ex. 8) at 6; Doughty Dep. (Ex. 10) at 132:22-133:16, 133:20-134:13, 135:19-136:16, 137:3-139:7, 141:9-146:5.

82. Defendant Repshire's acts and omissions were far below the standard of care in numerous respects, as opined in the reports of plaintiff's medical experts. *See* Moore Rept. (Ex. 2) at 17-19; Stern Rept. (Ex. 13) at 31-34; Gendel Rept. (Ex. 9) at 19.

F. Additional Facts Pertaining to Defendant Allen's Conduct

83. As set forth above, Defendant Allen visited Mr. Walter at his holding cell for about 10 minutes on April 17th. *See* ¶ 65, *supra.*

84. To justify her failure to address his Klonopin withdrawal, Dr. Allen claims that LPN Maestas dissuaded her from believing that Klonopin withdrawal could be an issue. Specifically, after her 10-minute visit with Mr. Walter, Dr. Allen claims she saw Maestas in the jail and asked her if Mr. Walter was taking any Klonopin before he came into jail. *See* Allen Dep. (Ex. 7) at 122:24-123:1, 123:10-13. She claims to have asked Maestas this: "Mainly, what I need to know is, was he taking any Klonopin before he came in here [to the jail]?" *Id.* at 122:24-123:13.

85. In response to her alleged question, Dr. Allen claims that Maestas replied, "Not really" and then proceeded to give her the impression that Mr. Walter had not been compliant with his prescription. *Id*. at 122:24-124:11. Dr. Allen cannot remember the exact words, but claims that Maestas's "basic message" was that Mr. Walter had not been taking the prescribed Klonopin prior to his coming into the jail. *Id*. as 124:6-11. According to Dr. Allen, Maestas gave her some sort of explanation to back up what she was saying about Mr. Walter's non-use of Klonopin before entering the jail. *Id*. at 122:24-124:14.

86. Dr. Allen knew that Mr. Walter's prescription medication bottles, including his Klonopin, were available for her to see, but she made no effort to check the bottles, which would have contained all the information she needed to know—information that Mr. Walter was unable to tell her—about his prescription, dosage, pharmacy, outside provider, frequency of use, and compliance. *See* Allen Dep. (Ex. 7) at 125:4-23; *see also* Ex. 14 (photos of prescription bottles). She claims the *reason* for not checking his medication bottles was because Maestas had informed her, in substance, that "Klonopin wasn't an issue," and Dr. Allen "took her word for it." *Id.* at 125:5-13. In short, Dr. Allen claims to have reasonably relied on this alleged information from Nurse Maestas in not following up on Mr. Walter's Klonopin history.

87. However, the evidence shows that the alleged conversation between Dr. Allen and Maestas *did not occur and could not have occurred* because Maestas was not at the jail on April 17th. From April 16th through 19th, Repshire was the only nurse at the jail. Repshire Dep. (Ex. 3) at 223:8-22. Maestas did not work at the jail on April 17th and has no reason to believe she was even at the jail on that date. Maestas Dep. (Ex. 5) 167:22-24, 165:25-166:3. Nor did she have any memory of the alleged conversation or one like it. *See id.* at 166:5-15.

88. When questioned about whether she would have had "any basis at all to tell [Dr.] Allen that Mr. Walter had not been really taking Klonopin before he got into the jail," Maestas testified that she would not because none of the policy-required medication verification processes had ever been completed for Mr. Walter. Maestas Dep. (Ex. 5) at 166:22-167:21. Maestas candidly admitted that the medication verification protocol was not followed in Mr. Walter's case—a protocol violation that was "a pretty significant failing when someone comes in with a prescription for Klonopin." *Id*. 178:4-179:6, 180:8-13.

89. Moreover, when Dr. Allen was asked in an interrogatory to "describe every communication [she] had with any other health care provider" about Mr. Walter, she swore that she did "not currently recollect any communications not recorded in the medical records regarding Mr. Walter between April 2, and April 20, 2014." *See* Ex. 44 at 8. There is no record of any conversation between Dr. Allen and Kathy Maestas. In short, the record shows that Dr. Allen's testimony is false—Nurse Maestas did *not* assure her that Mr. Walter's Klonopin use was a non-issue, and she could not have relied on the alleged assurance.

90. In arguing that she is entitled to summary judgment, Dr. Allen also asserts that she "diagnosed Mr. Walter with bipolar disorder by referring to the DSM-5." Def. Mot. (ECF 170) at 20. Both parts of this assertion are contradicted by Dr. Allen's own testimony. Regarding the claim that she "diagnosed Mr. Walter with bipolar disorder," Dr. Allen testified in her deposition that she "really didn't have enough information to know that for sure" and therefore used the term only provisionally. Allen Dep. (Ex. 7) at 144:23-25. Regarding the claim that her diagnosis was made

"by referring to the DSM-5," Dr. Allen admitted in her deposition that she did not consult any medical literature when she evaluated Mr. Walter on April 17th. *Id*. at 154:15-18.

91. Dr. Allen had Mr. Walter's medical chart on April 17th and would have reviewed the information therein. *See* Allen Dep. (Ex. 7) 133:4-15. She claims to have reviewed his chart before seeing Mr. Walter. *Id*. at 121:10-11.

92. The chart revealed the following as of April 17th:

A. Mr. Walter indicated at his April 3rd intake that he was on Klonopin, but his benzo medication was abruptly discontinued by P.A. Havens. *See* Ex. 6, p. L. Dr. Allen knew that any person on a benzo for more than one month should be tapered if discontinuance is anticipated. Allen Dep. (Ex. 7) at 163:2-11.

B. Mr. Walter never received the required initial health assessment. *See* Ex. 6.[6] Dr. Allen knew the standard of care and CHC's policies required this to have occurred. Allen Dep. (Ex. 7) at 101:20-102:2, 104:10-14.

C. Mr. Walter's medication history and verification of his medications had never occurred. *See* Ex. 6. Dr. Allen knew the standard of care required this to have occurred. Allen Dep. (Ex. 7) at 100:13-101:19.

D. P.A. Haven's April 3rd order to initiate the benzo withdrawal protocol had been ignored by the nurses and never even initiated. Stern Rept. (Ex. 13) at 37. *See also* Gendel Rept. (Ex. 9) at 17. Dr. Allen knew the standard of care required this monitoring to have occurred. *See* Allen Dep. (Ex. 7) at 102:12-16.

E. No one had taken any action to remediate the fact that the order to initiate the benzo withdrawal protocol had been ignored. *See* Ex. 6. *See also* Stern Rept. (Ex. 13) at 14.

F. No later than the 14th day of Mr. Walter's confinement (which was April 17th), CHC policy required that he receive a comprehensive health assessment. *See* Moore Rept. (Ex. 2) at 11.

[6] Exhibit 6 contains Mr. Walter's entire patient file, plus several additional pages. *See* Allen Dep. (Ex. 7) at 131:10-134:9. It is offered here (and below) to show the *absence* of certain information.

See also Ex. 48. Mr. Walter never received this required assessment. Maestas Dep. (Ex. 5) at 94:4-15; Moore Rept. (Ex. 2) at 11; Gendel Rept. (Ex. 9) at 10; Ex. 6. Dr. Allen knew that CHC's policies required this to have occurred no later than the date she was seeing him. *See* Allen Dep. (Ex. 7) at 104:15-105:2. Vital signs alone are "an essential guidepost in monitoring withdrawal," and the comprehensive health assessment "would have identified myriad serious medical concerns that had emerged and were continuing to emerge." Moore Rept. (Ex. 2) at 11.

G. Mr. Walter's blood pressure had been checked only twice (once on April 13th and once on 14th), and both times it was abnormally elevated. *See* Roy-Byrne Rept. (Ex. 8) at 8.

H. Despite the elevated blood pressure on April 13 and 14 and an order by Nurse Doughty to check it again every day for the next five days, no vital signs at all had been taken on April 15, 16 or 17. *See* Ex. 6. *See also* Doughty Dep. (Ex. 10) at 112:6-24. Dr. Allen knew that regular monitoring of vital signs several times daily should have occurred. *See* Allen Dep. (Ex. 7) at 102:17-103:25. She knew that no vitals had been taken for the three days before she saw Mr. Walter. *Id*. at 168:5-9. And she knew that no vital signs had been documented as having been taken during the first 10 days of his confinement and that this was not appropriate. *Id*. at 165:4-167:3.

I. Numerous other written policies, procedures, and protocols had been violated in the case of Mr. Walter's care leading up to April 17th. *See* Moore Rept. (Ex. 2) at 20-26; Gendel Rept. (Ex. 9) at 8-12; Roy-Byrne Rept. (Ex. 8) at 6; Doughty Dep. (Ex. 10) at 132:22-133:16, 133:20-134:13, 135:19-136:16, 137:3-139:7, 141:9-146:5.

93. If Dr. Allen had looked at the Inmate Welfare Checklist posted on outside of Mr. Walter's cell door, she would have seen that in the two days since Mr. Walter had been transferred to the holding cell, he had slept, *at most*, for only one-and-a-half hours. *See* Ex. 34.

94. Moreover, when Dr. Allen saw Mr. Walter on April 17th, he was not just mentally confused and disoriented. He was also pale, ill-appearing, thin or emaciated, and visibly *physically injured*. *See* Pl. Stmt. Add. Facts at ¶¶ 56, 63, *supra*; *id.* at ¶¶ 95-96, *infra.*

95. Deputy Lightcap worked from 10:00 p.m. to 6:00 a.m. on April 15-16 and April 16-17 leading up to Dr. Allen's April 17th visit. *See* Lightcap Dep. (Ex. 35) at 37:17-38:13. As a booking deputy, she had a clear view into Mr. Walter's cell from her workstation. *Id*. at 56:9-15. Multiple times on every shift she worked, she would carefully check on Mr. Walter in the holding cell. *Id*. at 56:16-57:22. Although she did not document Mr. Walter's extensive bodily injuries until April 19th (*see* Ex. 39), she noticed "more bruises showing up each day." *Id*. at 121:20-22. *See also id.* at 114:4-5 (describing how Mr. Walter "would receive bruises each – each day").

96. When Dr. Allen went to Mr. Walter's cell, he was fully naked from head to toe. *See* Allen Dep. (Ex. 7) at 135:23-24. Although she viewed Mr. Walter in a state of full-frontal nudity, she claims not to have seen any injuries, bruising, discoloration, or anything else. *Id*. at 136:21-24. Given the photographs that depict Mr. Walter's extensive injuries as of at least April 19th, as well as testimony from the detention deputies, a jury could well infer that Dr. Allen is not being truthful.

97. Dr. Allen also claims that when she saw Mr. Walter in the nude, he did not appear to be "thin, weak or ill." *See* Allen Dep. (Ex. 7) at 137:11-12. Given the extensive evidence from the detention staff about Mr. Walter's physical condition as observed between April 16-18, the jury could easily find that Dr. Allen is not being truthful. *See* Wilson Decl. (Ex. 20) ¶ 7 (describing Mr. Walter's physical appearance as "shocking" throughout the four-day period of April 16-19).

98. Even though Dr. Allen knew that Mr. Walter would be without any access to medical care for at least 12 hours out of every day following her April 17th visit with him, she did not follow up on his condition. *See* Allen Dep. (Ex. 7) at 109:23-110:1.

99. Dr. Allen's actions and omissions were grossly below the standard of care in numerous respects, as opined by Plaintiff's Experts. *See* Roy-Byrne Rept. (Ex. 8) at 10-11, 13-15; Gendel Rept. (Ex. 9) at 12-15, 20; Stern Rept. (Ex. 13) at 13-14, 38-41.

III. ARGUMENT

A. Legal Standards

Summary judgment is appropriate only if there are no genuine issues of material fact and the moving party is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(c). The Court must view the evidence and all reasonable inferences in the light most favorable to the non-moving party. *Adler v. Wal-Mart Stores*, 144 F.3d 664, 670 (10th Cir. 1998) (citing *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 587 (1986)).

Defendants lead by noting that the Eighth Amendment protects inmates from cruel and unusual punishment and that the subjective "deliberate indifference" standard applies to inadequate medical care claims brought under the Eighth Amendment. *See* ECF 170 at 14. They then argue that the evidence is insufficient to satisfy the subjective element of deliberate indifference. Before considering this argument, the Court should keep in mind that this is *not* an Eighth Amendment case. The Eighth Amendment applies only to convicted prisoners; as a pretrial detainee, Mr. Walter's constitutional rights are governed by the Fourteenth Amendment, which is the constitutional right asserted in the Second Amended Complaint.

The distinction between Fourteenth Amendment claims (due process—for pretrial detainees) and Eighth Amendment claims (cruel and unusual punishment—for convicted prisoners) has long been an academic one with no practical difference. But the distinction is no longer academic—even in cases, like this one, involving allegations of inadequate medical care. In 2015, the Supreme Court determined that an *objective* standard governs excessive force claims brought by pretrial detainees under the Fourteenth Amendment as distinct from the subjective standard that applies to such claims brought by convicted prisoners under the Eighth Amendment. *See Kingsley v. Hendrickson*, 135 S. Ct. 2466 (2015). Since then, at least two circuit courts have decided that the *Kingsley* holding extends beyond excessive force claims and applies to other

claims involving the Fourteenth Amendment rights of pretrial detainees, such as failure-to-protect claims and claims for overcrowding, lack of sanitation, and similar unconstitutional conditions of confinement. These courts have interpreted *Kingsley* as replacing the subjective "deliberate indifference" standard for pretrial detainees with a less-stringent, objective standard. *See Darnell v. Pineiro*, 849 F.3d 17 (2nd Cir. 2017); *Castro v. County of Los Angeles*, 833 F.3d 1060 (9th Cir. 2016) (en banc), cert. den., 137 S. Ct. 831 (U.S. Jan 23, 2017).

As of 2017, several district courts have relied on the Supreme Court's holding in *Kingsley,* as well as circuit court authority, to rule that a subjective showing of deliberate indifference is no longer required in inadequate medical care cases brought by pretrial detainees under the Fourteenth Amendment. *See, e.g.*, *Portillo v. Webb*, No. 16-cv-4731, 2017 U.S. Dist. LEXIS 168854, at *10-12 (S.D.N.Y. Oct. 11, 2017) (holding that "*Kingsley* altered the subjective prong where a claim is made by a pretrial detainee" in case alleging denial of medical care); *Murray v. McKay*, No. 1:17-cv-00564-MJS (PC), 2017 U.S. Dist. LEXIS 133566, at *10-11 (E.D. Cal. Aug. 18, 2017) ("[The Court sees no reason why the same rationale [in *Kingsley*] should not apply to other Fourteenth Amendment conditions of confinement and medical care claims"); *Borges v. Cty. of Humboldt*, No. 15-cv-00846 YGR, 2017 U.S. Dist. LEXIS 116387, at *8-10 (N.D. Cal. July 25, 2017) (explaining that after *Kingsley*, the subjective element is no longer applicable to a medical care claim under Fourteenth Amendment); *Sadler v. Dutton*, No. CV 16-00083-H-DLC-JTJ, 2017 U.S. Dist. LEXIS 119031, at *9-10 (D. Mont. June 1, 2017) (dispensing with subjective inquiry in Fourteenth Amendment medical care claim after *Kingsley*); *Lloyd v. City of New York*, No. 14-cv-9969, 2017 U.S. Dist. LEXIS 49526, at *25-29 (S.D.N.Y. March 31, 2017) (after *Kingsley*, the "'*mens rea* prong' of deliberate indifference to serious medical needs claims under the Fourteenth Amendment [will now] be analyzed objectively").

This Court has relied on *Kingsley* to eliminate the subjective inquiry in conditions of confinement cases brought by pretrial detainees. *See Eaves v. El Paso Cnty. Bd. of Cnty. Comm'rs*, No. 16-cv-01065, 2017 U.S. Dist. LEXIS 43307, at *16-17 (D. Colo. March 24, 2017). So too has at least one other district court in this circuit. *See Abila v. Funk*, 220 F. Supp. 3d 1121 (D. N.M. 2016). Given that the source of this change in the law is the Supreme Court, and given that the Tenth Circuit has not spoken on whether *Kingsley* extends to medical care claims for pretrial detainees, this Court could properly decide that a subjective state-of-mind requirement is no longer applicable to Fourteenth Amendment denial of medical care claims. However, the Court need not address this issue because plaintiff has ample evidence to satisfy the subjective deliberate indifference standard under the pre-*Kingsley* state of the law.

Deliberate indifference under the subjective standard asks whether the defendant was "aware of facts from which the inference could be drawn that a substantial risk of serious harm exists" and whether there is evidence that the defendant actually drew the inference. *Vasquez v. Davis*, 226 F. Supp. 3d 1189, 1209 (D. Colo. 2016) (citing *Farmer v. Brenan*, 511 U.S. 825, 837 (1994)). Whether a defendant had the requisite knowledge of a substantial risk of serious harm is "subject to demonstration in the usual ways, including inference from circumstantial evidence, and a factfinder may conclude that a prison official knew of a substantial risk from the very fact that the risk was obvious." *Id*. (quoting *Farmer*, 511 U.S. at 842).

"In medical cases particularly, objective standards of proper care may be introduced as circumstantial evidence about what a medical provider knew." *Id*. This includes expert testimony about what a medically educated individual would have realized. *Id*. (citing *LeMarbe v. Wisneski*, 266 F.3d 429, 436-38 & n. 6 (6th Cir. 2001)). "[C]ontemporary standards and opinions of the medical profession . . . are highly relevant in determining what constitutes deliberate indifference

to medical care." *Mata v. Saiz*, 427 F.3d 745, 757-58 (10th Cir. 2005) (internal citations omitted). In addition, circumstantial evidence of deliberate indifference can include references to a facility's internal policies and procedures. "[S]uch protocols certainly provide circumstantial evidence that a prison health care gatekeeper knew of a substantial risk of serious harm." *Id*. at 757.

As the Supreme Court has held, a plaintiff need not prove that the defendant "believ[ed] that harm would actually befall an inmate; it is enough that the official acted or failed to act despite knowing of a substantial *risk* of serious harm." *Farmer*, 511 U.S. at 842. Moreover, the risked "harm" need not be death; unnecessary pain or a worsening of the inmate's condition is sufficient even if the delay in medical treatment is brief. *Mata*, 427 F.3d at 755. Viewing the evidence in the light most favorable to the plaintiff, a reasonable jury could easily find that Defendants Repshire and Allen were deliberately indifferent to Mr. Walter's admittedly serious medical needs.[7]

B. There is Ample Evidence of Defendant Repshire's Deliberate Indifference

To minimize her subjective knowledge of the risks posed to Mr. Walter, the defense claims that "Nurse Repshire was not familiar with the signs of benzodiazepine withdrawal" and that "she did not believe [it] could lead to serious injury or death." *See* ECF 170 at 18. These claims flatly contract her sworn interrogatory answer in which she "affirmatively state[d] that she is familiar with the risks, signs and symptoms of benzodiazepine withdrawal from her education and practice as a nurse." Ex. 44 at 6-7. In the same set of interrogatory responses, she swore she "completed extensive medical training" that specifically "included education on benzodiazepine medications and withdrawal." *Id. at* 6. And in her binding answer to the operative complaint, she repeatedly

[7] Defendants Repshire and Allen do not challenge the fact that Mr. Walter had objectively serious medical needs throughout his 17-day confinement. Moreover, as employees of a private healthcare company, defendants recognize that they cannot assert any qualified immunity defense. *See Estate of Grubbs v. Weld Cnty. Sheriff's Office*, No. 16-cv-00714-PAB-STV, 2017 U.S. Dist. LEXIS 33009, at *17-19 (D. Colo. Mar. 8, 2017) (holding that qualified immunity is unavailable to employees of a private company providing medical services to jail inmates).

maintained that she was "familiar with the risks, signs, and symptoms of benzodiazepine withdrawal resulting from the discontinuation of benzodiazepine medications" at the time of Mr. Walter's confinement. ECF 134 ¶¶ 69, 71, 74. Considering this evidence, a jury could easily reject her feigned ignorance of the dangers of benzo withdrawal.[8]

The defense also claims "Nurse Repshire did not know that Mr. Walter had been placed on the benzodiazepine protocol or that he even had a remote risk of experiencing withdrawal." *See* ECF 170 at 18. However, this claim is also belied by the evidence. Indeed, Repshire signed the bottom of Mr. Walter's intake form on which he had indicated he was taking Klonopin. She did this on April 4th—the day after his booking. *See* Repshire Dep. (Ex. 3) at 130:18-131:2. She didn't just sign the form; she reviewed it and understood that Mr. Walter was on a Klonopin prescription. *See id*. at 131:19-132:3. She also knew that he brought his medication with him to the jail. *Id*. at 132:20-23. Given her nursing education and her familiarity with the "risks, signs, and symptoms of benzodiazepine withdrawal," she obviously recognized that Mr. Walter had more than a "remote risk" of suffering from benzo withdrawal. Even if she did not appreciate the magnitude of the risk on April 4th, that changed when he began begging her for his Klonopin and telling her that he would die without it. *See* Smith Decl. (Ex. 4) ¶ 6; Vercillo Decl. (Ex. 19) ¶ 4.

Defendant Repshire's purported lack of knowledge that Mr. Walter had been placed on the benzo protocol also strains credulity. She knew he was on a prescription benzodiazepine when he came to the jail, and she knew he was not being given his Klonopin or any substitute benzo. Armed with this knowledge, it is not credible to believe she had no idea that Mr. Walter had been put on the benzo protocol. More importantly, the order putting him on the benzo protocol was part of his

[8] In assessing the veracity of her claims, the jury could also consider the testimony of her employer's top medical officer, Dr. Herr, who agreed that "death is a well-recognized risk of acute benzo withdrawal" and that "all medical providers who work in the field of correctional medicine have an obligation to know about the symptoms, risks, and dangers associated with benzo withdrawal." Herr Dep. (Ex. 1) at 51:9-11, 55:16-20.

patient file or chart. *See* Ex. 6, p. L. *See also* Maestas Dep. (Ex. 5) at 200:8-12; Allen Dep. (Ex. 7) at 131:10-133:10. Once Mr. Walter began begging her for his medication (and telling her he would die without it), it would have been unreasonable of her *not* to look at his patient chart. When he later began experiencing his myriad signs and symptoms, it would have been beyond unreasonable of her not to look at his chart. Even her own supervisor, HSA Maestas, agreed that failing to start the benzo protocol was a "significant" failure on the part "of *all the nurses* who were working at the jail." Maestas Dep (Ex. 5) at 194:19-195:4 (emphasis added).

The benzo protocol was not the only policy violated by Repshire. Indeed, multiple policies, protocols, and procedures were disregarded by the nursing staff during Mr. Walter's confinement. *See* Moore Rept. (Ex. 2) at 20-26; Gendel Rept. (Ex. 9) at 8-12; Roy-Byrne Rept. (Ex. 8) at 6; Doughty Dep. (Ex. 10) at 132:22-133:16, 133:20-134:13, 135:19-136:16, 137:3-139:7, 141:9-146:5. While some of these were not Repshire's responsibility, many of them were. This included, among other policy violations, failing to give Mr. Walter an initial medical screening, failing to verify his medications, failing to contact his provider, failing to conduct a mental health screening, failing monitor his opiate withdrawal, failing to follow the "change in behavior" policy, failing to conduct a comprehensive 14-day health assessment, and failing to secure emergency care for him. *See* Moore Rept. (Ex. 2) at 17-18. A reasonable jury could find Repshire's failure to follow these policies and protocols evidence of her deliberate indifference. *See* Moore Rept. (Ex. 2) at 20-26.

Defendant Repshire also failed to follow the order to conduct daily blood pressure checks, which was put in place by another nurse (who is not a defendant) after she found Mr. Walter's blood pressure to be abnormally high. *See* Doughty Dep. (Ex. 25) at 98:2-6, 98:23-99:4. Defendant Repshire was the only LPN on duty on April 16, 17, 18, and 19, and she was aware of the order. *See* Ex. 3 at 211:16-19. Yet, despite her knowledge of the order to check Mr. Walter's blood pressure, she failed to do so in violation of the standard of care. *See* Moore Rept. (Ex. 2) at 8-9;

Roy-Byrne Rept. (Ex. 8) at 8; Repshire Dep. (Ex. 3) at 201:15-202:11, 66:17-67:2. Knowing a patient has high blood pressure and consciously disregarding an order to check his blood pressure is the very essence of deliberate indifference—particularly given Mr. Walter's numerous other concerning signs and symptoms and Repshire's knowledge of his benzo discontinuance and her admitted knowledge of the signs, symptoms and risks of benzo withdrawal.

Defendant Repshire's acts and omissions were far below the standard of care in numerous additional respects as detailed at great length in the reports of plaintiff's experts. *See, e.g.*, Moore Rept. (Ex. 2) at 17-19; Stern Rept. (Ex. 13) at 31-34. The experts do not paint a picture of simple negligence on the part of Nurse Repshire; rather, they describe her conduct as "egregious," "shameful," "utterly below the standard of care," and "far, far below the standard of care," and they provide detailed analysis of her gross mismanagement of Mr. Walter. "The standard of care required that Mr. Walter be transferred to a hospital for treatment by at least April 15th. The need for hospital treatment grew more urgent with each passing day and hour." Gendel Rept. (Ex. 9) at 19. The failure to transport [him] to the hospital was particularly shocking because the Fremont County Jail "was totally ill-suited to address his serious medical needs." *Id*.

Among the most glaring examples of Defendant Repshire's deliberate indifference took place when Mr. Walter was in the holding cell during the last five days of his life. Regardless of whether she knew the underlying cause of his signs and symptoms, they were serious enough for anyone, even a lay person, to know that (1) he needed to be transported to a hospital, and (2) not doing so put him at risk of serious harm. He was barely eating; he was visibly diminishing in size from weight loss; he was thin and emaciated (he lost at least 30 pounds during his confinement); he was not sleeping for days on end; he was mentally confused and disoriented as to time and place (not knowing the month or year and not even realizing he was in a jail); he was delusional, talking nonsensically, and hallucinating; he was visibly ill, sick, and pale; he weak—too weak to get a cup

of water; he was unresponsive to verbal direction; he was unable to communicate his medical needs or fill out a kite for assistance; he was naked inside his cell in full view of others; he was injuring himself in his cell; his eyes were twitching; he was shaking, shuddering, and involuntarily convulsing on the floor; he was badly injured, bruised, and was bleeding; and he had urinated in his cell. In the face of all of this, Defendant Repshire did not even take a single vital sign.

Virtually the entire detention staff knew that Mr. Walter was in a profound medical crisis. Concerns were repeatedly brought to Defendant Repshire, who failed to take any responsive action. They were so frustrated with her lack of response to Mr. Walter's medical needs that they reported their concerns up the chain of command. One sergeant testified that 18 members of the detention staff had come to him with concerns about Mr. Walter's deteriorating condition. The supervisory staff also went to Defendant Repshire, who continued to ignore the situation. When Mr. Walter continued to deteriorate, corporals and sergeants made reports to the jail's command staff, who, in turn, went to Repshire demanding action. One officer who saw Mr. Walter on April 19th thought his condition, by then, was so dire that he would not survive another day in jail. *See* Wilson Decl. ¶ 10. Another officer agreed. *Id*. They were right. If there was ever a case in which a medical urgency is so glaringly obvious that even a layperson would recognize it, this is it.

Nurse Repshire was the only medical provider at the jail on April 16, 17, 18, and 19. She observed everything about Mr. Walter's condition that the detention staff observed. She had the power, the legal duty, and the moral obligation to facilitate his hospital transport on each of those days, and she failed to do so. The defense attempts to excuse this failure by claiming that she "tried to coordinate Mr. Walter's care by higher level providers." ECF 170 at 18. However, this claim is spurious. Regarding her alleged "referral" to P.A. Havens, there is no evidence that she ever even spoke to him. She merely put a sticky note on Mr. Walter's chart so that Havens would look at it. However, the chart was missing crucial information, *including the vital fact that his order to*

initiate the benzo protocol had not been followed. She also claims to have referred Mr. Walter to Dr. Allen; however, once again, all she did (at most) was put Mr. Walter's woefully incomplete chart on top of a stack. She gave Dr. Allen no substantive information whatsoever. There is no evidence that she even spoke to Dr. Allen, who only spent 10 minutes with Mr. Walter. Finally, she claims to have consulted with Dr. Herr. However, the evidence suggests that the alleged phone call either never took place or that she failed to provide him with any pertinent information. Far from absolving her of responsibility, Repshire's communication with the other providers was so deficient that it constituted another violation of the standard of care, *see, e.g.*, Moore Rept. (Ex. 2) at 18, and is further evidence of her deliberate indifference.

C. There is Ample Evidence of Defendant Allen's Deliberate Indifference

Defendant Allen is the only medical doctor who saw Mr. Walter in person during his 17-day confinement. When she saw him on April 17th, he was in urgent need of hospital transport. *See* Gendel Rept. (Ex. 9) at 19. Despite being perfectly healthy and normal upon entering the jail, as his chart indicated, he was now severely disoriented and confused. He did not know the month or year and did not even realize he was in a jail—thinking, instead, he was in a community hospital. He was naked, delirious, hallucinating, tremulous, and sleep deprived. Due to the sheer magnitude of his mental decompensation, Dr. Allen knew that she could not rely on Mr. Walter to communicate his medical symptoms to her. In addition to his severely compromised mental state, Mr. Walter was, according to multiple first-hand accounts, pale, sickly, ill-appearing, emaciated, and visibly physically injured.

If, as she claims, she looked at Mr. Walter's chart, Dr. Allen also knew that he had come into the jail on a prescription benzodiazepine and that his medication was abruptly discontinued (with no tapering), in violation of the standard of care. She was familiar with the signs, symptoms, and risks of benzodiazepine withdrawal. She knew that a benzo protocol had been ordered, which

would have required monitoring and regularly checking vital signs, but that this order had been ignored by the LPNs—in violation of the standard of care. She knew that his medications had not been verified, in violation of the standard of care. She knew that he never received an initial health screening, which the standard of care required. She knew that in addition to his benzo prescription, he also had a prescription for high blood pressure medication and that he was not being given that medication either (for no apparent reason). She knew that his blood pressure had only been checked twice and that it was abnormally elevated both times. She knew there was an order to take his blood pressure daily (for five days, beginning on April 13th), but that no vital signs had been taken for the previous three days. She knew that he had not been given a comprehensive health assessment despite a mandatory policy to do so. And she knew that numerous other policies, procedures, and protocols had been violated in the two weeks leading up to her visit.

Despite all above, she spent no more than 10 minutes with this patient, Mr. Walter. She did not check his blood pressure, his pulse, or any other vital signs. She did not re-prescribe his benzodiazepine or his high blood pressure medication. She did not contact his community medical provider, who was identified in his chart. She did not consult with the physician assistant who had discontinued his medication. She did not speak to the LPNs about him. While she claims to have been told by LPN Kathy Maestas that Mr. Walter had been noncompliant with his Klonopin prescription (before entering the jail), supposedly enabling Dr. Allen to rule out benzodiazepine withdrawal, the evidence shows this to be false. Nurse Maestas was not working at that jail that day, does not recall speaking with Dr. Allen, and had no basis whatsoever to tell her that Mr. Walter was not regularly taking his medication. Although the standard of care required her to conduct a differential diagnosis, which she claims to have done, there is no documentation of her doing so, and she did not spend nearly enough time with Mr. Walter to conduct one.

After spending 10 minutes with Mr. Walter, she provisionally diagnosed him with bipolar disorder based on something he said to her about a medication he may have once taken—even though she admits he was mentally incapable of providing reliable information and even though he had no history of bipolar disorder. She wrote a prescription to treat bipolar disorder, based on her provisional diagnosis, and that was it. Despite his bruises and contusions and other visible injuries, she did nothing to assess them or determine their cause. Despite his emaciated appearance, she did nothing to determine how much weight he had lost. Despite his sickly appearance, she did not take his temperature. Despite his documented high blood pressure on April 13th and 14th and the lack of any readings in the three-days after that, she did not check his blood pressure. And despite multiple policy violations leading up to her visit, she did nothing to rectify them and issued no relevant instructions to the part time LPNs. She just left.

It is important to remember the circumstances in which she left Mr. Walter. Defendant Allen was aware that the jail had no infirmary. She knew that there was no on-site doctor or RN. She knew there was no on-site physician assistant (other than one who came to the jail for about an hour a week and had who had already been that week). She knew that the only on-site medical providers were LPNs, who needed supervision, who had failed to follow multiple protocols, and who were only there for 12 hours a day. She knew that the jail did not have any medical providers there at all for 12 hours out of every day. And she knew that *she* would not be back to the jail for two weeks. As detailed by plaintiff's experts, her actions and omissions were *grossly* below the standard of care in many respects. *See* Roy-Byrne Rept. (Ex. 8) at 10-11, 13-15; Gendel Rept. (Ex. 9) at 12-15, 20; Stern Rept. (Ex. 13) at 13-14, 38-41. In light of the foregoing, a reasonable jury could easily conclude that she was deliberately indifferent to Mr. Walter's serious medical needs.

IV. CONCLUSION

The Court should deny summary judgment to Defendants Repshire and Allen.

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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Dated this 6th day of November, 2017.

/s/ Sally Hartmann