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IN THE UNITED STATES DISTRICT COURT
DISTRICT OF UTAH, CENTRAL DIVISION

CALVIN DONALD OSTLER, as personal representative of the Estate of Lisa Marie Ostler, Plaintiff, v. HOLLY PATRICE HARRIS, ZACHARY PAUL FREDERICKSON, TODD ALLAN BOOTH, RONALD PAUL SEEWER, JR., BRENT LEE TUCKER, and SALT LAKE COUNTY, a political subdivision of the State of Utah, Defendants.	**SECOND AMENDED COMPLAINT** **JURY TRIAL DEMANDED** Case No. 2:18-cv-00254-001 Judge Bruce S. Jenkins

Plaintiffs previously filed a First Amended Complaint [ECF 59], with respect to which the Court ordered dismissal of some of the claims and parties [ECF 139 and ECF 163]. Plaintiffs filed a Motion for Leave to File a Second Amended

Complaint [ECF 165], and Defendants filed an Opposition to Plaintiff's Motion for Leave to File Second Amended Complaint [ECF 167]. The Court entered a Memorandum Opinion and Order Granting in Part and Denying in Part Plaintiffs' Motion for Leave to File a Second Amended Complaint [ECF 174]. Plaintiffs contend that the Court's dismissal of claims in Plaintiffs' First Amended Complaint and the Court's denial of leave to file certain claims in the Second Amended Complaint was in error and reserve their right to challenge those decisions by the Court on appeal following a final decision in this matter. In order to file a Second Amended Complaint in conformance with DUCivR 15-1 ("A party who has been granted leave to file must subsequently file the amended complaint with the court. The amended complaint filed must be the same complaint proffered to the court, *unless the court has ordered otherwise*" (emphasis added)), and because the Court denied Plaintiffs' Motion for Leave to File a Second Amended Complaint "to the extent it attempts to reinstate the previously dismissed Heirs and Supervisors as Proposed Parties" [ECF 174, at 13] and granted Plaintiffs' Motion for Leave to File a Second Amended Complaint "to the extent the proposed amendments support Plaintiff's *Monell* claim against the County," *id*., this Second Amended Complaint is being filed to reflect only the claims and parties permitted by the Court and to reflect matters that "support Plaintiff's *Monell* claim against the County",

notwithstanding Plaintiffs' reservation of rights to challenge on appeal the Court's dismissal of claims and parties and denial of leave to add claims and parties in the Second Amended Complaint.[1]

Plaintiff complains of Defendants and, demanding trial by jury of the First and Second Claims for Relief, alleges as follows:

PARTIES

1. Plaintiff Calvin Donald Ostler ("Cal") is a citizen and resident of the State of Utah; he is the surviving father of Lisa Marie Ostler ("Lisa"), deceased; he is the personal representative of the estate of Lisa; and he is the adoptive father and next friend of the three surviving minor children of Lisa, C.K., E.L.K., and L.M.O.

2. Defendants Holly Patrice Harris ("Harris"), Zachary Paul Frederickson ("Frederickson"), and Todd Allan Booth ("Booth") (collectively "Guard Defendants") are citizens and residents of the State of Utah and at all times material hereto were officers, agents, or employees of Salt Lake County, assigned to work at the Salt Lake County Metro Jail.

[1] For ease of reference, attached as Exhibit "A" is a red-lined version reflecting the changes that have been made in this Second Amended Complaint in comparison with the proposed Second Amended Complaint proffered to the Court in connection with Plaintiffs' Motion for Leave to File Second Amended Complaint.

3. Defendants Ronald Paul Seewer, Jr. ("Seewer") and Brent Lee Tucker ("Tucker") (collectively "Nurse Defendants") are citizens and residents of the State of Utah and at all times material hereto were registered nurses working at the Salt Lake County Metro Jail and employed by Salt Lake County.

4. Defendant Salt Lake County, a political subdivision of the State of Utah, maintains the Salt Lake County Metro Jail and is responsible for the implementation and establishment of policies and procedures, customs, and the supervision and training of officers, agents, and employees assigned to work at the Salt Lake County Metro Jail.

JURISDICTION AND VENUE

5. This action arises under the United States Constitution, particularly the provisions of the Fourteenth Amendment, 42 U.S.C. § 1983, and the Utah Constitution, particularly Article I, Sections 7 and 9.

6. This Court has jurisdiction over this action pursuant to 28 U.S.C. §§ 1331 and 1367.

7. Venue in this Court is proper pursuant to 28 U.S.C. § 1391 because the conduct complained of herein took place in Salt Lake County, Utah.

8. The acts of the Defendants described herein to be in violation of 42 U.S.C. § 1983 and the United States Constitution were undertaken by the Defendants

and each of them under color of state law, particularly the statutes, ordinances, regulations, policies, customs, practices, and usages of, and under the authority of, Defendant Salt Lake County, and the individual offices of Defendants as officers, agents, contractors, and/or employees of Defendant Salt Lake County.

9. Jurisdiction for violations of the Utah Constitution is founded upon supplemental jurisdiction because the claims of violations of federal law are substantial and the supplemental claims derive from a common nucleus of operative facts and are so related to the federal claims that they form part of the same case or controversy under Article III of the United States Constitution.

10. Under protest, and vigorously asserting the inapplicability or the unconstitutionality of the Bond requirement of Utah Code § 78B-3-104, under the Due Process, Petition, and Equal Protection guarantees of the United States and Utah Constitutions, as well as the Open Courts Clause of the Utah Constitution, Plaintiff has deposited with the Clerk of the Court $300 for the Bond and filed with the Court a Bond, pursuant to DUCivR 67-1(c). Plaintiff seeks (1) a declaratory judgment that the Bond requirement violates the Due Process and Equal Protection clauses of the Utah and United States Constitutions and the Open Courts Clause of the Utah Constitution and (2) a refund of the $300 deposited with the Clerk of the Court for the unconstitutional Bond.

FIRST CLAIM FOR RELIEF
(Survival Action Under 42 U.S.C. § 1983)

For his First Claim for Relief, Plaintiff complains against the Defendants and alleges as follows:

11. Plaintiff repeats and incorporates by this reference the allegations set forth in paragraphs 1 through 10 above.

12. Lisa, a pretrial detainee who was entitled to be free from punishment, and who was entitled to medical treatment for her severe, life-threatening medical condition, under (1) the Due Process clause of the Fourteenth Amendment to the United States Constitution, (2) the Due Process clause of Article I, Section 7 of the Utah Constitution, and (3) the prohibition against the treatment of persons arrested or imprisoned with unnecessary rigor, under Article I, Section 9 of the Utah Constitution, was held in, and under the care and supervision of, the Salt Lake County Metro Jail and the Defendants from March 29, 2016, until April 2, 2016.

13. During April 1 and April 2, 2016, when Lisa was held in Pod C, Section 8 ("8C"), cell 16 of the Salt Lake County Metro Jail, Lisa exhibited obvious signs of excruciating pain from life-threatening peritonitis, was unable and failed to eat or drink anything since, at the latest, the morning of March 31, 2016, and experienced obvious and life-threatening dehydration. Lisa, as well as other detainees, repeatedly pleaded for medical help for Lisa. Those pleas for help, and Lisa's signs of life-

threatening medical need, which were so obvious that even a lay person would easily recognize the necessity for a doctor's attention, were outrageously ignored and cruelly dismissed by the Nurse Defendants and the Guard Defendants, leading to the utter failure by such Defendants to obtain, provide, or arrange for monitoring, evaluation, medical diagnosis, or medical treatment for Lisa, ultimately leading to Lisa's untimely, horrifyingly painful, and wholly unnecessary death.

14. As a result of the deliberate indifference of the Defendants, Lisa was found in her cell unresponsive, without a pulse and not breathing, on April 2, 2016, and she died on April 3, 2016, when it was determined at a hospital that there was no longer any sign of a heartbeat and Lisa was pronounced dead. The Guard Defendants and Nurse Defendants engaged in abuse and treatment of Lisa that was needlessly harsh, degrading, and dehumanizing.

15. On March 30, 2016, an employee or agent of Salt Lake County Jail completed a "Comprehensive Nurse Examination" form about Lisa, providing a "Health and Mental Health Rating" of "Level 3," noting "multiple medical issues," noting a history of gastric bypass surgery, and confirming that Lisa was "instructed on proper procedure to access medical, dental or mental health care through sick call request process." Also on March 30, 2016, an employee or agent of Salt Lake County

completed a "Medication Verification Worksheet" noting that Lisa reported taking multiple medications, including Pentasa, for Crohn's disease.

16. On March 31, 2016, while being held in Pod C, Section 5 ("5C") of the Salt Lake County Metro Jail, after not eating when breakfast was made available around 6 a.m. and not eating when lunch was made available around noon, Lisa presented to an employee of the Salt Lake County Metro Jail with obvious signs of extreme confusion, asking where "Claudia" was because they were going to go to a wedding together. That incident was noted in the records of the Salt Lake County Metro Jail, as was a recommendation for follow-up, which were available to the Guard Defendants and the Nurse Defendants, yet were wholly ignored by those Defendants.

17. Defendant Seewer knew that Lisa was, according to physician orders, established procedures, and policies applicable at the Salt Lake County Metro Jail, to have her vital signs and withdrawal symptoms measured and recorded twice daily for five days. On the morning of April 1, 2016, Defendant Seewer purported to record vital signs of Lisa Ostler onto Lisa's medical records and thereby indicate that her vital signs had been measured, but, in fact, failed and refused to measure, or assure the measurement of, all of Lisa's vital signs and wrote fabricated information

into her medical records that erroneously and misleadingly reflected Lisa's vital signs were normal and healthy.

18. On April 1, 2016, Lisa was moved from Unit 5C to Unit 8C of the Salt Lake County Metro Jail. Since at least the previous morning, March 31, until Lisa was found in her cell unresponsive and not breathing on April 2, she did not eat anything, a fact well known to the Guard Defendants and the Nurse Defendants. In fact, Defendant Tucker was expressly notified by Defendant Frederickson that Lisa had not eaten for at least two days, yet Tucker wholly failed to determine how long it had been since Lisa had last eaten anything and casually and dismissively stated erroneously that there was no medical concern until someone had not eaten for seventy-two hours. Defendant Tucker made that assessment without ever examining, monitoring, evaluating, diagnosing, or providing medical treatment for Lisa, or arranging for a competent medical professional to examine, monitor, evaluate, diagnose, or provide medical care for Lisa.

19. At about 3:25 p.m. on April 1, 2016, Defendant Seewer was informed by Lisa that she was experiencing severe pain, which Lisa's bearing and expressions confirmed. By then, as with anyone suffering from untreated peritonitis, Lisa was in excruciating pain, signifying that she was suffering from a serious medical condition. It was Seewer's personal responsibility, pursuant to physician orders,

protocols, and policies applicable at the Salt Lake County Metro Jail, to measure and record Lisa's vital signs and withdrawal symptoms on the afternoon of April 1, 2016, because he was the nurse assigned to Pod C for that day. Seewer failed to measure and record Lisa's vital signs and withdrawal symptoms. Seewer did not check Lisa's blood pressure, pulse, or temperature, he did not palpate her abdomen, and he did not chart anything regarding any semblance of a medical examination, which he failed to perform. Seewer also wholly failed to arrange for a medical examination, evaluation, or treatment by a medical professional competent to examine, evaluate, and treat Lisa and, with complete indifference to her obviously serious medical condition, simply "cleared her to stay in the unit."

20. On April 1, 2016, after detainees were locked down at approximately 4 p.m. to eat dinner, Lisa was heard by other inmates, even some on a different tier and several cells down from Lisa's, yelling and moaning, obviously in excruciating pain and obviously in need of immediate medical attention. One inmate has described what she heard from Lisa as being "like a deathly holler," a "growl," and "horrific." At that time, Defendant Booth was at the control desk and heard Lisa calling out in pain and for help, yet he did nothing to help her or to cause anyone else to help her, in utter disregard of Lisa's pain and obviously serious, life-threatening medical condition, which would have been, and was, obvious to any

layperson, as was the requirement that Lisa be provided immediate medical attention.

21. Lisa had been locked in her cell alone since she arrived at 8C, while every other detainee in 8C was free to walk around and talk to other detainees and officers, other than during lockdowns for meals, sleep, and certain urgent matters. Lisa was essentially left, locked up alone, without any diagnosis or treatment, or referral for diagnosis and treatment, and was physically unable, without great difficulty and pain, to leave her cell because of her rapidly deteriorating, life-threatening medical condition, which required close medical observation, evaluation, checking of vital signs, and diagnosis and treatment, or referral for diagnosis and treatment, none of which was provided by any of the Defendants.

22. The Guard Defendants and Nurse Defendants all knew, or were charged with knowing, Lisa had not eaten for at least two days, that she was in horrific pain, that she was not free or able, without great difficulty and pain, to walk outside of her cell (notwithstanding that she was entitled to be free from punishment because she was a pretrial detainee), and that she was obviously in need of urgent medical diagnosis and treatment—and the need was so obvious that a layperson would have easily recognized the necessity for medical attention—yet they failed and refused to monitor, evaluate, examine or treat Lisa and failed and refused to provide or arrange

for a competent medical professional to monitor, evaluate, diagnose, examine, or provide medical care for Lisa. At about 6 p.m. on April 1, 2016, a detainee, Summer Johnson ("Johnson"), who had earlier heard Lisa moaning loudly and calling out for help, left her cell on the upper tier of 8C after dinner lock-down and walked down to the lower tier to Lisa's cell because she knew that whoever was there was obviously suffering tremendously. Unlike the uncaring, callous Guard Defendants and Nurse Defendants, Johnson was extremely concerned about Lisa because it was obvious even to a layperson that Lisa's severe medical condition required medical treatment, yet nothing was being done for Lisa by the Guard Defendants or the Nurse Defendants.

23. Johnson looked into Lisa's cell, which was visible through large windows, and saw Lisa sitting on the bunk, "crunching" back and forth, all the way up and all the way down, curling up into a ball, demonstrating that Lisa was in obviously serious pain and distress, requiring immediate medical attention. Johnson could see that Lisa was obviously extremely sick and in horrendous pain, yet nothing was being done by the Guard Defendants or the Nurse Defendants to medically assist, or arrange medical assistance for, Lisa.

24. Johnson believed that Lisa was going to die because of her horrifying bodily movements, her obliviousness to everything else around her as she was writhing in pain, and her earlier loud moans and calling out for help.

25. At that point, Johnson asked Defendant Booth if he was going to "call medical" and stated to Booth that the girl in Lisa's cell (Johnson did not know Lisa's name at that point) was in urgent need of medical attention. Booth responded, rudely, sarcastically, and dismissively, as if Johnson were bothering him, that "We're watching her. She's just coming down off of drugs."

26. Defendant Booth then went to Lisa's cell, opened the door, and said, facetiously, with a sneer on his face, "I'll bet it feels like you're going to die, doesn't it? Just a couple more days." Booth then slammed the door hard and walked away, again without arranging for anyone to provide medical assistance for Lisa, whose need for medical treatment was obvious, and would have been obvious, to any reasonable layperson.

27. Lisa did indeed feel like she was going to die, as cruelly and sarcastically suggested by Defendant Booth—and she did die because of the cruel, dismissive, deliberate indifference of Booth, the other Guard Defendants, and the Nurse Defendants.

28. As one detainee, Candice Walker ("Walker"), who was in 8C has stated: "I can recall when Lisa came into the unit. She looked very frail. As I would serve meals we would take note of what women would not eat. Lisa did not eat. I remember trying to serve her one afternoon. She seemed to be in a lot of pain. Not being sure of her situation I asked her if she would try to eat something. She kept holding her stomach and crying out for help. I recall when Officer Booth was on duty she [Lisa] was at the door asking for help. Her voice was low and not very audible. He just waved at her from the officers station." Walker continued: "I would explain to the officer [Defendant Booth] that clearly she [Lisa] needed medical attention." Walker also notes: "I repeated to the housing officer if she [Lisa] didn't get medical attention she was going to die."

29. At about 10 p.m. or later on April 1, 2016, Johnson, from her cell, heard very loud yelling and moaning from Lisa and it seemed obvious to her that Lisa must be dying and that nothing was being done for her. Johnson heard repeated beeping from a button ("alarm button") provided to detainees in their cells for use if they needed to call for help.

30. Throughout the night of April 1 and early morning of April 2, 2016, Lisa repeatedly pushed the alarm intercom button in her cell, the beeping from which could be heard throughout 8C. Defendant Harris ordered Lisa to stop pushing the

alarm button, assuring her that she could "get medical" in the morning, which Defendant Harris failed to ever arrange.

31. During that same night and early morning, Lisa continued seeking help, and Defendant Harris was heard at one point saying to her that she would not even talk to Lisa and that she was going to write her up for continuing to push the alarm button. During the entire evening and early morning, Harris failed and refused to provide or obtain timely and proper monitoring, evaluation, medical care, and treatment for Lisa, which failure and refusal constituted deliberate indifference to Lisa's serious medical needs and constitutional right to receive medical care for her serious medical condition while incarcerated in the Salt Lake County Metro Jail.

32. Between 4 a.m. and 6 a.m., Lisa was again heard crying out, obviously miserable in her pain and suffering and seeking help. At one point, Lisa was so desperate to get out of her cell, where she was still locked down, that she tried to get her arm and body through the cuff-port in her cell door. Lisa was, and had been, out of her mind in pain, confusion, sickness, and desperation—all of which was obvious to anyone caring to pay attention, and which was obvious to other detainees, but which was deliberately and entirely ignored by the indifferent, uncaring, mean-spirited, and callous Guard Defendants and Nurse Defendants.

33. Between 6 a.m. and 8 a.m. on April 2, 2016, Lisa cried out loudly, obviously extremely sick and begging for help, leading Johnson to believe she was listening to someone dying then and there. None of the Defendants paid any attention to Lisa; none of them provided any monitoring, evaluation, medical care or treatment for her; and none of them arranged for any monitoring, evaluation, medical care or treatment for her, notwithstanding the obvious need for immediate medical attention.

34. Around 6:30 a.m. on April 2, Defendant Tucker entered 8C. Defendant Tucker was responsible for being a gatekeeper for other medical personnel capable of treating Lisa's condition and consistently and outrageously failed and refused to fulfill his gatekeeper role when there was such an obvious need for treatment or referral to diagnose, monitor, and treat the life-threatening illness, pain, and suffering experienced by Lisa. Defendant Tucker did not speak with Lisa, he did not check on or monitor her, and he did nothing to obtain medical assistance for her or to determine if she required medical assistance and, if so, the urgency of obtaining the assistance.

35. At about 8 a.m. on April 2, Defendant Frederickson walked along cells on both tiers in 8C. When he arrived at Johnson's cell, she spoke to him through the door, asking him if he had checked on "that girl" and stating that she [Lisa] needed "medical." Frederickson's appalling response was that he had just checked on Lisa

and that she was "fine"—then he said, "If she dies it will be your fault," laughing as if it were all a joke. Then he added, "Well, she's not going to die on my watch." As it turned out, Lisa had virtually died at that point. Johnson walked to Lisa's cell, where Lisa was still locked in, looked into Lisa's window, and saw her body on the floor, leaned against the bunk, with her head all the way back, mouth open, and her eyes open. Johnson yelled at Defendant Frederickson, "She's not breathing . . . . You said you just checked her!"

36. Lisa was found in full cardiac and respiratory arrest, CPR was administered, and Lisa was finally transported to a hospital by an ambulance, but it was too late. Lisa was pronounced dead at 1:14 a.m. on April 3, 2016.

37. From the time Lisa was found unresponsive in her cell until she was pronounced dead, she never regained consciousness. Because of the absence of monitoring and charting by the Guard Defendants and Nurse Defendants, and because no one from the Salt Lake County Metro Jail informed medical personnel at the hospital of Lisa's obvious symptoms of abdominal pain, the physicians and nurses at the hospital were deprived of vital information that should have been made available to them about Lisa's severe abdominal pain, as well as all other information relevant to her medical condition that was, or should have been, available from Nurse

Defendants and Guard Defendants, and which adequate policies, procedures, practices, custom, training, and supervision would have caused to be available.

38. Lisa's death would have been prevented if any of the Guard Defendants or Nurse Defendants had called for qualified medical assistance or if Nurse Defendants had even provided the most rudimentary diagnostic evaluation procedures, such as checking Lisa's blood pressure, temperature, or pulse, palpating her abdomen, or conducting an examination for rebound tenderness, and then taken the obviously necessary steps that would have led to Lisa being further examined and immediately treated. Lisa's blood pressure and other vital signs were never checked the entire time she was in 8C, despite her many cries for help and despite the adamant demands of at least one other detainee that Lisa's blood pressure and other vital signs be checked. Had Lisa's vital signs been checked, it would have been even more readily apparent that she required urgent medical care.

39. Because of the Defendants' failures to respond to Lisa's obvious life-threatening medical condition, she died from the effects of peritonitis, which is life-threatening if not treated and causes extreme pain and suffering, as well as dehydration, before death. According to the Medical Examiner, Lisa "died as a result of peritonitis due to gastrointestinal perforation at the anastomosis site of a remote

gastric bypass. The decedent's medical history is significant for Crohn's disease which may have been a contributing factor to the perforation."

40. Other complications of peritonitis are dehydration and loss of appetite. Had the Guard Defendants or Nurse Defendants arranged for a competent medical professional to evaluate Lisa, such a medical professional would have recognized the symptoms exhibited by Lisa as being life-threatening and requiring immediate medical attention.

41. Lisa's temperature right after she had been taken from the Salt Lake County Metro Jail was 93.6 degrees Fahrenheit, which was extremely low and could easily have been determined had she been provided any semblance of medical diagnosis or treatment, or even simply the taking of her vital signs, while under the control and experiencing the extraordinary neglect and deliberate indifference of the Guard Defendants and the Nurse Defendants at the Salt Lake County Metro Jail.

42. Hours and days before Lisa's death, Lisa's medical history, her history of not eating for days before her death, her dehydration (which could easily have been checked and ascertained), her severe, obvious abdominal pain, and other symptoms would have caused any competent medical professional who evaluated her to recognize that, whatever she was suffering from, she needed emergency

medical diagnosis and treatment, which would have saved Lisa's life and prevented her from experiencing the incomprehensible agony she suffered before her death.

43. In light of the patent seriousness of Lisa's severe medical condition, which was obvious to all—upon seeing her and upon hearing her—which Lisa repeatedly validated by her many desperate complaints of pain and misery and her cries for help, (1) the failures and refusals of the Guard Defendants to monitor or arrange for monitoring, evaluation, medical diagnosis, medical care and treatment and (2) the failures and refusals of the Nurse Defendants to monitor, diagnose, evaluate, and treat, or to arrange for monitoring, evaluation, diagnosis and medical care and treatment by a medical professional competent to recognize and treat Lisa's deadly peritonitis, each constituted outrageous and deliberate indifference to Lisa's urgent and critical medical condition.

44. The failures and refusals by the Nurse Defendants to (1) provide medically necessary monitoring, evaluation, the taking and recording of vital signs, diagnosis, and medical care and treatment for Lisa, (2) notify a physician of Lisa's serious medical condition, or (3) arrange for such monitoring, evaluation, diagnosis, or medical care and treatment by a medical professional competent to diagnose and treat Lisa, constituted deliberate indifference insofar as they had a responsibility to serve as a gatekeeper for other medical personnel capable of treating Lisa's

condition, yet failed and refused to fulfill that gatekeeper role in the face of the obvious need for treatment or referral for Lisa while she was obviously suffering a deadly medical emergency with attendant obvious and extreme pain and suffering.

45. Such failures and refusals by the Nurse Defendants to provide, or arrange for, medically necessary diagnosis and treatment for Lisa constituted an extraordinary degree of neglect insofar as (1) they recognized their inability to treat Lisa due to the seriousness of her condition and their lack of expertise, but refused and failed to obtain medical help for Lisa; (2) they failed to treat, or obtain treatment for, Lisa's extreme abdominal pain and suffering, the existence and severity of which medical condition was so obvious that even a layperson would, and laywomen detainees did, recognize the condition and its deadly seriousness; and (3) they entirely denied monitoring, evaluation, medical care and treatment although they were presented with recognizable symptoms which created and obviously signified a severe medical emergency. The Nurse Defendants completely refused to fulfill their duty as medical gatekeepers when they observed obvious signs of Lisa's medical emergency, but neither treated nor summoned medical assistance despite Lisa's and others' pleas that Lisa receive medical attention. The Nurse Defendants chose to provide no treatment for Lisa rather than treatment or referral for treatment that professional judgment obviously dictated.

46. Richard Bell, who at all material times was the "Responsible Health Authority" of the Salt Lake County Metro Jail and responsible at the Salt Lake County Metro Jail (1) to arrange for all levels of health care; (2) to assure the quality, accessibility, and timeliness of health services for inmates; (3) for the training and supervision of all medical personnel; and (4) for the formulation, adoption, execution, implementation, and enforcement of all policies, procedures, and officially sanctioned customs relating to the provision of medical care at the Salt Lake County Metro Jail, and Pamela Lofgreen ("Lofgreen"), who at all times material hereto was the Salt Lake County Sheriff's Office Chief Deputy and Commander of the Salt Lake County Metro Jail, in charge of setting and implementing the policies and procedures for, and providing supervision over, the Salt Lake County Metro Jail and its employees, each were supervising officials at the Salt Lake County Metro Jail, responsible for assuring that detainees received necessary medical services. Bell and Lofgreen had the power and duty to alleviate the conditions which led to the constitutional violations suffered by Lisa, but they failed and refused to alleviate the conditions.

47. The Salt Lake County Jail Health Services Unit Policies and Procedures includes a policy entitled "RESPONSIBLE HEALTH AUTHORITY" that states as follows:

> The responsible health authority (RHA) arranges for all levels of health care and *assures quality, accessible and timely health services for inmates*. . . . The RHA is responsible for overseeing the medical, mental health, and dental services, including reviewing the *accessibility, the quality, and the timeliness of health services provided in the Jail*. (Emphasis added.)

48. The Salt Lake County Jail Health Services Unit Policies and Procedures includes a policy entitled "ACCESS TO CARE" that states as follows:

> PURPOSE: To ensure that patients have access to health care to meet their serious medical, dental, and mental health needs.
> POLICY: It is the responsibility of the RHA to ensure that the Health Services Unit policies allow patients unrestricted access to health care in a timely manner, and that the policies are enforced so that there are not any barriers to patients receiving professional clinical judgments about their health care needs, and that care ordered is received.

Bell's Customs and Policies Regarding Medical Records

49. Bell was responsible for ensuring that nurses at the Salt Lake County Metro Jail were trained to document medical records in a manner that would allow incarcerated people to receive adequate, reasonable, and timely health services. Bell, with deliberate indifference toward the medical needs of incarcerated people, failed and refused to carry out that responsibility. Instead, he created, condoned, and failed to remedy a custom, culture, and practice that encouraged and led to the training and supervision in such a manner that nurses failed to provide material, accurate information in medical records and treated medical record-keeping in a sloppy,

dangerous, casual manner, putting the health, safety, and lives of incarcerated people at risk. For example:

a. Bell, reflecting his own deliberate indifference and perpetuating a custom of deliberate indifference at the Salt Lake County Metro Jail, actively endorsed, condoned, promoted, and failed to correct an unconstitutional policy and custom of nurses creating medical records that obscure and minimize any indications that staff had committed medical errors or that an incarcerated person's safety was in jeopardy as a result of the conduct or decisions of medical staff.

b. Bell ratified, condoned, promoted, and failed to remedy the unconstitutional decisions of subordinates to train nurses to create medical records that obscure and minimize any indications that staff had committed medical errors or that an incarcerated person's safety was in jeopardy as a result of the conduct or decisions of medical staff. In general, Bell ratified, condoned, promoted, and failed to remedy the policy of making, and the training of medical staff at the jail to make, notations in medical records with a primary view toward protecting the County and its staff from accountability, legal and otherwise. That training was part of a widespread practice, amounting to and creating an unconstitutional custom, at the Salt

Lake County Metro Jail, of carelessly and often erroneously documenting patients' medical records, which was actively endorsed, condoned, ratified, and not remedied by Bell.

50. As a result of the unconstitutional training, policies, and customs relating to the creation and maintenance of medical records, which encouraged and condoned sloppiness and callous disregard of the need for accurate and comprehensive medical records, nurses who made notations in Lisa's medical record misrepresented or fabricated Lisa's vital signs and withdrawal assessment scores and omitted critical information about Lisa's medical condition, reflecting deliberate indifference in the monitoring, evaluation, and treatment of incarcerated people at the Salt Lake County Metro Jail. For instance, Lisa's medical record maintained by the Salt Lake County Metro Jail contained the following glaring errors and omissions:

(a) On March 30, 2016, Lisa's respiration rate was recorded as being 98 breaths per minute.

(b) On March 30, 2016, Lisa's oxygen saturation rate was recorded as being zero.

(c) On the afternoon of March 31, 2016, Lisa's resting heart rate of 133 beats per minute was scored as a "2" on the Clinical Institute Withdrawal

Assessment ("CIWA") worksheet, even though a resting heart rate at or above 110 beats per minute was required to be scored as a "4."

(d) Throughout Lisa's electronic medical record, the times recorded for her CIWA and Wellcon Opiate Withdrawal Scale ("WOWS") assessments and the monitoring of her vital signs do not reflect the actual times those assessments and monitoring occurred.

(e) On April 2, 2016, Lisa's weight was recorded as 200 pounds, falsely reflecting an impossible weight gain of 76 pounds since Lisa's weight measurement on March 30, 2016.

(f) In violation of written policies requiring documentation in the medical record about "communication with outside resources that might have relevant information about the patient," nowhere in the medical records is there any mention of the highly relevant information that:

i. Defendant Booth communicated to Defendant Seewer about Lisa's "pain" on the afternoon of April 1, 2016.

ii. Lisa was screaming and crying out in pain throughout the night, as heard by housing officers and other incarcerated people.

iii. Lisa constantly asked for a nurse throughout the night.

iv. Lisa was repeatedly pressing her emergency button throughout the night, approximately sixteen separate times, asking over the intercom for medical help.

v. Other incarcerated people told housing officers that Lisa had not received medical treatment and they were concerned Lisa was going to die if she did not receive immediate medical treatment.

vi. According to Defendant Harris (but unsupported by any other evidence), she called a nurse during the night about the concerns other incarcerated people had that Lisa was going to die.

vii. Defendant Frederickson communicated in person with Defendant Tucker and nurse Colby James, as well as by telephone and radio with Defendant Tucker, about Lisa's "medical concerns" on the morning of April 2, 2016.

(g) In "assessing" Lisa pursuant to the CIWA protocol on the afternoon of March 31, 2016, one or more nurses violated written policies, protocols, and physician orders by failing to measure or record anything at all regarding Lisa's (i) signs and symptoms of tremor; (ii) signs and symptoms of paroxysmal sweats; (iii) signs and symptoms of anxiety; (iv) signs and symptoms of agitation; (v) signs and symptoms of tactile

disturbances; (vi) signs and symptoms of auditory hallucinations; (vii) signs and symptoms of visual disturbances; (viii) signs and symptoms of headache; (ix) orientation to time, place, and person; (x) signs and symptoms of agitation; or (xi) total CIWA score, all of which were required to be recorded by a nurse on the CIWA form for Lisa.

(h) Lisa's electronic medical record maintained by the Salt Lake County Metro Jail does not include the majority of Lisa's substance withdrawal assessments and nearly all of the measurements of Lisa's vital signs were not entered in Lisa's electronic medical record as text or displayed within the graphical representation of her vital signs.

(i) Lisa's electronic medical record maintained by the Salt Lake County Metro Jail does not include any information about why, in blatant violation of written policies, protocol, and physician orders, no one bothered to measure and record Lisa's vital signs or to conduct her CIWA and WOWS assessments on the afternoon of April 1, 2016, or morning of April 2, 2016.

(j) Lisa's medical record maintained by the Salt Lake County Metro Jail contained false, misleading, and fabricated entries for the morning of April 1, 2016, reflecting that her systolic blood pressure was 105, her

diastolic blood pressure was 75, her heart rate was 95, her temperature was 97.6 degrees Fahrenheit, and her respiratory rate was 18 breaths per minute, all of which were very unlikely, even perhaps impossible, given Lisa's medical condition.

51. Despite the numerous glaring errors and omissions in Lisa's medical record, which Bell has admitted violate written policy, Bell made no recommendations for any changes in either policy or practice after reviewing what happened to Lisa. In fact, neither Bell nor anyone else purportedly reviewing Lisa's medical record after her death even recognized or noted any of the numerous glaring errors and omissions in Lisa's medical record.

52. Bell actively endorsed, implemented, encouraged, and condoned a custom at the Salt Lake County Metro Jail that nurses were not required to make any notation in the medical record if the nurse is made aware of an incarcerated person screaming out in pain and requesting medical treatment. Bell also failed, with deliberate indifference toward the medical needs of incarcerated people, to ensure that nurses at the Salt Lake County Metro Jail created and maintained proper and complete medical records, including noting instances where an incarcerated person screams out in pain and requests medical attention.

53. As a result of that custom, nothing in Lisa's medical record reflects, as was obvious to everyone in Unit 8C on April 1 and April 2 of 2016, that Lisa had been crying out and screaming in extreme pain and distress and pleading for medical help, all of which indicated she was experiencing a life-threatening medical emergency.

54. Because nothing about Lisa's horrific pain, extreme distress, or pleas and screams for help was noted in the medical record, all medical personnel who reviewed Lisa's medical records prior to her being pronounced dead were deprived of critical information about Lisa's signs and symptoms, including Defendant Tucker, who purportedly reviewed Lisa's medical record within two hours before Lisa was found unresponsive and not breathing in her cell.

55. Because of the inaccurate and incomplete information contained in Lisa's medical record, all medical professionals were denied the knowledge of an accurate history of Lisa's vital signs, withdrawal assessment scores, Lisa's screaming out in pain and begging for medical help, and other signs and symptoms of her life-threatening medical condition. As a result, Lisa's obviously life-threatening medical condition was callously ignored by Nurse Defendants and Guard Defendants until she was found unresponsive and not breathing in her cell.

Bell's Customs and Policies Regarding Responses to Substance Withdrawal, Abdominal Pain, and Requests for Medical Help

56. Even though the Salt Lake County Metro Jail is responsible for providing medical care for more patients experiencing substance withdrawal than any substance abuse facility in the state of Utah, Bell, with deliberate indifference toward the medical needs of incarcerated people, failed to ensure that staff employed at the Salt Lake County Metro Jail, including nurses and housing officers, were trained to recognize, or ensure the determination of, whether the signs and symptoms of serious medical conditions suffered by incarcerated people, which may indicate a life-threatening emergency such as severe abdominal pain and distress, are the result of substance withdrawal or a different life-threatening medical condition that requires immediate medical attention.

57. Bell, with deliberate indifference toward the serious medical conditions of incarcerated people, implemented and actively endorsed an unconstitutional policy, and widespread practice amounting to a custom, that incarcerated people who were believed to be at risk for substance withdrawal would not receive evaluation or diagnosis to determine whether their signs and symptoms of serious medical problems, including abdominal pain and distress, resulted from substance withdrawal or a life-threatening medical condition other than substance withdrawal.

Also, Bell, with deliberate indifference toward the serious medical conditions of incarcerated people, failed to ensure that incarcerated people who were believed to be at risk for substance withdrawal received evaluation, monitoring, or diagnosis to determine whether signs and symptoms of medical conditions, including abdominal pain and distress, resulted from substance withdrawal or a life-threatening medical condition other than substance withdrawal.

58. As a result of the policy, custom, and deliberately indifferent failure to train nurses and housing officers described in paragraphs 56 to 57 above, any incarcerated person who was identified as being at risk for substance withdrawal and who experienced severe abdominal pain and obvious distress, such as someone whose appendix ruptured or, as in Lisa's case, experienced a perforated peptic ulcer and peritonitis, was virtually guaranteed to be ignored, with staff at the Salt Lake County Metro Jail assuming that the person's signs and symptoms were simply the result of common substance withdrawal.

59. As a result of the unconstitutional policy, custom, and deliberately indifferent failure to train nurses and housing officers described in paragraphs 56 to 57 above, for which Bell is responsible, Lisa's horrific abdominal pain and obvious distress were ignored, and Lisa did not receive any monitoring or any form of evaluation for her abdominal pain. A simple evaluation for abdominal pain on April

1 or April 2 of 2016, which could have included simply inquiring about the history, severity, and area of pain, and conducting simple tests such as for rebound tenderness, which takes only seconds to perform and requires no equipment, would have conclusively shown that Lisa was experiencing a life-threatening medical emergency and immediately required further urgent evaluation, diagnosis, and treatment.

60. Bell actively endorsed, implemented, and condoned an unconstitutional custom of ignoring requests for medical help, including in conjunction with signs and symptoms of abdominal pain. Bell also failed, with deliberate indifference toward the medical needs of incarcerated people, to ensure that staff at the Salt Lake County Metro Jail adequately and timely responded to requests for medical help made by incarcerated people, including in conjunction with signs and symptoms of abdominal pain.

61. Bell actively endorsed, implemented, encouraged, and condoned an unconstitutional custom of ignoring complaints of pain and distress from incarcerated people who had been identified as being at risk for substance withdrawal. Bell also failed, with deliberate indifference toward the medical needs of incarcerated people, to ensure that staff at the Salt Lake County Metro Jail

adequately and timely responded to complaints of pain and distress made by incarcerated people who were identified as being at risk for substance withdrawal.

62. That unconstitutional custom led housing officers and nurses to simply leave incarcerated people they assumed were suffering from substance withdrawal in their cells, without monitoring, medical evaluation, or treatment, to withdraw cold turkey and often missing many meals without any medical evaluation or intervention whatsoever.

63. The unconstitutional customs described in paragraphs 60 to 61 above were in contravention of formal policy at the Salt Lake County Jail that housing officers are to contact a nurse about each and every instance in which an incarcerated person contacts a housing officer and requests medical assistance, and nurses are to respond as soon as possible and evaluate the incarcerated person.

64. The customs described in paragraphs 60 to 61 above were also in contravention of written policy that all matters of medical and nursing judgment are the sole responsibility of Health Services personnel.

65. As a result of the customs described in paragraphs 56 to 57 and 60 to 61 above, and reflecting them:

(a) Bell contends that nothing indicated Lisa was experiencing a medical emergency—and even contends that, based on what he currently knows,

there is nothing that indicates Lisa was suffering a serious medical condition—even though Lisa died from her untreated emergency medical condition, she had been crying out in pain all night and repeatedly asked to see a nurse, and it was obvious to numerous incarcerated people, who reported their concerns to housing officers, that Lisa was experiencing a medical emergency.

(b) If Defendant Seewer "cleared" Lisa to remain in her housing unit, which is not reflected in any medical or other records except one notation by a medically untrained housing officer, he did so (i) without performing any evaluation or test related to Lisa's abdominal pain, (ii) without ascertaining or recording Lisa's vital signs, (iii) without recording any information at all in Lisa's medical record, and (iv) despite the fact that Lisa was exhibiting obvious signs of extreme abdominal pain and distress and was desperately pleading for emergency medical help, circumstances which incarcerated people in the same housing unit, as laypeople, found obviously indicated that Lisa was extremely sick, was in severe pain, may very well be dying, and was in need of immediate medical treatment.

(c) Defendant Booth failed to do anything for Lisa from approximately 3:30 p.m. on April 1, 2016, through the end of his shift at approximately 10:00

p.m. on April 1, 2016, even though Lisa was exhibiting obvious signs of extreme abdominal pain and distress and was desperately pleading for emergency medical help.

(d) A housing officer informed at least one central control room operator, Scott Sparkuhl, that he should ignore communications from Lisa through her emergency button and intercom about her extreme abdominal pain and her urgent need for medical assistance.

(e) Scott Sparkuhl, a central control room operator who was directed by a housing officer to ignore communications from Lisa's cell did, in fact, ignore communications from Lisa through her emergency button and intercom about her extreme abdominal pain and her urgent need for medical assistance, as well as ignoring communications from at least two other incarcerated people, through their emergency buttons and intercoms, indicating that Lisa was in severe distress.

(f) Defendant Harris failed to do anything for Lisa for the entirety of Defendant Harris's shift, from approximately 10:00 p.m. on April 1, 2016, until approximately 6:00 a.m. on April 2, 2016, other than tell Defendant Frederickson, at the end of Harris's shift and the beginning of Frederickson's shift, that Lisa had been crying and screaming all night

and constantly asked to see a nurse, which Defendants Harris and Frederickson failed even to note in their shift logs.

(g) Defendant Frederickson failed, from approximately 6:00 a.m. through approximately 8:00 a.m. on April 2, 2016, to communicate over the radio or otherwise that a nurse needed to immediately respond to Lisa's obvious and extreme abdominal pain and distress.

(h) Defendant Frederickson, in conformity with the customs and policies in place at the Salt Lake County Metro Jail, which Bell actively endorsed, ratified, and failed to remedy, failed to disclose to either Defendant Tucker or Nurse Colby James that (1) Lisa displayed obvious signs and symptoms of extreme abdominal pain and distress; (2) Defendant Frederickson was briefed at the beginning of his shift that Lisa had been crying and screaming all night and had been constantly pressing her emergency button all night long asking for a nurse; and (3) another incarcerated person informed Defendant Frederickson that she was worried Lisa was going to die and that no medical personnel had come to help Lisa.

(i) Defendant Tucker failed to do anything for Lisa even though Defendant Tucker was in Unit 8C, within a few yards of where Lisa was located,

within two hours prior to Lisa being found unresponsive and not breathing in her cell. Additionally, Defendant Tucker baselessly and erroneously assumed, without any medical evaluation, that Lisa's abdominal symptoms, as reported to Defendant Tucker by Defendant Frederickson, were caused by substance withdrawal.

(j) While Nurse Colby James was in Unit 8C minutes before Lisa was found unresponsive and not breathing in her cell, he failed to even walk over to Lisa's cell when he was informed by Defendant Frederickson that Lisa was seeking medical help. Colby James's failure to do so was in conformity with established unconstitutional customs at the Salt Lake County Jail, which Bell actively endorsed, ratified, and failed to remedy, even if Colby James knew that Lisa had been crying out in pain, begging for medical treatment, hitting the emergency button all night long, and that another inmate had expressed her concern that Lisa had not received medical treatment and was going to die. Colby James's justification for not walking to where Lisa was located and evaluating her was that she had not filled out a sick call request form, although the written policy of the jail was that if incarcerated people had what they believed to be an emergency medical condition, they were not to fill out sick call request

forms, but, instead, they were to inform a housing officer and that officer was to notify a nurse, who was to visit and evaluate the incarcerated person as soon as possible.

(k) For approximately twenty-two hours before Lisa was found unresponsive and not breathing in her cell, Lisa received no meaningful evaluation, did not even have her vital signs measured and recorded, and was provided no medical treatment or referral for treatment, even though Lisa (i) repeatedly and loudly complained of horrific pain, (ii) repeatedly and urgently asked to see a nurse, (ii) cried out and screamed all night asking for help, (iii) pressed her emergency intercom button all night asking for a nurse, and (iv) was so obviously in need of emergency medical intervention that other incarcerated people repeatedly told housing officers that Lisa needed immediate medical help and that she might die if she did not receive it.

66. Written policy applicable at the Salt Lake County Metro Jail required that when an incarcerated person on a substance withdrawal protocol exhibited certain signs of withdrawal, including having a heart rate greater than 110 beats per minute, a nurse was to immediately contact a physician.

67. In direct contravention of that written policy, Bell actively endorsed, encouraged, condoned, and ratified an unconstitutional custom of nurses deliberately failing to contact a physician when an incarcerated person who was on a substance withdrawal protocol exhibited one or more of the specified signs of withdrawal, including having a heart rate greater than 110 beats per minute. Bell also failed, with deliberate indifference toward the medical needs of incarcerated people, to ensure that nurses at the Salt Lake County Metro Jail followed all written policies relating to substance withdrawal, including that nurses immediately contact a physician when an incarcerated person displays signs of withdrawal, including a heart rate greater than 110 beats per minute.

68. As a result of that unconstitutional custom, in direct violation of written policy, no one contacted a physician when Lisa's heart rate was measured to be 133 beats per minute on March 31, 2016.

69. As a direct result of a physician not being informed of Lisa's heart rate of 133, Lisa was denied a medical evaluation, monitoring, diagnosis, and emergency medical treatment, ultimately leading to Lisa's wrongful death.

70. Written policy applicable at the jail required that incarcerated people who were placed on the WOWS protocol or CIWA protocol for substance

withdrawal were to have an assessment, including having vital signs measured and recorded, twice daily for a period of five days.

71. Bell actively endorsed, encouraged, condoned, and ratified an unconstitutional custom of contradicting that written policy and failing to perform all required assessments under the WOWS and CIWA protocols. Bell also failed, with deliberate indifference toward the medical needs of incarcerated people, to ensure that nurses at the Salt Lake County Metro Jail complied with written policies and physicians' orders relating to substance withdrawal, including that all ordered assessments and monitoring of vital signs were completed.

72. Because Lisa was placed on the WOWS and CIWA protocols, written policy and physician orders required that Lisa was to have an assessment, including having her vital signs measured and recorded, twice daily for five days, beginning March 30, 2016.

73. In contravention of written policy, the WOWS and CIWA protocols, and physician orders, no one performed the required assessments for Lisa or measured and recorded Lisa's vital signs during the afternoon or evening of April 1, 2016, or the morning of April 2, 2016, which Defendant Seewer was required to perform or to ensure were performed by another nurse. Had the assessments been performed and had Lisa's vital signs been monitored, any trained medical staff

person would have recognized that Lisa was suffering from a serious, perhaps life-threatening, medical condition and Lisa would have been urgently provided, or transported for, diagnosis and emergency treatment for her life-threatening peritonitis. Lisa would have survived had Defendant Seewer not been working in a culture and pursuant to a custom of sloppy, unaccountable, dismissive, and reckless medical monitoring and care, for which Bell was responsible, where Seewer did not even know it was his responsibility to make certain that the CIWA and WOWS assessments of Lisa were performed and that her vital signs were monitored on the afternoon of April 1, 2016.

74. Bell's active endorsement, encouragement, condonation, and ratification of the unconstitutional custom of failing to perform all required evaluations under the WOWS and CIWA protocols includes Bell's failure to take any corrective action after learning that Defendant Seewer failed to perform the WOWS and CIWA evaluations for Lisa Ostler, as he was required to do, on the afternoon of April 1, 2016.

75. As a direct result of Lisa not being evaluated pursuant to the WOWS and CIWA protocols and not having her vital signs measured and recorded, Lisa was denied a medical evaluation, monitoring, diagnosis, and emergency medical treatment, ultimately leading to Lisa's wrongful death.

Bell's Customs Regarding Nurses' Entertainment Activities on the Job

76. As the result of Bell's failure to provide appropriate supervision and training, nurses and mental health workers at the Salt Lake County Metro Jail routinely spent hours during their shift, while not on break, engaged in personal entertainment such as watching movies, watching YouTube videos, and browsing the internet.

77. Bell actively endorsed the unconstitutional custom of medical personnel engaging in entertainment activities while on the job. Bell also failed, with deliberate indifference toward the medical needs of incarcerated people, to ensure that nurses worked while they were at work, which would obviously require that nurses not be allowed to openly and notoriously spend hours a day watching videos, browsing the internet, and otherwise entertaining themselves with personal recreational activities.

78. Bell failed to supervise nurses to prevent them from spending portions of their shifts engaged in personal entertainment activities.

79. As a direct result of Bell's endorsement of, and failure to prevent, nurses from spending portions of their shifts engaged in personal entertainment activities, nurses became accustomed to not attending to incarcerated people's needs and, hence, because of a culture of indifference toward the serious medical needs of

incarcerated people, for which Bell was responsible, no nurse provided any form of medical intervention for Lisa's life-threatening medical emergency until Lisa was found unresponsive and not breathing in her cell.

Bell's Customs and Policies Regarding Review of In-Custody Deaths

80. Bell was responsible, in the case of each in-custody death, to participate in a "morbidity and mortality" review to "determine the appropriateness of custody and medical's emergency response actions surrounding the death" and to "assess the appropriateness of medical care received prior to the death."

81. In complete dereliction of his duties to assure that health services for incarcerated people are accessible, timely, and of appropriate quality, and to identify and remedy practices and policies that contribute to or cause the deaths of incarcerated people, Bell has ignored and does not even know the circumstances of the deaths of incarcerated people who died in the Salt Lake County Jail while Bell was the Responsible Health Authority; in fact, he does not even know the names of many incarcerated people who have died during the time he has been the top person responsible for (i) the quality, responsiveness, and timeliness of medical care provided at the Salt Lake County Metro Jail, (ii) thoroughly investigating the causes of deaths of inmates and whether there were problems in the provision of medical

care contributing to the deaths, and (iii) taking measures to prevent unnecessary deaths in the future.

82. Indicative of Bell's normal practice in the case of in-custody deaths, for at least one year after Lisa's death, Bell did nothing to obtain information from Defendants Holly Harris, Todd Booth, or Ron Seewer about the circumstances leading up to Lisa's death.

83. Indicative of Bell's normal, careless, slip-shod practice in connection with in-custody deaths, when Bell participated in a "morbidity and mortality" review to "determine the appropriateness of custody and medical's emergency response" relating to Lisa's death and "assess the appropriateness of medical care" provided to Lisa, none of the participants were aware of Lisa's cause of death, there had not even been interviews of many important witnesses in possession of highly relevant information, and a purported review of the medical records missed at least six glaring errors and omission in Lisa's CIWA and WOWS assessment records, including the fact that no one had monitored Lisa's vital signs during the approximately twenty-two hours before she was found unresponsive and not breathing, in violation of medical orders and formal jail policies, which led to Lisa's wrongful death.

84. Bell further actively endorsed and ratified a custom and policy of maintaining no records of communications during the "morbidity and mortality"

reviews, undermining even the possibility that corrective actions could be taken in response to the numerous in-custody deaths at the Salt Lake County Metro Jail.

85. Through Bell's actions and omissions, he actively endorsed, implemented, encouraged, and condoned an unconstitutional custom and culture of deliberate indifference toward the deaths of incarcerated people at the Salt Lake County Metro Jail and toward investigating and gaining knowledge about them so as to recognize problems and resolve them to protect other incarcerated people in the future.

86. Indicative of the culture and unconstitutional custom of deliberate indifference toward the deaths of incarcerated people, Defendant Zachary Frederickson, when he was informed by another incarcerated person that she was concerned Lisa was going to die if she did not receive emergency medical assistance, told that person that Lisa was not going to "die on my watch," but had failed to ensure that a nurse evaluated Lisa, even though two nurses physically came to the housing unit during Frederickson's shift before Lisa was found unresponsive and not breathing.

87. As a direct result of the unconstitutional custom and culture of deliberate indifference toward the deaths of incarcerated people, all staff at the Salt Lake County Metro Jail, including all housing officers, control room operators,

nurses, and supervisors, failed to medically intervene, or ensure that someone medically intervened, in response to Lisa's obviously life-threatening medical emergency until she was found unresponsive and not breathing in her cell.

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88. Lofgreen was at all material times the Chief Deputy Sheriff and Commander at the Salt Lake County Metro Jail and was responsible for (a) the management, supervision, and training of all officers at the Salt Lake County Metro Jail, (b) ensuring compliance with all official policies applicable at the Salt Lake County Metro Jail, and (c) ensuring that operations, policies, procedures, and customs at the Salt Lake County Metro Jail protected the constitutional rights of incarcerated people, including access to adequate and reasonable medical care.

Lofgreen's Customs and Policies Regarding Instructions to "Ignore" All Communications from a Particular Incarcerated Person

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89. In at least March and April of 2016, it was the unconstitutional custom at the Salt Lake County Metro Jail that housing officers could instruct a central control room operator to "ignore" communications from a cell, including ringing of an emergency bell and conversations over an intercom, which was commonly understood to mean an instruction that the central control room operator was to communicate to the housing officer only *new* information being reported by the

person in that cell and to otherwise ignore communications from that cell. Lofgreen condoned and ratified that custom, and permitted it to continue, in violation of her duties to ensure timely and adequate medical responses to urgent, serious medical conditions of incarcerated people. Lofgreen failed, with deliberate indifference toward the medical needs of incarcerated people, to ensure that central control room operators adequately and timely communicated information about the medical needs of incarcerated people to a housing officer and to ensure that housing officers adequately and timely communicated that information to a nurse, both of which would most obviously require that, absolutely, neither housing officers nor central control room operators could decide to "ignore" communications from a cell.

90. As a direct result of that custom, on April 1, 2016, a housing officer instructed Scott Sparkuhl, a central control room operator, to "ignore" Lisa's cell.

91. On the night of April 1, 2016, into the morning of April 2, Lisa communicated to Scott Sparkuhl through the emergency button and intercom in her cell approximately one to two times per hour, for a total of approximately sixteen communications throughout Scott Sparkuhl's eight-hour graveyard shift. In those communications, Lisa repeatedly informed Scott Sparkuhl that Lisa was in pain and needed medical help. As a direct result of the instruction he received to "ignore" Lisa's cell, Scott Sparkuhl only contacted a housing officer one or two times about

Lisa throughout the night and otherwise did not relay any information to anyone about Lisa's repeated communications about her pain and her urgent need for medical help.

92. Also because Scott Sparkuhl was instructed to ignore Lisa's cell, Scott Sparkuhl ignored communications from at least two other incarcerated people in the same unit where Lisa was located, who expressed their concerns about either Lisa's need for medical treatment or the amount of noise Lisa was making.

Lofgreen's Customs and Policies Regarding Failures to Log and Maintain Thorough and Accurate Information

93. Lofgreen actively endorsed and implemented a policy and custom at the Salt Lake County Metro Jail that housing officers were not allowed to record information in their logs about the medical complaints of incarcerated people. Lofgreen also failed, with deliberate indifference toward the medical needs of incarcerated people, to ensure that housing officers recorded all relevant and necessary information in their logs, including information relating to the medical complaints of incarcerated people. As a result of that policy and custom:

(a) Defendant Booth failed to note anything about Lisa's abdominal pain, obvious distress, and urgent pleas for medical help other than that Lisa

did not take her lunch tray because she was "sick" and that Defendant Seewer "examined" Lisa, who was "complaining of pain."

(b) Defendant Harris failed to log anything at all about Lisa, even though Lisa's condition was so severe and obvious that she was screaming, moaning, and crying out in pain all night, begging for medical help, and at least three or four incarcerated people spoke with Defendant Harris about their concerns that Lisa needed emergency medical intervention.

(c) Defendant Frederickson failed to log anything about Lisa's horrific abdominal pain, obvious distress, and urgent pleas for medical help other than that Lisa "refused breakfast," "has not eaten since she arrived in the unit yesterday," and "confirmed that she doesn't want to eat and also reports that she is bleeding vaginally."

(d) Because Defendants Booth, Harris, and Frederickson failed to log critical information about Lisa's emergency medical condition and urgent pleas for medical intervention, staff at the Salt Lake County Metro Jail on April 1 and April 2 of 2016, including nurses, housing officers, sergeants, and commanders, were unable to properly intervene to ensure that Lisa received emergency medical evaluation and treatment or referral for treatment.

94. Policy and custom at the Salt Lake County Metro Jail required that housing officers communicate to their supervising sergeants and a member of the Health Services staff about each instance in which an incarcerated person did not take a meal.

95. Lofgreen actively endorsed and implemented an unconstitutional policy and custom of deleting those records as soon as the incarcerated person did not refuse a meal tray, which could have been because the incarcerated person died or because the incarcerated person took the meal tray and did not eat any of the meal. Lofgreen also failed, with deliberate indifference toward the medical needs of incarcerated people, to ensure that accurate records, including emails from housing officers, reflecting the missed meals of incarcerated people were maintained and preserved.

96. As a result of that custom and policy, staff at the Salt Lake County Metro Jail failed to maintain accurate records relating to Lisa's missed meals, depriving nurses, housing officers, and their supervisors of accurate information about the duration and severity of Lisa's life-threatening medical emergency.

Lofgreen's Customs Regarding the Ignoring of Medical Complaints

97. At least during March and April of 2016, it was the unconstitutional custom at the Salt Lake County Metro Jail, which was condoned, encouraged,

ratified, and actively endorsed by Lofgreen, that housing officers could ignore the signs and symptoms of abdominal pain and emergency requests for medical help made by incarcerated people. Lofgreen also failed, with deliberate indifference toward the medical needs of incarcerated people, to ensure that housing officers informed medical personnel of all emergency requests for medical help and to ensure that housing officers did not fail to disclose in their communications with nurses all relevant information about an incarcerated person, including that an incarcerated person experienced signs and symptoms of abdominal pain.

98. As a result of, and reflecting, that unconstitutional custom, housing officers were provided no training whatsoever to recognize or appropriately respond to life-threatening abdominal conditions. Lofgreen knowingly failed to provide that training and ratified the decisions of her subordinates to not provide that training, all of which reflects the deliberate indifference of Lofgreen and Defendant Salt Lake County toward the constitutional rights and medical needs of incarcerated people.

99. Also as a direct result of that unconstitutional custom:

(a) Defendant Booth failed to do anything for Lisa from approximately 3:30 p.m. on April 1, 2016, through the end of his shift at approximately 10:00 p.m. on April 1, 2016, even though Lisa was exhibiting obvious signs of

extreme abdominal pain and distress and was desperately pleading for emergency medical help.

(b) A housing officer instructed at least one central control room operator, Scott Sparkuhl, to ignore Lisa's cell, and at least one central control room operator in fact did ignore calls from Lisa about her abdominal pain and urgent need for medical attention as well as calls from other incarcerated people about Lisa.

(c) Defendant Harris failed to do anything for Lisa for the entirety of her shift, from approximately 10:00 p.m. on April 1, 2016, until approximately 6:00 a.m. on April 2, 2016, other than tell Defendant Frederickson, at the end of Harris's shift and the beginning of Frederickson's shift, that Lisa had been crying and screaming all night and constantly asked to see a nurse, which Defendants Harris and Frederickson failed even to note in their shift logs.

(d) Defendant Frederickson failed, from approximately 6:00 a.m. through approximately 8:00 a.m. on April 2, 2016, to communicate over the radio or otherwise that a nurse needed to immediately respond to Lisa's obvious and extreme abdominal pain and distress.

(e) When Lisa desperately sought help from Defendant Frederickson for Lisa's horrific abdominal pain and reported to him that she was "bleeding," Defendant Frederickson baselessly, erroneously, and with deliberate indifference to Lisa's life-threatening abdominal condition assumed that Lisa was experiencing "vaginal bleeding," despite the fact that Lisa had not experienced vaginal bleeding, and thus would not have reported "vaginal" bleeding.

(f) Defendant Frederickson, in conformity with the customs and policies in place at the Salt Lake County Metro Jail, which were actively endorsed and ratified by Lofgreen, failed to disclose to either Defendant Tucker or Nurse Colby James that (1) Lisa displayed obvious signs and symptoms of extreme abdominal pain and distress; (2) Defendant Frederickson was briefed at the beginning of his shift that Lisa had been crying and screaming all night and had been constantly pressing her emergency button all night long asking for a nurse; or (3) another incarcerated person informed Defendant Frederickson that she was worried Lisa was going to die and that no medical personnel had come to help Lisa.

Bell's and Lofgreen's Customs and Policies Regarding the Failure to Train Housing Officers to Recognize and Respond to Abdominal Pain

100. Bell was responsible for ensuring that all staff at the Salt Lake County Metro Jail were properly trained so that people incarcerated at the Salt Lake County Metro Jail would receive quality, accessible, unrestricted, and timely health services. Bell personally reviewed and authorized the training provided to housing officers regarding CPR and first aid, which together constituted the only training housing officers received about recognizing signs and symptoms of serious medical conditions and responding to emergency medical conditions. Lofgreen was responsible for ensuring that all housing officers and their supervisors were properly trained so that people incarcerated at the Salt Lake County Metro Jail would receive adequate, reasonable, and timely health services.

101. Bell and Lofgreen, with deliberate indifference, each failed to adequately train, or ensure the adequate training of, housing officers at the Salt Lake County Metro Jail to recognize signs and symptoms of serious, life-threatening abdominal conditions and adequately respond to life-threatening abdominal medical conditions.

102. Bell and Lofgreen ratified the decisions of subordinates, who were delegated the responsibility of training housing officers, to provide no training

whatsoever to housing officers to recognize and adequately respond to life-threatening abdominal medical conditions.

103. As a result of Bell's and Lofgreen's deliberately indifferent failure to ensure housing officers were trained to recognize and adequately respond to life-threatening abdominal medical conditions, Defendants Booth, Harris, and Frederickson callously failed to provide an appropriate emergency-level response to Lisa's obvious signs of extreme abdominal pain and desperate pleas for help, leading to the failure by housing officers, nurses, and jail doctors to provide Lisa the timely evaluation and treatment to which she was constitutionally entitled, ultimately leading to Lisa's wrongful death.

Bell's and Lofgreen's Customs Regarding the Delegation of Responsibilities Among Housing Officers and Nurses

104. Bell and Lofgreen, with deliberate indifference toward the serious medical needs of incarcerated people, each perpetuated and ratified an unconstitutional custom at the Salt Lake County Metro Jail that housing officers, with no medical training, were expected or allowed to use their own discretion to determine whether the medical complaints of an incarcerated person were sufficiently serious to necessitate the housing officer to immediately notify a nurse

about the medical complaints so the nurse would immediately come to and evaluate the incarcerated person.

105. That custom was in direct contravention of policy at the Salt Lake County Jail that housing officers are to contact a nurse about each and every instance in which an inmate requests immediate medical assistance.

106. That custom was also in contravention of written policy that all matters of medical and nursing judgment are the sole responsibility of Health Services personnel.

107. As a result of that custom, Defendants Booth, Harris, and Frederickson, who were medically untrained and, specifically, untrained to recognize the signs and symptoms of serious abdominal medical conditions, each made their own determination, based on no medical training or knowledge whatsoever and without any medical evaluation or assessment, that the many requests for medical help made by Lisa did not require the housing officer to call a nurse about Lisa's medical condition and to get a nurse to come to and evaluate Lisa, even though she was exhibiting obvious signs of extreme abdominal pain and distress, she was communicating that she was suffering severe pain, and she was desperately pleading for emergency medical help, which custom led to Lisa not receiving timely

evaluation and treatment, to which she was constitutionally entitled and which ultimately led to Lisa's wrongful death.

108. With deliberate indifference toward the medical needs of incarcerated people, Bell and Lofgreen each actively endorsed, promoted, and condoned a custom at the Salt Lake County Metro Jail that housing officers, with no medical training, made medically baseless determinations as to whether an incarcerated person's medical complaint constituted a medical emergency and that nurses relied on those medically baseless determinations instead of going to see and evaluate the incarcerated person to determine if further evaluation, monitoring, diagnosis, or treatment was required. Bell and Lofgreen each failed, with deliberate indifference toward the medical needs of incarcerated people, to ensure that nurses, not housing officers, made all determinations about whether incarcerated people were suffering from medical emergencies.

109. That custom was in contravention of written policy that all matters of medical and nursing judgment are the sole responsibility of Health Services personnel.

110. As a result of that custom, Defendants Booth, Harris, and Frederickson each made their own determination, based on no medical training or knowledge whatsoever and without any medical evaluation or assessment, that Lisa would not

receive an emergency medical evaluation, a medical diagnosis, or treatment, or a referral for a medical diagnosis or treatment, even though Lisa was exhibiting obvious signs of extreme abdominal pain and distress and was desperately pleading for emergency medical help.

111. Also as a result of that custom, Defendant Tucker and Nurse Colby James, who are nurses with medical training, education, and certification, each requested, and left it to, Defendant Frederickson, a housing officer with no medical knowledge, training, or expertise, to determine whether it *appeared to Defendant Frederickson* that Lisa was having a medical emergency in the hours and minutes before Lisa became unresponsive and not breathing. Likewise, if, as she maintains (but which is not reflected or corroborated by any evidence, including the medical records, which have no notation of Lisa's vital signs during the entire approximately twenty-two hours she was in Unit 8C), Defendant Holly Harris called a nurse about Lisa, as a result of the custom described in paragraph 115, the nurse left it to Defendant Harris, a housing officer with no medical knowledge, training, or experience, to determine whether it appeared to Defendant Harris that Lisa was experiencing a medical emergency during the evening and early morning hours before Lisa became unresponsive and was not breathing.

112. The custom sanctioned by Bell and Lofgreen that housing officers were to determine whether an incarcerated person is experiencing a medical emergency led to Lisa not receiving the timely and efficacious evaluation, diagnosis, and treatment to which she was constitutionally entitled, and ultimately leading to Lisa's wrongful death.

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113. As high-ranking officials and administrators of the Salt Lake County Metro Jail, Bell and Lofgreen each had a constitutional duty to provide necessary medical treatment to inmates.

114. Bell failed to remedy serious incompetence and serious deficiencies in the health care system at the Salt Lake County Metro Jail, including deficiencies in training and procedures, that prevented the diagnosis and treatment of Lisa.

115. Lofgreen failed to remedy serious incompetence and serious deficiencies in the policies, practices, customs, and training given to housing officers, their supervisors, and central control room operators with respect to their role in ensuring that incarcerated people received adequate, timely, and reasonable health care.

116. At all times material hereto, Bell and Defendant Salt Lake County followed, established, and implemented a policy and custom of failing to train or

adequately supervise its officers and nurses who they were responsible for supervising at the Salt Lake County Metro Jail.

117. At all times material hereto, Lofgreen and Defendant Salt Lake County followed, established, and implemented a policy and custom of failing to train or adequately supervise housing officers and their direct supervisors.

118. The policies and customs of Bell, Lofgreen, and Defendant Salt Lake County constituted and reflected deliberate indifference to the serious medical needs and constitutional right of Lisa to receive proper and necessary medical care for her obviously serious, life-threatening medical condition while detained in the Salt Lake County Metro Jail. Those policies and customs also led to the infliction of punishment on Lisa, including the disregard of her serious medical condition and locking her down and refusing medical observation, with the intent to make her withdraw from drugs cold-turkey (when drug withdrawal is itself a serious medical condition), without any medical observation, evaluation, or treatment, in violation of her due process rights under the United States and Utah Constitutions.

119. Bell and Defendant Salt Lake County caused Lisa to be denied medical treatment for her serious medical condition insofar as they developed, adopted, implemented, condoned, administered, and failed to remedy policies, practices, patterns, customs, and a widespread culture of callousness and deliberate

indifference toward the serious, potentially life-threatening medical needs of incarcerated people, which were followed by the Nurse Defendants and Guard Defendants in their conduct described above, that (1) denied nurses and other jail personnel the ability or authority to obtain a physician's care for detainees; (2) permitted nurses and other jail personnel to conceal the existence of serious physical ailments from physicians; (3) depended on nurses to recognize and treat serious physical ailments; (4) enabled nurses to fail or refuse to provide medical care and to prevent detainees from receiving medical treatment from physicians; (5) created excessive delays in the provision of medical treatment by physicians; (6) permitted prison medical personnel to provide improper or inadequate treatment to seriously ill detainees; (7) failed to provide for or effectuate competent, timely, and responsive medical treatment for detainees; (8) allowed and caused nurses to provide no evaluation of abdominal pain when abdominal pain was disclosed; (9) encouraged nurses to ignore complaints of abdominal pain by inmates who were placed on a withdrawal protocol; (10) caused the failure to transition medical care and monitoring when an inmate is transferred from a quarantine unit to another housing unit; (11) permitted nurses to fail to perform essential job functions and instead spend multiple hours per shift watching videos on the internet and engaging in other personal and recreational activities entirely unrelated to the nurses' essential job

functions; (12) allowed nurses to defer to or allow medically untrained housing officers to determine whether an inmate is experiencing a medical emergency; (13) encouraged and permitted nurses to instruct inmates, directly or through housing officers, to complete a paper medical request form to seek medical help, even when the inmates' symptoms may indicate a medical emergency, and to otherwise ignore the inmates' requests for urgent medical help; (14) allowed nurses to fail to monitor and record the vital signs of inmates, even when in contravention of physician orders, protocols, and written policy applicable at the Salt Lake County Metro Jail; (15) allowed nurses to fail to determine, and fail to inquire about, an inmate's relevant medical history before determining that the inmate is "cleared" to remain in a housing unit with no further medical monitoring, evaluation, diagnosis, or treatment until at least the next day; and (16) allowed the falsification, deletion, and alteration of portions of inmates' medical records and the failure to note all relevant information in those medical records.

120. Bell, Lofgreen, and Defendant Salt Lake County caused Lisa to be denied medical treatment for her serious medical condition insofar as they developed, adopted, implemented, condoned, administered, and failed to remedy policies, practices, patterns, customs, and a widespread culture of callousness and deliberate indifference toward the serious, potentially life-threatening medical needs

of incarcerated people, which were followed by the Nurse Defendants and Guard Defendants in their conduct described above, that (1) permitted jail personnel to improperly or inadequately make, or fail to make, referrals for treatment by competent medical professionals to seriously ill detainees; (2) provided grossly inadequate training, or no training at all, to housing officers pertaining to the recognition of life-threatening medical situations, including life-threatening abdominal conditions, in contravention of written policy; (3) allowed jail staff to fail to instruct inmates during the intake and booking process how to request emergency medical assistance; (4) encouraged and permitted jail personnel to instruct inmates to complete a paper medical request form to seek medical help, even when the inmates' symptoms may indicate a medical emergency, and to otherwise ignore the inmates' requests for urgent medical help; (5) encouraged and permitted jail personnel to treat an inmate's request for medical help as an emergency only if the inmate is excessively bleeding, having a seizure, or not breathing; (6) allowed housing officers to withhold from nurses vital information about an inmate's request for medical help, such as, in Lisa's case, that she was suffering from extreme abdominal pain, was in obvious distress, was screaming and crying out throughout the night, and repeatedly begged to see a nurse, among other information; and (7)

allowed medically untrained housing officers to determine whether an inmate is experiencing a medical emergency.

121. The policies and customs developed, adopted, implemented, and administered by Bell, Lofgreen, and Defendant Salt Lake County denied Lisa and other inmates access to necessary medical care and demonstrate deliberate indifference to Lisa's and other inmates' serious medical needs in violation of the Fourteenth Amendment to the United States Constitution.

122. Bell knew, and reasonably should have known, that the policies, customs, patterns, practices, culture, failures to train, failures to supervise, and failures to carry out his responsibilities described in paragraphs 49–87, 100–112, 114, 116, and 118–120 above would cause employees at the Salt Lake County Metro Jail to deprive incarcerated people of their constitutional right to adequate and reasonable medical care.

123. As a direct result of the policies, customs, patterns, practices, culture, failures to train, failures to supervise, and failures to carry out responsibilities described in paragraphs 49–87, 100–112, 114, 116, and 118–120 above, employees at the Salt Lake County Metro Jail deprived Lisa of her constitutional right to adequate and reasonable medical care, causing her wrongful death.

124. Bell is responsible, due to his affirmative conduct, and, at minimum, his failures to take corrective action, for each of the policies, customs, patterns, practices, culture, failures to train, failures to supervise, and failures to carry out his responsibilities described in paragraphs 49–87, 100–112, 114, 116, and 118–120 above, which affirmatively link Bell's conduct, and failures to act, to the violations of Lisa's constitutional rights.

125. Lofgreen knew, and reasonably should have known, that the policies, customs, patterns, practices, culture, failures to train, failures to supervise, and failures to carry out her responsibilities described in paragraphs 89–112, 115, 117, 118, and 120 above would cause employees at the Salt Lake County Metro Jail to deprive incarcerated people of their constitutional right to adequate and reasonable medical care.

126. As a direct result of the policies, customs, patterns, practices, culture, failures to train, failures to supervise, and failures to carry out responsibilities described in paragraphs 89–112, 115, 117, 118, and 120 above, employees at the Salt Lake County Metro Jail deprived Lisa of her constitutional right to adequate and reasonable medical care, causing her wrongful death.

127. Lofgreen is responsible, due to her affirmative conduct, and, at minimum, failures to take corrective action, for each of the policies, customs,

patterns, practices, culture, failures to train, failures to supervise, and failures to carry out her responsibilities described in paragraphs 89–112, 115, 117, 118, and 120 above, which affirmatively link Lofgreen's conduct, and failures to act, to the violations of Lisa's constitutional rights.

128. As a result of the unconstitutional policies, customs, patterns, practices, culture, failures to train, failures to supervise, and failures to carry out their responsibilities described in paragraphs 49–87, 89–112, and 114–120, Bell, Lofgreen, and Defendant Salt Lake County established a deeply flawed system of delivering medical care at the Salt Lake County Metro Jail. That flawed system and those who established it were deliberately indifferent to the medical needs of incarcerated people, particularly those who were identified as being at risk for substance withdrawal. Under that flawed system, it was inevitable that Lisa's life-threatening medical condition would be ignored until Lisa was essentially dead. That flawed system: (a) caused housing officers to ignore and fail to communicate to nurses that Lisa was suffering obvious symptoms of a life-threatening emergency and was desperately pleading to see a nurse for many hours; (b) caused nurses to fail to intervene and to rely on medically untrained housing officers to determine whether Lisa was having a medical emergency, which the housing officers failed to do; and (c) caused nurses to violate written policies, protocols, and physician orders

by failing to assess Lisa, including measuring and recording her vital signs, for more than twenty-two hours before she was found unresponsive and not breathing.

129. The presence of gross deficiencies in the medical care system at the Salt Lake County Metro Jail, which led to the failures to provide or to obtain from a competent medical provider medical treatment and care of Lisa's severe, life-threatening medical condition, and the failure of Bell, Lofgreen, and Defendant Salt Lake County to remedy those deficiencies, demonstrated deliberate disregard for a known or obvious risk that was very likely to result in the violation of the constitutional rights of Lisa and other pretrial detainees held at the Salt Lake County Metro Jail. Consequently, those failures evidence deliberate indifference to Lisa's and others' serious medical needs by Bell and Salt Lake County.

130. Indicative of the culture, policies, procedures, and customs permitted, condoned, and perpetuated by Bell, Lofgreen, and Defendant Salt Lake County, which led to the grossly deficient and indifferent medical care system at the Salt Lake County Jail:

- Carlos Umana, a mentally ill inmate, was allowed to die of starvation and dehydration after spending four months in custody at the Salt Lake County Metro Jail.

- Alexa Hamme, 25 years old, was found unresponsive in her cell at the Salt Lake County Metro Jail and died after the failure to attend to her serious medical needs.
- Lindsey Goggin died as a result of severe dehydration while being held at the Salt Lake County Metro Jail.
- Dustin Bliss was found unresponsive in a holding cell in the booking area of the Salt Lake County Metro Jail and died, never having received adequate medical treatment at the Salt Lake County Metro Jail.
- Meagan Deadrich was 27-weeks pregnant when her baby died and she had to have her uterus removed, all because jail nurses brushed off her complaints of bleeding and simply told her that bleeding during pregnancy is normal.
- Scott Osterkamp fell off a top bunk and broke his arm, then jail staff refused to provide medical assistance for several days as he turned yellow and became incoherent, notwithstanding repeated calls to jail staff by his former wife who pleaded for medical assistance for Mr. Osterkamp, and, because of the delay in treatment, Mr. Osterkamp died after finally being transferred to a hospital.
- Angie Turner died of a stroke after pleading for help for weeks for her excruciating headaches while housing officers ridiculed her complaints about

her headaches and her slurred speech and used profanity to insult her for seeking medical help.

- Daniel Davis was murdered by another inmate, who had been expressing to others his rage toward Mr. Davis and his desire to kill him, but never received any mental health services.
- David Walker repeatedly expressed to many his extreme anxiety and fears, but he was never treated by nursing or mental health staff, leading him to commit suicide.

The deaths of detainees at the Salt Lake County Metro Jail have contributed to Utah having the highest rate of county inmate deaths per capita in 2016, with at least eleven inmates dying in county jails in 2015 and twenty-three in 2016.

131. As a direct and proximate result of the wrongful conduct and deliberate indifference of the Defendants, (1) Lisa consciously suffered severe and excruciating physical, emotional, and mental pain prior to her death; (2) Lisa's emergency medical condition, which could have been successfully treated had Defendants not been deliberately indifferent to her serious medical needs, and the pain and suffering she endured as a result of it, became far worse, leading to her premature death and her loss of the enjoyment of life and of the love, affection, and consortium of her parents and children and being able to enjoy the delight and pleasure of parenting

her beloved children; (3) medical, funeral, and cremation expenses for Lisa were incurred; (4) Lisa and her Estate lost substantial earnings based on the probable duration of Lisa's life had her serious medical condition been appropriately and constitutionally addressed and treated; and (5) Lisa and her Estate suffered other damages recognized at law, for which Defendants are liable to Plaintiff Calvin Donald Ostler, as personal representative of the Estate of Lisa Marie Ostler, for the benefit of Lisa's heirs, in an amount that shall be proven at trial.

132. Plaintiff is entitled to recover from and against the Defendants, jointly and severally, all damages sustained as a result of the Defendants' wrongful conduct and deliberate indifference, including but not limited to the damages described above and, in addition, all reasonable attorneys' fees and costs incurred in this action, pursuant to 42 U.S.C. §§ 1983 and 1988.

133. Plaintiff is further entitled to recover from and against the Defendants, except Salt Lake County, punitive damages, in an amount determined at trial, for the Defendants' willful, wanton, deliberate, reckless, and callous indifference toward Lisa's federally protected rights, which proximately caused the extreme, worsening, excruciating pain and suffering experienced by Lisa and her tragic and unnecessary death.

SECOND CLAIM FOR RELIEF
(Survival Action for Violations of the Utah Constitution, Article I, Sections 7 and 9)

For his Second Claim for Relief, Plaintiff complains against the Defendants and allege as follows:

134. Plaintiff repeats and incorporates by this reference the allegations set forth in paragraphs 1 through 133 above.

135. By their acts and omissions, as described above, Defendants deprived Lisa of her rights guaranteed by Article I, Section 7 of the Utah Constitution, which provides that "[n]o person shall be deprived of life, liberty or property, without due process of law," including their deliberately indifferent treatment of, and failure to treat, Lisa and their unlawful punishment of Lisa.

136. By their acts and omissions, as described above, Defendants deprived Lisa of her rights guaranteed by Article I, Section 9 of the Utah Constitution, which provides that "[p]ersons arrested or imprisoned shall not be treated with unnecessary rigor."

137. The only remedy for these violations of the Utah Constitution is under the common law, and because of the repugnance of Defendants' conduct and omissions and the strong interests of the State of Utah in discouraging similar future conduct and omissions, no special factors counsel hesitation by this Court in

providing or fashioning an appropriate remedy for the violations of Lisa's State constitutional rights in this case.

138. Lisa suffered flagrant violations by Defendants of her clearly established constitutional rights.

139. No existing remedies redress Lisa's pain, suffering, and unnecessary death. That is particularly true where different standards apply under the Due Process Clause of the Federal Constitution and the Unnecessary Rigor Clause of the Utah Constitution and it cannot be known until a jury verdict is returned whether a federal remedy will adequately redress the injuries and damages alleged herein.

140. Equitable relief, such as an injunction, was and is wholly inadequate to protect Lisa's rights or redress her pain, suffering, and unnecessary death as a result of Defendants' unconstitutional conduct and omissions.

141. The Guard Defendants and the Nurse Defendants intentionally denied and delayed access to medical treatment for Lisa, resulting in her extreme pain, suffering, and death.

142. The conduct and omissions of the Defendants toward Lisa were an abuse to the extent that they cannot be justified by necessity and were needlessly harsh, degrading, and dehumanizing treatment of Lisa.

143. The conduct and omissions of the Guard Defendants and Nurse Defendants toward Lisa, and their ability to engage in such conduct and omissions under the constitutionally deficient policies, customs, patterns, practices, training, and supervision of Lofgreen, Bell, and Defendant Salt Lake County, was treatment that was clearly deficient and unjustified, constituting unnecessarily rigorous treatment of Lisa in violation of Article I, section 9 of the Utah Constitution.

144. As a direct and proximate result of the wrongful conduct, the deliberate indifference, and unnecessarily rigorous treatment by the Defendants, (1) Lisa consciously suffered severe and excruciating physical, emotional, and mental pain prior to her death; (2) Lisa's emergency medical condition, and the pain and suffering she endured as a result of it, became far worse, leading to her premature death and her loss of the enjoyment of life and of the love, affection, and consortium of her parents and children and being able to enjoy the delight and pleasure of parenting her beloved children; (3) medical, funeral, and cremation expenses for Lisa were incurred; (4) Lisa and her Estate lost substantial earnings based on the probable duration of Lisa's life had her serious medical condition been appropriately and constitutionally addressed and treated; and (5) Lisa and her Estate suffered other damages recognized at law, for which Defendants are liable to Plaintiff Calvin

Donald Ostler, as personal representative of the Estate of Lisa Marie Ostler, for the benefit of Lisa's heirs, in an amount that shall be proven at trial.

145. Plaintiff is entitled to recover from and against the Defendants, jointly and severally, all damages sustained as a result of the Defendants' wrongful conduct and deliberate indifference, including but not limited to the damages described above and, in addition, all reasonable attorneys' fees and costs incurred in this action, pursuant to Utah Code § 78B-3-104(3).

146. Plaintiff is further entitled to recover from and against the Defendants, except Salt Lake County, punitive damages, in an amount determined at trial, for the Defendants' willful, wanton, deliberate, reckless, and callous indifference and disregard toward Lisa's constitutionally protected rights, which proximately caused the extreme, worsening, excruciating pain and suffering experienced by Lisa and to her tragic and unnecessary death.

THIRD CLAIM FOR RELIEF
(Violations of the Due Process Clauses of the Fifth and Fourteenth Amendments to the United States Constitution; the Equal Protection Clause of the Fourteenth Amendments to the United States Constitution; the Due Process Clause of Article I, § 7 of the Utah Constitution; the Uniform Operation of Laws Clause of Article I, § 24 of the Utah Constitution; and the Open Courts Clause of Article I, § 11 of the Utah Constitution)

For his Third Claim for Relief, Plaintiff alleges as follows:

147. Plaintiff repeats and incorporates by this reference the allegations set forth in paragraphs 1 through 146 above.

148. Plaintiff challenges the constitutionality of Utah Code § 78B-3-104 (the "Bond Statute"), which places an unreasonable and oppressive burden on people injured or heirs of people killed by wrongful acts of law enforcement officers and deprive people with limited financial resources access to the courts. The right of injured parties who seek access to the courts for violation of their rights is guaranteed by the Due Process and Equal Protection Clauses of the Fifth and Fourteenth Amendments to the United States Constitution, the Due Process Clause of Article I, § 7 of the Utah Constitution, the Open Courts Clause of Article I, § 11 of the Utah Constitution, and the Uniform Operation of Laws Clause of Article I, § 24 of the Utah Constitution.

149. The Bond Statute requires a person filing an action against a law enforcement officer to post a bond before the action is filed, in an amount determined

by the court, to cover all estimated costs and attorneys' fees the officer is likely to incur in defending the action. Utah Code § 78B-3-104.

150. The Bond statute provides no guidance as to how the Court is to determine the amount of the bond required by the Bond Statute. The Bond Statute prevents the filing of "an action against a law enforcement officer … unless the [plaintiff] *has* posted a bond in an amount determined by the court." (Emphasis added). The Bond Statute provides no guidance as to how a plaintiff may obtain a determination of the amount of the bond prior to filing the complaint, or at any time.

151. The Bond Statute places an unreasonable and discriminatory burden on Plaintiff and, at the same time, protects a small and specific class of people. Under the Bond Statute, access to money alone determines whether Plaintiff in this action, and similarly situated plaintiffs in other actions, get into court at all.

152. Plaintiff contends that, both on its face and as applied to them, the Bond Statute violates the Due Process and Equal Protection Clauses of the Fifth and Fourteenth Amendments to the United States Constitution; the Due Process Clause of Article I, §7 of the Utah Constitution; the Open Courts Clause of Article I, § 11 of the Utah Constitution; and the Uniform Operation of Laws Clause of Article I, § 24 of the Utah Constitution.

153. Accordingly, declaratory relief pursuant to 28 U.S.C. § 2201(a) and Rule 57 of the Federal Rules of Civil Procedure is appropriate.

154. Pursuant to Rule 5.1(a), Federal Rules of Civil Procedure, Plaintiff has served notice of the constitutional question on the Utah Attorney General.

155. Pursuant to DUCivR 24-1, Plaintiff has served notice on the Clerk of the Court of Plaintiff's constitutional challenge.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff prays for relief on his claims for relief against Defendants as follows:

Under his First Claim for Relief, Plaintiff demands judgment against Defendants, jointly and severally, as follows:

1. For an award of compensatory damages, including all special and general damages, the amount of which will be established at trial, with pre-judgment interest on all special damages.

2. For an award of punitive damages against all Defendants, except Salt Lake County, in an amount to be established at trial;

3. For an award of reasonable attorneys' fees and costs, pursuant to 42 U.S.C. § 1988; and

4. For such other and further relief as the Court deems proper.

Under his Second Claim for Relief, Plaintiff demands judgment against Defendants, jointly and severally, as follows:

1. For an award of compensatory damages, including all special and general damages, the amount of which will be established at trial, with pre-judgment interest on all special damages.

2. For an award of punitive damages against all Defendants, except Salt Lake County, in an amount to be established at trial;

3. For an award of reasonable attorneys' fees and costs, pursuant to Utah Code § 78B-3-104(3); and

4. For such other and further relief as the Court deems proper.

Under his Third Claim for Relief, Plaintiff respectfully requests the Court to enter judgment as follows:

1. To enter a declaratory judgment that Utah Code § 78B-3-104, facially and as applied to Plaintiff, violates the Due Process Clauses of the Fifth and Fourteenth Amendments to the United States Constitution and Article I, § 7 of the Utah Constitution, and 42 U.S.C. § 1983;

2. To enter a declaratory judgment that Utah Code § 78B-3-104, facially and as applied to Plaintiff, violates the Equal Protection Clause of the Fourteenth

Amendment to the United States Constitution and the Uniform Operation of Laws Clause of the Utah Constitution in Article I, § 24;

3. To enter a declaratory judgment that Utah Code § 78B-3-104, facially and as applied to Plaintiff, violates the Open Courts Clause of the Utah Constitution;

4. For reasonable attorneys' fees as provided by 42 U.S.C. § 1988 and by Utah law; and

5. For such other and further relief as the Court deems just and appropriate.

DEMAND FOR JURY

Plaintiff hereby demands a trial by jury on all his claims, except those under the Third Claim for Relief, and have submitted the jury fee.

DATED this 5th day of November 2019:

LAW OFFICES OF ROCKY ANDERSON

/s/ Ross C. Anderson
Ross C. Anderson
Attorney for Plaintiff

Plaintiff's Address:
1094 W. Greasewood Drive
Riverton, Utah 84065

Exhibit A

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Attorneys for Plaintiff~~s~~

IN THE UNITED STATES DISTRICT COURT
DISTRICT OF UTAH, CENTRAL DIVISION

CALVIN DONALD OSTLER, ~~individually and~~ as personal representative of the Estate of Lisa Marie Ostler, ~~KIM OSTLER, and the three minor children of Lisa Marie Ostler, C.K., E.L.K., and L.M.O., through their adoptive parents and next friends, CALVIN DONALD OSTLER and KIM OSTLER,~~

Plaintiff~~s~~,

v.

HOLLY PATRICE HARRIS, ZACHARY PAUL FREDERICKSON, TODD ALLAN BOOTH, RONALD PAUL SEEWER, JR., BRENT LEE TUCKER, ~~PAM LOFGREEN, RICHARD BELL,~~ and SALT LAKE COUNTY, a political subdivision of the State of Utah,

Defendants.

SECOND AMENDED COMPLAINT

JURY TRIAL DEMANDED

Case No. 2:18-cv-00254-001

Judge Bruce S. Jenkins

Plaintiffs previously filed a First Amended Complaint [ECF 59], with respect to which the Court ordered dismissal of some of the claims and parties [ECF 139 and ECF 163]. Plaintiffs filed a Motion for Leave to File a Second Amended Complaint [ECF 165], and Defendants filed an Opposition to Plaintiff's Motion for Leave to File Second Amended Complaint [ECF 167]. The Court entered a Memorandum Opinion and Order Granting in Part and Denying in Part Plaintiffs' Motion for Leave to File a Second Amended Complaint [ECF 174]. Plaintiffs contend that the Court's dismissal of claims in Plaintiffs' First Amended Complaint and the Court's denial of leave to file certain claims in the Second Amended Complaint was in error and reserve their right to challenge those decisions by the Court on appeal following a final decision in this matter. In order to file a Second Amended Complaint in conformance with DUCivR 15-1 ("A party who has been granted leave to file must subsequently file the amended complaint with the court. The amended complaint filed must be the same complaint proffered to the court, *unless the court has ordered otherwise*" (emphasis added)), and because the Court denied Plaintiffs' Motion for Leave to File a Second Amended Complaint "to the extent it attempts to reinstate the previously dismissed Heirs and Supervisors as Proposed Parties" [ECF 174, at 13] and granted Plaintiffs' Motion for Leave to File a Second Amended Complaint "to the extent the proposed amendments support

Plaintiff's *Monell* claim against the County," *id*., this Second Amended Complaint is being filed to reflect only the claims and parties permitted by the Court and to reflect matters that "support Plaintiff's *Monell* claim against the County", notwithstanding Plaintiffs' reservation of rights to challenge on appeal the Court's dismissal of claims and parties and denial of leave to add claims and parties in the Second Amended Complaint.[1]

Plaintiff~~s~~ complains of Defendants and, demanding trial by jury of the First and Second Claims for Relief, alleges as follows:

PARTIES

1. Plaintiff Calvin Donald Ostler ("Cal") is a citizen and resident of the State of Utah; he is the surviving father of Lisa Marie Ostler ("Lisa"), deceased; he is the personal representative of the estate of Lisa; and he is the adoptive father and next friend of the three surviving minor children of Lisa, C.K., E.L.K., and L.M.O.

~~2. Plaintiff Kim Ostler ("Kim") is a citizen and resident of the State of Utah; she is the surviving mother of Lisa Marie Ostler, deceased; and she is the~~

[1] For ease of reference, attached as Exhibit "A" is a red-lined version reflecting the changes that have been made in this Second Amended Complaint in comparison with the proposed Second Amended Complaint proffered to the Court in connection with Plaintiffs' Motion for Leave to File Second Amended Complaint.

~~adoptive mother and next friend of the three surviving minor children described in Paragraph 1 above.~~

~~3. C.K. is a citizen and resident of the State of Utah and is the surviving fifteen-year-old son of Lisa Marie Ostler, deceased.~~

~~4. E.L.K. is a citizen and resident of the State of Utah and is the surviving fourteen-year-old daughter of Lisa Marie Ostler, deceased.~~

~~5. L.M.O. is a citizen and resident of the State of Utah and is the surviving eight-year-old daughter of Lisa Marie Ostler, deceased.~~

~~6.~~2. Defendants Holly Patrice Harris ("Harris"), Zachary Paul Frederickson ("Frederickson"), and Todd Allan Booth ("Booth") (collectively "Guard Defendants") are citizens and residents of the State of Utah and at all times material hereto were officers, agents, or employees of Salt Lake County, assigned to work at the Salt Lake County Metro Jail.

~~7. Defendant Pam Lofgreen ("Lofgreen") is a citizen and resident of the State of Utah and at all times material hereto was the Salt Lake County Sheriff's Office Chief Deputy and Commander of the Salt Lake County Metro Jail, in charge of setting and implementing the policies and procedures for, and providing supervision over, the Salt Lake County Metro Jail and its employees.~~

~~8. Defendant Richard Bell ("Bell"), is a citizen and resident of the State of Utah and at all times material hereto was the "Responsible Health Authority" of the Salt Lake County Metro Jail. Defendant Bell was responsible at the Salt Lake County Metro Jail (1) to arrange for all levels of health care; (2) to assure the quality, accessibility, and timeliness of health services for inmates; (3) for the training and supervision of all medical personnel; and (4) for the formulation, adoption, execution, implementation, and enforcement of all policies, procedures, and officially sanctioned customs relating to the provision of medical care at the Salt Lake County Metro Jail.~~

~~9.~~3. Defendants Ronald Paul Seewer, Jr. ("Seewer") and Brent Lee Tucker ("Tucker") (collectively "Nurse Defendants") are citizens and residents of the State of Utah and at all times material hereto were registered nurses working at the Salt Lake County Metro Jail and employed by Salt Lake County.

~~10.~~4. Defendant Salt Lake County, a political subdivision of the State of Utah, maintains the Salt Lake County Metro Jail and is responsible for the implementation and establishment of policies and procedures, customs, and the supervision and training of officers, agents, and employees assigned to work at the Salt Lake County Metro Jail.

JURISDICTION AND VENUE

~~11.~~5. This action arises under the United States Constitution, particularly the provisions of the Fourteenth Amendment, 42 U.S.C. § 1983, and the Utah Constitution, particularly Article I, Sections 7 and 9.

~~12.~~6. This Court has jurisdiction over this action pursuant to 28 U.S.C. §§ 1331 and 1367.

~~13.~~7. Venue in this Court is proper pursuant to 28 U.S.C. § 1391 because the conduct complained of herein took place in Salt Lake County, Utah.

~~14.~~8. The acts of the Defendants described herein to be in violation of 42 U.S.C. § 1983 and the United States Constitution were undertaken by the Defendants and each of them under color of state law, particularly the statutes, ordinances, regulations, policies, customs, practices, and usages of, and under the authority of, Defendant Salt Lake County, and the individual offices of Defendants as officers, agents, contractors, and/or employees of Defendant Salt Lake County.

~~15.~~9. Jurisdiction for violations of the Utah Constitution ~~and for the individual Plaintiffs' state wrongful death claims~~ is founded upon supplemental jurisdiction because the claims of violations of federal law are substantial and the supplemental claims derive from a common nucleus of operative facts and are so

related to the federal claims that they form part of the same case or controversy under Article III of the United States Constitution.

~~16.~~10. Under protest, and vigorously asserting the inapplicability or the unconstitutionality of the Bond requirement of Utah Code § 78B-3-104, under the Due Process, Petition, and Equal Protection guarantees of the United States and Utah Constitutions, as well as the Open Courts Clause of the Utah Constitution, Plaintiff~~s~~ has~~ve~~ deposited with the Clerk of the Court $300 for the Bond and filed with the Court a Bond, pursuant to DUCivR 67-1(c). Plaintiff~~s~~ seeks (1) a declaratory judgment that the Bond requirement violates the Due Process and Equal Protection clauses of the Utah and United States Constitutions and the Open Courts Clause of the Utah Constitution and (2) a refund of the $300 deposited with the Clerk of the Court for the unconstitutional Bond.

FIRST CLAIM FOR RELIEF
(Survival ~~and Wrongful Death~~ Action~~s~~ Under 42 U.S.C. § 1983)[2]

For ~~their~~ his First Claim for Relief, Plaintiff~~s~~ complains against the Defendants and alleges as follows:

~~17.~~11. Plaintiff~~s~~ repeats and incorporates by this reference the allegations set forth in paragraphs 1~~6~~ through 10 above.

~~18.~~12. Lisa, a pretrial detainee who was entitled to be free from punishment, and who was entitled to medical treatment for her severe, life-threatening medical condition, under (1) the Due Process clause of the Fourteenth Amendment to the United States Constitution, (2) the Due Process clause of Article I, Section 7 of the Utah Constitution, and (3) the prohibition against the treatment of persons arrested or imprisoned with unnecessary rigor, under Article I, Section 9 of the Utah Constitution, was held in, and under the care and supervision of, the Salt Lake County Metro Jail and the Defendants from March 29, 2016, until April 2, 2016.

~~19.~~13. During April 1 and April 2, 2016, when Lisa was held in Pod C, Section 8 ("8C"), cell 16 of the Salt Lake County Metro Jail, Lisa exhibited obvious signs of excruciating pain from life-threatening peritonitis, was unable and failed to eat or

~~[2] Plaintiffs acknowledge that the wrongful death claims of the individual Plaintiffs under 42 U.S.C. § 1983 have been dismissed by the Court, but they are set forth here to preserve the record for appeal.~~

drink anything since, at the latest, the morning of March 31, 2016, and experienced obvious and life-threatening dehydration. Lisa, as well as other detainees, repeatedly pleaded for medical help for Lisa. Those pleas for help, and Lisa's signs of life-threatening medical need, which were so obvious that even a lay person would easily recognize the necessity for a doctor's attention, were outrageously ignored and cruelly dismissed by the Nurse Defendants and the Guard Defendants, leading to the utter failure by such Defendants to obtain, provide, or arrange for monitoring, evaluation, medical diagnosis, or medical treatment for Lisa, ultimately leading to Lisa's untimely, horrifyingly painful, and wholly unnecessary death.

~~20.~~14. As a result of the deliberate indifference of the Defendants, Lisa was found in her cell unresponsive, without a pulse and not breathing, on April 2, 2016, and she died on April 3, 2016, when it was determined at a hospital that there was no longer any sign of a heartbeat and Lisa was pronounced dead. The Guard Defendants and Nurse Defendants engaged in abuse and treatment of Lisa that was needlessly harsh, degrading, and dehumanizing.

~~21.~~15. On March 30, 2016, an employee or agent of Salt Lake County Jail completed a "Comprehensive Nurse Examination" form about Lisa, providing a "Health and Mental Health Rating" of "Level 3," noting "multiple medical issues," noting a history of gastric bypass surgery, and confirming that Lisa was "instructed

on proper procedure to access medical, dental or mental health care through sick call request process." Also on March 30, 2016, an employee or agent of Salt Lake County completed a "Medication Verification Worksheet" noting that Lisa reported taking multiple medications, including Pentasa, for Crohn's disease.

~~22.~~16. On March 31, 2016, while being held in Pod C, Section 5 ("5C") of the Salt Lake County Metro Jail, after not eating when breakfast was made available around 6 a.m. and not eating when lunch was made available around noon, Lisa presented to an employee of the Salt Lake County Metro Jail with obvious signs of extreme confusion, asking where "Claudia" was because they were going to go to a wedding together. That incident was noted in the records of the Salt Lake County Metro Jail, as was a recommendation for follow-up, which were available to the Guard Defendants and the Nurse Defendants, yet were wholly ignored by those Defendants.

~~23.~~17. Defendant Seewer knew that Lisa was, according to physician orders, established procedures, and policies applicable at the Salt Lake County Metro Jail, to have her vital signs and withdrawal symptoms measured and recorded twice daily for five days. On the morning of April 1, 2016, Defendant Seewer purported to record vital signs of Lisa Ostler onto Lisa's medical records and thereby indicate that her vital signs had been measured, but, in fact, failed and refused to measure, or

assure the measurement of, all of Lisa's vital signs and wrote fabricated information into her medical records that erroneously and misleadingly reflected Lisa's vital signs were normal and healthy.

~~24.~~18. On April 1, 2016, Lisa was moved from Unit 5C to Unit 8C of the Salt Lake County Metro Jail. Since at least the previous morning, March 31, until Lisa was found in her cell unresponsive and not breathing on April 2, she did not eat anything, a fact well known to the Guard Defendants and the Nurse Defendants. In fact, Defendant Tucker was expressly notified by Defendant Frederickson that Lisa had not eaten for at least two days, yet Tucker wholly failed to determine how long it had been since Lisa had last eaten anything and casually and dismissively stated erroneously that there was no medical concern until someone had not eaten for seventy-two hours. Defendant Tucker made that assessment without ever examining, monitoring, evaluating, diagnosing, or providing medical treatment for Lisa, or arranging for a competent medical professional to examine, monitor, evaluate, diagnose, or provide medical care for Lisa.

~~25.~~19. At about 3:25 p.m. on April 1, 2016, Defendant Seewer was informed by Lisa that she was experiencing severe pain, which Lisa's bearing and expressions confirmed. By then, as with anyone suffering from untreated peritonitis, Lisa was in excruciating pain, signifying that she was suffering from a serious medical

condition. It was Seewer's personal responsibility, pursuant to physician orders, protocols, and policies applicable at the Salt Lake County Metro Jail, to measure and record Lisa's vital signs and withdrawal symptoms on the afternoon of April 1, 2016, because he was the nurse assigned to Pod C for that day. Seewer failed to measure and record Lisa's vital signs and withdrawal symptoms. Seewer did not check Lisa's blood pressure, pulse, or temperature, he did not palpate her abdomen, and he did not chart anything regarding any semblance of a medical examination, which he failed to perform. Seewer also wholly failed to arrange for a medical examination, evaluation, or treatment by a medical professional competent to examine, evaluate, and treat Lisa and, with complete indifference to her obviously serious medical condition, simply "cleared her to stay in the unit."

~~26.~~20. On April 1, 2016, after detainees were locked down at approximately 4 p.m. to eat dinner, Lisa was heard by other inmates, even some on a different tier and several cells down from Lisa's, yelling and moaning, obviously in excruciating pain and obviously in need of immediate medical attention. One inmate has described what she heard from Lisa as being "like a deathly holler," a "growl," and "horrific." At that time, Defendant Booth was at the control desk and heard Lisa calling out in pain and for help, yet he did nothing to help her or to cause anyone else to help her, in utter disregard of Lisa's pain and obviously serious, life-

threatening medical condition, which would have been, and was, obvious to any layperson, as was the requirement that Lisa be provided immediate medical attention.

~~27.~~21. Lisa had been locked in her cell alone since she arrived at 8C, while every other detainee in 8C was free to walk around and talk to other detainees and officers, other than during lockdowns for meals, sleep, and certain urgent matters. Lisa was essentially left, locked up alone, without any diagnosis or treatment, or referral for diagnosis and treatment, and was physically unable, without great difficulty and pain, to leave her cell because of her rapidly deteriorating, life-threatening medical condition, which required close medical observation, evaluation, checking of vital signs, and diagnosis and treatment, or referral for diagnosis and treatment, none of which was provided by any of the Defendants.

~~28.~~22. The Guard Defendants and Nurse Defendants all knew, or were charged with knowing, Lisa had not eaten for at least two days, that she was in horrific pain, that she was not free or able, without great difficulty and pain, to walk outside of her cell (notwithstanding that she was entitled to be free from punishment because she was a pretrial detainee), and that she was obviously in need of urgent medical diagnosis and treatment—and the need was so obvious that a layperson would have easily recognized the necessity for medical attention—yet they failed and refused to

monitor, evaluate, examine or treat Lisa and failed and refused to provide or arrange for a competent medical professional to monitor, evaluate, diagnose, examine, or provide medical care for Lisa. At about 6 p.m. on April 1, 2016, a detainee, Summer Johnson ("Johnson"), who had earlier heard Lisa moaning loudly and calling out for help, left her cell on the upper tier of 8C after dinner lock-down and walked down to the lower tier to Lisa's cell because she knew that whoever was there was obviously suffering tremendously. Unlike the uncaring, callous Guard Defendants and Nurse Defendants, Johnson was extremely concerned about Lisa because it was obvious even to a layperson that Lisa's severe medical condition required medical treatment, yet nothing was being done for Lisa by the Guard Defendants or the Nurse Defendants.

~~29.~~23. Johnson looked into Lisa's cell, which was visible through large windows, and saw Lisa sitting on the bunk, "crunching" back and forth, all the way up and all the way down, curling up into a ball, demonstrating that Lisa was in obviously serious pain and distress, requiring immediate medical attention. Johnson could see that Lisa was obviously extremely sick and in horrendous pain, yet nothing was being done by the Guard Defendants or the Nurse Defendants to medically assist, or arrange medical assistance for, Lisa.

~~30.~~24. Johnson believed that Lisa was going to die because of her horrifying bodily movements, her obliviousness to everything else around her as she was writhing in pain, and her earlier loud moans and calling out for help.

~~31.~~25. At that point, Johnson asked Defendant Booth if he was going to "call medical" and stated to Booth that the girl in Lisa's cell (Johnson did not know Lisa's name at that point) was in urgent need of medical attention. Booth responded, rudely, sarcastically, and dismissively, as if Johnson were bothering him, that "We're watching her. She's just coming down off of drugs."

~~32.~~26. Defendant Booth then went to Lisa's cell, opened the door, and said, facetiously, with a sneer on his face, "I'll bet it feels like you're going to die, doesn't it? Just a couple more days." Booth then slammed the door hard and walked away, again without arranging for anyone to provide medical assistance for Lisa, whose need for medical treatment was obvious, and would have been obvious, to any reasonable layperson.

~~33.~~27. Lisa did indeed feel like she was going to die, as cruelly and sarcastically suggested by Defendant Booth—and she did die because of the cruel, dismissive, deliberate indifference of Booth, the other Guard Defendants, and the Nurse Defendants.

~~34.~~28. As one detainee, Candice Walker ("Walker"), who was in 8C has stated: "I can recall when Lisa came into the unit. She looked very frail. As I would serve meals we would take note of what women would not eat. Lisa did not eat. I remember trying to serve her one afternoon. She seemed to be in a lot of pain. Not being sure of her situation I asked her if she would try to eat something. She kept holding her stomach and crying out for help. I recall when Officer Booth was on duty she [Lisa] was at the door asking for help. Her voice was low and not very audible. He just waved at her from the officers station." Walker continued: "I would explain to the officer [Defendant Booth] that clearly she [Lisa] needed medical attention." Walker also notes: "I repeated to the housing officer if she [Lisa] didn't get medical attention she was going to die."

~~35.~~29. At about 10 p.m. or later on April 1, 2016, Johnson, from her cell, heard very loud yelling and moaning from Lisa and it seemed obvious to her that Lisa must be dying and that nothing was being done for her. Johnson heard repeated beeping from a button ("alarm button") provided to detainees in their cells for use if they needed to call for help.

~~36.~~30. Throughout the night of April 1 and early morning of April 2, 2016, Lisa repeatedly pushed the alarm intercom button in her cell, the beeping from which could be heard throughout 8C. Defendant Harris ordered Lisa to stop pushing the

alarm button, assuring her that she could "get medical" in the morning, which Defendant Harris failed to ever arrange.

~~37.~~31. During that same night and early morning, Lisa continued seeking help, and Defendant Harris was heard at one point saying to her that she would not even talk to Lisa and that she was going to write her up for continuing to push the alarm button. During the entire evening and early morning, Harris failed and refused to provide or obtain timely and proper monitoring, evaluation, medical care, and treatment for Lisa, which failure and refusal constituted deliberate indifference to Lisa's serious medical needs and constitutional right to receive medical care for her serious medical condition while incarcerated in the Salt Lake County Metro Jail.

~~38.~~32. Between 4 a.m. and 6 a.m., Lisa was again heard crying out, obviously miserable in her pain and suffering and seeking help. At one point, Lisa was so desperate to get out of her cell, where she was still locked down, that she tried to get her arm and body through the cuff-port in her cell door. Lisa was, and had been, out of her mind in pain, confusion, sickness, and desperation—all of which was obvious to anyone caring to pay attention, and which was obvious to other detainees, but which was deliberately and entirely ignored by the indifferent, uncaring, mean-spirited, and callous Guard Defendants and Nurse Defendants.

~~39.~~33. Between 6 a.m. and 8 a.m. on April 2, 2016, Lisa cried out loudly, obviously extremely sick and begging for help, leading Johnson to believe she was listening to someone dying then and there. None of the Defendants paid any attention to Lisa; none of them provided any monitoring, evaluation, medical care or treatment for her; and none of them arranged for any monitoring, evaluation, medical care or treatment for her, notwithstanding the obvious need for immediate medical attention.

~~40.~~34. Around 6:30 a.m. on April 2, Defendant Tucker entered 8C. Defendant Tucker was responsible for being a gatekeeper for other medical personnel capable of treating Lisa's condition and consistently and outrageously failed and refused to fulfill his gatekeeper role when there was such an obvious need for treatment or referral to diagnose, monitor, and treat the life-threatening illness, pain, and suffering experienced by Lisa. Defendant Tucker did not speak with Lisa, he did not check on or monitor her, and he did nothing to obtain medical assistance for her or to determine if she required medical assistance and, if so, the urgency of obtaining the assistance.

~~41.~~35. At about 8 a.m. on April 2, Defendant Frederickson walked along cells on both tiers in 8C. When he arrived at Johnson's cell, she spoke to him through the door, asking him if he had checked on "that girl" and stating that she [Lisa] needed "medical." Frederickson's appalling response was that he had just checked on Lisa

and that she was "fine"—then he said, "If she dies it will be your fault," laughing as if it were all a joke. Then he added, "Well, she's not going to die on my watch." As it turned out, Lisa had virtually died at that point. Johnson walked to Lisa's cell, where Lisa was still locked in, looked into Lisa's window, and saw her body on the floor, leaned against the bunk, with her head all the way back, mouth open, and her eyes open. Johnson yelled at Defendant Frederickson, "She's not breathing . . . . You said you just checked her!"

~~42.~~36. Lisa was found in full cardiac and respiratory arrest, CPR was administered, and Lisa was finally transported to a hospital by an ambulance, but it was too late. Lisa was pronounced dead at 1:14 a.m. on April 3, 2016.

~~43.~~37. From the time Lisa was found unresponsive in her cell until she was pronounced dead, she never regained consciousness. Because of the absence of monitoring and charting by the Guard Defendants and Nurse Defendants, and because no one from the Salt Lake County Metro Jail informed medical personnel at the hospital of Lisa's obvious symptoms of abdominal pain, the physicians and nurses at the hospital were deprived of vital information that should have been made available to them about Lisa's severe abdominal pain, as well as all other information relevant to her medical condition that was, or should have been, available from Nurse

Defendants and Guard Defendants, and which adequate policies, procedures, practices, custom, training, and supervision would have caused to be available.

~~44.~~38. Lisa's death would have been prevented if any of the Guard Defendants or Nurse Defendants had called for qualified medical assistance or if Nurse Defendants had even provided the most rudimentary diagnostic evaluation procedures, such as checking Lisa's blood pressure, temperature, or pulse, palpating her abdomen, or conducting an examination for rebound tenderness, and then taken the obviously necessary steps that would have led to Lisa being further examined and immediately treated. Lisa's blood pressure and other vital signs were never checked the entire time she was in 8C, despite her many cries for help and despite the adamant demands of at least one other detainee that Lisa's blood pressure and other vital signs be checked. Had Lisa's vital signs been checked, it would have been even more readily apparent that she required urgent medical care.

~~45.~~39. Because of the Defendants' failures to respond to Lisa's obvious life-threatening medical condition, she died from the effects of peritonitis, which is life-threatening if not treated and causes extreme pain and suffering, as well as dehydration, before death. According to the Medical Examiner, Lisa "died as a result of peritonitis due to gastrointestinal perforation at the anastomosis site of a remote

gastric bypass. The decedent's medical history is significant for Crohn's disease which may have been a contributing factor to the perforation."

~~46.~~40. Other complications of peritonitis are dehydration and loss of appetite. Had the Guard Defendants or Nurse Defendants arranged for a competent medical professional to evaluate Lisa, such a medical professional would have recognized the symptoms exhibited by Lisa as being life-threatening and requiring immediate medical attention.

~~47.~~41. Lisa's temperature right after she had been taken from the Salt Lake County Metro Jail was 93.6 degrees Fahrenheit, which was extremely low and could easily have been determined had she been provided any semblance of medical diagnosis or treatment, or even simply the taking of her vital signs, while under the control and experiencing the extraordinary neglect and deliberate indifference of the Guard Defendants and the Nurse Defendants at the Salt Lake County Metro Jail.

~~48.~~42. Hours and days before Lisa's death, Lisa's medical history, her history of not eating for days before her death, her dehydration (which could easily have been checked and ascertained), her severe, obvious abdominal pain, and other symptoms would have caused any competent medical professional who evaluated her to recognize that, whatever she was suffering from, she needed emergency

medical diagnosis and treatment, which would have saved Lisa's life and prevented her from experiencing the incomprehensible agony she suffered before her death.

~~49.~~43. In light of the patent seriousness of Lisa's severe medical condition, which was obvious to all—upon seeing her and upon hearing her—which Lisa repeatedly validated by her many desperate complaints of pain and misery and her cries for help, (1) the failures and refusals of the Guard Defendants to monitor or arrange for monitoring, evaluation, medical diagnosis, medical care and treatment and (2) the failures and refusals of the Nurse Defendants to monitor, diagnose, evaluate, and treat, or to arrange for monitoring, evaluation, diagnosis and medical care and treatment by a medical professional competent to recognize and treat Lisa's deadly peritonitis, each constituted outrageous and deliberate indifference to Lisa's urgent and critical medical condition.

~~50.~~44. The failures and refusals by the Nurse Defendants to (1) provide medically necessary monitoring, evaluation, the taking and recording of vital signs, diagnosis, and medical care and treatment for Lisa, (2) notify a physician of Lisa's serious medical condition, or (3) arrange for such monitoring, evaluation, diagnosis, or medical care and treatment by a medical professional competent to diagnose and treat Lisa, constituted deliberate indifference insofar as they had a responsibility to serve as a gatekeeper for other medical personnel capable of treating Lisa's

condition, yet failed and refused to fulfill that gatekeeper role in the face of the obvious need for treatment or referral for Lisa while she was obviously suffering a deadly medical emergency with attendant obvious and extreme pain and suffering.

~~51.~~45. Such failures and refusals by the Nurse Defendants to provide, or arrange for, medically necessary diagnosis and treatment for Lisa constituted an extraordinary degree of neglect insofar as (1) they recognized their inability to treat Lisa due to the seriousness of her condition and their lack of expertise, but refused and failed to obtain medical help for Lisa; (2) they failed to treat, or obtain treatment for, Lisa's extreme abdominal pain and suffering, the existence and severity of which medical condition was so obvious that even a layperson would, and laywomen detainees did, recognize the condition and its deadly seriousness; and (3) they entirely denied monitoring, evaluation, medical care and treatment although they were presented with recognizable symptoms which created and obviously signified a severe medical emergency. The Nurse Defendants completely refused to fulfill their duty as medical gatekeepers when they observed obvious signs of Lisa's medical emergency, but neither treated nor summoned medical assistance despite Lisa's and others' pleas that Lisa receive medical attention. The Nurse Defendants chose to provide no treatment for Lisa rather than treatment or referral for treatment that professional judgment obviously dictated.

~~52.~~46. ~~Defendants~~ Richard Bell, who at all material times was the "Responsible Health Authority" of the Salt Lake County Metro Jail and responsible at the Salt Lake County Metro Jail (1) to arrange for all levels of health care; (2) to assure the quality, accessibility, and timeliness of health services for inmates; (3) for the training and supervision of all medical personnel; and (4) for the formulation, adoption, execution, implementation, and enforcement of all policies, procedures, and officially sanctioned customs relating to the provision of medical care at the Salt Lake County Metro Jail, and Pamela Lofgreen ("Lofgreen"), who at all times material hereto was the Salt Lake County Sheriff's Office Chief Deputy and Commander of the Salt Lake County Metro Jail, in charge of setting and implementing the policies and procedures for, and providing supervision over, the Salt Lake County Metro Jail and its employees, each were supervising officials at the Salt Lake County Metro Jail, responsible for assuring that detainees received necessary medical services. ~~and, as such, are liable for violation of Lisa's constitutional rights to be free from the deliberate disregard of her serious medical condition and from unnecessarily rigorous treatment. Defendants~~ Bell and Lofgreen had the power and duty to alleviate the conditions which led to the constitutional violations suffered by Lisa, but they failed and refused to alleviate the conditions.

~~53. At all relevant times, Defendant Bell was the "Responsible Health Authority" for the Salt Lake County Metro Jail and the Salt Lake County Oxbow Jail.~~

~~54.~~47. The Salt Lake County Jail Health Services Unit Policies and Procedures includes a policy entitled "RESPONSIBLE HEALTH AUTHORITY" that states as follows:

> The responsible health authority (RHA) arranges for all levels of health care and *assures quality, accessible and timely health services for inmates*. . . . The RHA is responsible for overseeing the medical, mental health, and dental services, including reviewing the *accessibility, the quality, and the timeliness of health services provided in the Jail*. (Emphasis added.)

~~55.~~48. The Salt Lake County Jail Health Services Unit Policies and Procedures includes a policy entitled "ACCESS TO CARE" that states as follows:

> PURPOSE: To ensure that patients have access to health care to meet their serious medical, dental, and mental health needs.
>
> POLICY: It is the responsibility of the RHA to ensure that the Health Services Unit policies allow patients unrestricted access to health care in a timely manner, and that the policies are enforced so that there are not any barriers to patients receiving professional clinical judgments about their health care needs, and that care ordered is received.

~~Defendant~~ Bell's Customs and Policies Regarding Medical Records

~~56.~~49. ~~Defendant~~ Bell was responsible for ensuring that nurses at the Salt Lake County Metro Jail were trained to document medical records in a manner that would

allow incarcerated people to receive adequate, reasonable, and timely health services. ~~Defendant~~ Bell, with deliberate indifference toward the medical needs of incarcerated people, failed and refused to carry out that responsibility. Instead, he created, condoned, and failed to remedy a custom, culture, and practice that encouraged and led to the training and supervision in such a manner that nurses failed to provide material, accurate information in medical records and treated medical record-keeping in a sloppy, dangerous, casual manner, putting the health, safety, and lives of incarcerated people at risk. For example:

a. ~~Defendant~~ Bell, reflecting his own deliberate indifference and perpetuating a custom of deliberate indifference at the Salt Lake County Metro Jail, actively endorsed, condoned, promoted, and failed to correct an unconstitutional policy and custom of nurses creating medical records that obscure and minimize any indications that staff had committed medical errors or that an incarcerated person's safety was in jeopardy as a result of the conduct or decisions of medical staff.

b. ~~Defendant~~ Bell ratified, condoned, promoted, and failed to remedy the unconstitutional decisions of subordinates to train nurses to create medical records that obscure and minimize any indications that staff had committed medical errors or that an incarcerated person's safety was in jeopardy as a

result of the conduct or decisions of medical staff. In general, ~~Defendant~~ Bell ratified, condoned, promoted, and failed to remedy the policy of making, and the training of medical staff at the jail to make, notations in medical records with a primary view toward protecting the County and its staff from accountability, legal and otherwise. That training was part of a widespread practice, amounting to and creating an unconstitutional custom, at the Salt Lake County Metro Jail, of carelessly and often erroneously documenting patients' medical records, which was actively endorsed, condoned, ratified, and not remedied by ~~Defendant~~ Bell.

~~57.~~50. As a result of the unconstitutional training, policies, and customs relating to the creation and maintenance of medical records, which encouraged and condoned sloppiness and callous disregard of the need for accurate and comprehensive medical records, nurses who made notations in Lisa's medical record misrepresented or fabricated Lisa's vital signs and withdrawal assessment scores and omitted critical information about Lisa's medical condition, reflecting deliberate indifference in the monitoring, evaluation, and treatment of incarcerated people at the Salt Lake County Metro Jail. For instance, Lisa's medical record maintained by the Salt Lake County Metro Jail contained the following glaring errors and omissions:

(a) On March 30, 2016, Lisa's respiration rate was recorded as being 98 breaths per minute.

(b) On March 30, 2016, Lisa's oxygen saturation rate was recorded as being zero.

(c) On the afternoon of March 31, 2016, Lisa's resting heart rate of 133 beats per minute was scored as a "2" on the Clinical Institute Withdrawal Assessment ("CIWA") worksheet, even though a resting heart rate at or above 110 beats per minute was required to be scored as a "4."

(d) Throughout Lisa's electronic medical record, the times recorded for her CIWA and Wellcon Opiate Withdrawal Scale ("WOWS") assessments and the monitoring of her vital signs do not reflect the actual times those assessments and monitoring occurred.

(e) On April 2, 2016, Lisa's weight was recorded as 200 pounds, falsely reflecting an impossible weight gain of 76 pounds since Lisa's weight measurement on March 30, 2016.

(f) In violation of written policies requiring documentation in the medical record about "communication with outside resources that might have relevant information about the patient," nowhere in the medical records is there any mention of the highly relevant information that:

i. Defendant Booth communicated to Defendant Seewer about Lisa's "pain" on the afternoon of April 1, 2016.

ii. Lisa was screaming and crying out in pain throughout the night, as heard by housing officers and other incarcerated people.

iii. Lisa constantly asked for a nurse throughout the night.

iv. Lisa was repeatedly pressing her emergency button throughout the night, approximately sixteen separate times, asking over the intercom for medical help.

v. Other incarcerated people told housing officers that Lisa had not received medical treatment and they were concerned Lisa was going to die if she did not receive immediate medical treatment.

vi. According to Defendant Harris (but unsupported by any other evidence), she called a nurse during the night about the concerns other incarcerated people had that Lisa was going to die.

vii. Defendant Frederickson communicated in person with Defendant Tucker and nurse Colby James, as well as by telephone and radio with Defendant Tucker, about Lisa's "medical concerns" on the morning of April 2, 2016.

(g) In "assessing" Lisa pursuant to the CIWA protocol on the afternoon of March 31, 2016, one or more nurses violated written policies, protocols, and physician orders by failing to measure or record anything at all regarding Lisa's (i) signs and symptoms of tremor; (ii) signs and symptoms of paroxysmal sweats; (iii) signs and symptoms of anxiety; (iv) signs and symptoms of agitation; (v) signs and symptoms of tactile disturbances; (vi) signs and symptoms of auditory hallucinations; (vii) signs and symptoms of visual disturbances; (viii) signs and symptoms of headache; (ix) orientation to time, place, and person; (~~i~~x) signs and symptoms of agitation; or (xi) total CIWA score, all of which were required to be recorded by a nurse on the CIWA form for Lisa.

(h) Lisa's electronic medical record maintained by the Salt Lake County Metro Jail does not include the majority of Lisa's substance withdrawal assessments and nearly all of the measurements of Lisa's vital signs were not entered in Lisa's electronic medical record as text or displayed within the graphical representation of her vital signs.

(i) Lisa's electronic medical record maintained by the Salt Lake County Metro Jail does not include any information about why, in blatant violation of written policies, protocol, and physician orders, no one

bothered to measure and record Lisa's vital signs or to conduct her CIWA and WOWS assessments on the afternoon of April 1, 2016, or morning of April 2, 2016.

(j) Lisa's medical record maintained by the Salt Lake County Metro Jail contained false, misleading, and fabricated entries for the morning of April 1, 2016, reflecting that her systolic blood pressure was 105, her diastolic blood pressure was 75, her heart rate was 95, her temperature was 97.6 degrees Fahrenheit, and her respiratory rate was 18 breaths per minute, all of which were very unlikely, even perhaps impossible, given Lisa's medical condition.

~~58.~~51. Despite the numerous glaring errors and omissions in Lisa's medical record, which ~~Defendant~~ Bell has admitted violate written policy, ~~Defendant~~ Bell made no recommendations for any changes in either policy or practice after reviewing what happened to Lisa. In fact, neither Bell nor anyone else purportedly reviewing Lisa's medical record after her death even recognized or noted any of the numerous glaring errors and omissions in Lisa's medical record.

~~59.~~52. ~~Defendant~~ Bell actively endorsed, implemented, encouraged, and condoned a custom at the Salt Lake County Metro Jail that nurses were not required to make any notation in the medical record if the nurse is made aware of an

incarcerated person screaming out in pain and requesting medical treatment. ~~Defendant~~ Bell also failed, with deliberate indifference toward the medical needs of incarcerated people, to ensure that nurses at the Salt Lake County Metro Jail created and maintained proper and complete medical records, including noting instances where an incarcerated person screams out in pain and requests medical attention.

~~60.~~53. As a result of that custom, nothing in Lisa's medical record reflects, as was obvious to everyone in Unit 8C on April 1 and April 2 of 2016, that Lisa had been crying out and screaming in extreme pain and distress and pleading for medical help, all of which indicated she was experiencing a life-threatening medical emergency.

~~61.~~54. Because nothing about Lisa's horrific pain, extreme distress, or pleas and screams for help was noted in the medical record, all medical personnel who reviewed Lisa's medical records prior to her being pronounced dead were deprived of critical information about Lisa's signs and symptoms, including Defendant Tucker, who purportedly reviewed Lisa's medical record within two hours before Lisa was found unresponsive and not breathing in her cell.

~~62.~~55. Because of the inaccurate and incomplete information contained in Lisa's medical record, all medical professionals were denied the knowledge of an accurate history of Lisa's vital signs, withdrawal assessment scores, Lisa's

screaming out in pain and begging for medical help, and other signs and symptoms of her life-threatening medical condition. As a result, Lisa's obviously life-threatening medical condition was callously ignored by Nurse Defendants and Guard Defendants until she was found unresponsive and not breathing in her cell.

~~*Defendant*~~ *Bell's Customs and Policies Regarding Responses to Substance Withdrawal, Abdominal Pain, and Requests for Medical Help*

~~63.~~56. Even though the Salt Lake County Metro Jail is responsible for providing medical care for more patients experiencing substance withdrawal than any substance abuse facility in the state of Utah, ~~Defendant~~ Bell, with deliberate indifference toward the medical needs of incarcerated people, failed to ensure that staff employed at the Salt Lake County Metro Jail, including nurses and housing officers, were trained to recognize, or ensure the determination of, whether the signs and symptoms of serious medical conditions suffered by incarcerated people, which may indicate a life-threatening emergency such as severe abdominal pain and distress, are the result of substance withdrawal or a different life-threatening medical condition that requires immediate medical attention.

~~64.~~57. ~~Defendant~~ Bell, with deliberate indifference toward the serious medical conditions of incarcerated people, implemented and actively endorsed an unconstitutional policy, and widespread practice amounting to a custom, that

incarcerated people who were believed to be at risk for substance withdrawal would not receive evaluation or diagnosis to determine whether their signs and symptoms of serious medical problems, including abdominal pain and distress, resulted from substance withdrawal or a life-threatening medical condition other than substance withdrawal. Also, ~~Defendant~~ Bell, with deliberate indifference toward the serious medical conditions of incarcerated people, failed to ensure that incarcerated people who were believed to be at risk for substance withdrawal received evaluation, monitoring, or diagnosis to determine whether signs and symptoms of medical conditions, including abdominal pain and distress, resulted from substance withdrawal or a life-threatening medical condition other than substance withdrawal.

~~65.~~58. As a result of the policy, custom, and deliberately indifferent failure to train nurses and housing officers described in paragraphs ~~63~~ 56 to 57 ~~64~~ above, any incarcerated person who was identified as being at risk for substance withdrawal and who experienced severe abdominal pain and obvious distress, such as someone whose appendix ruptured or, as in Lisa's case, experienced a perforated peptic ulcer and peritonitis, was virtually guaranteed to be ignored, with staff at the Salt Lake County Metro Jail assuming that the person's signs and symptoms were simply the result of common substance withdrawal.

~~66.~~59. As a result of the unconstitutional policy, custom, and deliberately indifferent failure to train nurses and housing officers described in paragraphs ~~63~~ 56 to ~~64~~ 57 above, for which Bell is responsible, Lisa's horrific abdominal pain and obvious distress were ignored, and Lisa did not receive any monitoring or any form of evaluation for her abdominal pain. A simple evaluation for abdominal pain on April 1 or April 2 of 2016, which could have included simply inquiring about the history, severity, and area of pain, and conducting simple tests such as for rebound tenderness, which takes only seconds to perform and requires no equipment, would have conclusively shown that Lisa was experiencing a life-threatening medical emergency and immediately required further urgent evaluation, diagnosis, and treatment.

~~67.~~60. ~~Defendant~~ Bell actively endorsed, implemented, and condoned an unconstitutional custom of ignoring requests for medical help, including in conjunction with signs and symptoms of abdominal pain. ~~Defendant~~ Bell also failed, with deliberate indifference toward the medical needs of incarcerated people, to ensure that staff at the Salt Lake County Metro Jail adequately and timely responded to requests for medical help made by incarcerated people, including in conjunction with signs and symptoms of abdominal pain.

~~68.~~61. ~~Defendant~~ Bell actively endorsed, implemented, encouraged, and condoned an unconstitutional custom of ignoring complaints of pain and distress from incarcerated people who had been identified as being at risk for substance withdrawal. ~~Defendant~~ Bell also failed, with deliberate indifference toward the medical needs of incarcerated people, to ensure that staff at the Salt Lake County Metro Jail adequately and timely responded to complaints of pain and distress made by incarcerated people who were identified as being at risk for substance withdrawal.

~~69.~~62. That unconstitutional custom led housing officers and nurses to simply leave incarcerated people they assumed were suffering from substance withdrawal in their cells, without monitoring, medical evaluation, or treatment, to withdraw cold turkey and often missing many meals without any medical evaluation or intervention whatsoever.

~~70.~~63. The unconstitutional customs described in paragraphs ~~67~~ 60 to ~~68~~ 61 above were in contravention of formal policy at the Salt Lake County Jail that housing officers are to contact a nurse about each and every instance in which an incarcerated person contacts a housing officer and requests medical assistance, and nurses are to respond as soon as possible and evaluate the incarcerated person.

~~71.~~64. The customs described in paragraphs ~~67~~ 60 to ~~68~~ 61 above were also in contravention of written policy that all matters of medical and nursing judgment are the sole responsibility of Health Services personnel.

~~72.~~65. As a result of the customs described in paragraphs 56~~63~~ to ~~64~~ 57 and ~~67~~ 60 to ~~68~~ 61 above, and reflecting them:

(a) ~~Defendant~~ Bell contends that nothing indicated Lisa was experiencing a medical emergency—and even contends that, based on what he currently knows, there is nothing that indicates Lisa was suffering a serious medical condition—even though Lisa died from her untreated emergency medical condition, she had been crying out in pain all night and repeatedly asked to see a nurse, and it was obvious to numerous incarcerated people, who reported their concerns to housing officers, that Lisa was experiencing a medical emergency.

(b) If Defendant Seewer "cleared" Lisa to remain in her housing unit, which is not reflected in any medical or other records except one notation by a medically untrained housing officer, he did so (i) without performing any evaluation or test related to Lisa's abdominal pain, (ii) without ascertaining or recording Lisa's vital signs, (iii) without recording any information at all in Lisa's medical record, and (iv) despite the fact that

Lisa was exhibiting obvious signs of extreme abdominal pain and distress and was desperately pleading for emergency medical help, circumstances which incarcerated people in the same housing unit, as laypeople, found obviously indicated that Lisa was extremely sick, was in severe pain, may very well be dying, and was in need of immediate medical treatment.

(c) Defendant Booth failed to do anything for Lisa from approximately 3:30 p.m. on April 1, 2016, through the end of his shift at approximately 10:00 p.m. on April 1, 2016, even though Lisa was exhibiting obvious signs of extreme abdominal pain and distress and was desperately pleading for emergency medical help.

(d) A housing officer informed at least one central control room operator, Scott Sparkuhl, that he should ignore communications from Lisa through her emergency button and intercom about her extreme abdominal pain and her urgent need for medical assistance.

(e) Scott Sparkuhl, a central control room operator who was directed by a housing officer to ignore communications from Lisa's cell did, in fact, ignore communications from Lisa through her emergency button and intercom about her extreme abdominal pain and her urgent need for medical assistance, as well as ignoring communications from at least two

other incarcerated people, through their emergency buttons and intercoms, indicating that Lisa was in severe distress.

(f) Defendant Harris failed to do anything for Lisa for the entirety of Defendant Harris's shift, from approximately 10:00 p.m. on April 1, 2016, until approximately 6:00 a.m. on April 2, 2016, other than tell Defendant Frederickson, at the end of Harris's shift and the beginning of Frederickson's shift, that Lisa had been crying and screaming all night and constantly asked to see a nurse, which Defendants Harris and Frederickson failed even to note in their shift logs.

(g) Defendant Frederickson failed, from approximately 6:00 a.m. through approximately 8:00 a.m. on April 2, 2016, to communicate over the radio or otherwise that a nurse needed to immediately respond to Lisa's obvious and extreme abdominal pain and distress.

(h) Defendant Frederickson, in conformity with the customs and policies in place at the Salt Lake County Metro Jail, which ~~Defendant~~ Bell actively endorsed, ratified, and failed to remedy, failed to disclose to either Defendant Tucker or Nurse Colby James that (1) Lisa displayed obvious signs and symptoms of extreme abdominal pain and distress; (2) Defendant Frederickson was briefed at the beginning of his shift that Lisa

had been crying and screaming all night and had been constantly pressing her emergency button all night long asking for a nurse; and (3) another incarcerated person informed Defendant Frederickson that she was worried Lisa was going to die and that no medical personnel had come to help Lisa.

(i) Defendant Tucker failed to do anything for Lisa even though Defendant Tucker was in Unit 8C, within a few yards of where Lisa was located, within two hours prior to Lisa being found unresponsive and not breathing in her cell. Additionally, Defendant Tucker baselessly and erroneously assumed, without any medical evaluation, that Lisa's abdominal symptoms, as reported to Defendant Tucker by Defendant Frederickson, were caused by substance withdrawal.

(j) While Nurse Colby James was in Unit 8C minutes before Lisa was found unresponsive and not breathing in her cell, he failed to even walk over to Lisa's cell when he was informed by Defendant Frederickson that Lisa was seeking medical help. Colby James's failure to do so was in conformity with established unconstitutional customs at the Salt Lake County Jail, which ~~Defendant~~ Bell actively endorsed, ratified, and failed to remedy, even if Colby James knew that Lisa had been crying out in

pain, begging for medical treatment, hitting the emergency button all night long, and that another inmate had expressed her concern that Lisa had not received medical treatment and was going to die. Colby James's justification for not walking to where Lisa was located and evaluating her was that she had not filled out a sick call request form, although the written policy of the jail was that if incarcerated people had what they believed to be an emergency medical condition, they were not to fill out sick call request forms, but, instead, they were to inform a housing officer and that officer was to notify a nurse, who was to visit and evaluate the incarcerated person as soon as possible.

(k) For approximately twenty-two hours before Lisa was found unresponsive and not breathing in her cell, Lisa received no meaningful evaluation, did not even have her vital signs measured and recorded, and was provided no medical treatment or referral for treatment, even though Lisa (i) repeatedly and loudly complained of horrific pain, (ii) repeatedly and urgently asked to see a nurse, (ii) cried out and screamed all night asking for help, (iii) pressed her emergency intercom button all night asking for a nurse, and (iv) was so obviously in need of emergency medical intervention that other incarcerated people repeatedly told housing

officers that Lisa needed immediate medical help and that she might die if she did not receive it.

~~73.~~66. Written policy applicable at the Salt Lake County Metro Jail required that when an incarcerated person on a substance withdrawal protocol exhibited certain signs of withdrawal, including having a heart rate greater than 110 beats per minute, a nurse was to immediately contact a physician.

~~74.~~67. In direct contravention of that written policy, ~~Defendant~~ Bell actively endorsed, encouraged, condoned, and ratified an unconstitutional custom of nurses deliberately failing to contact a physician when an incarcerated person who was on a substance withdrawal protocol exhibited one or more of the specified signs of withdrawal, including having a heart rate greater than 110 beats per minute. ~~Defendant~~ Bell also failed, with deliberate indifference toward the medical needs of incarcerated people, to ensure that nurses at the Salt Lake County Metro Jail followed all written policies relating to substance withdrawal, including that nurses immediately contact a physician when an incarcerated person displays signs of withdrawal, including a heart rate greater than 110 beats per minute.

~~75.~~68. As a result of that unconstitutional custom, in direct violation of written policy, no one contacted a physician when Lisa's heart rate was measured to be 133 beats per minute on March 31, 2016.

~~76.~~69. As a direct result of a physician not being informed of Lisa's heart rate of 133, Lisa was denied a medical evaluation, monitoring, diagnosis, and emergency medical treatment, ultimately leading to Lisa's wrongful death.

~~77.~~70. Written policy applicable at the jail required that incarcerated people who were placed on the WOWS protocol or CIWA protocol for substance withdrawal were to have an assessment, including having vital signs measured and recorded, twice daily for a period of five days.

~~78.~~71. ~~Defendant~~ Bell actively endorsed, encouraged, condoned, and ratified an unconstitutional custom of contradicting that written policy and failing to perform all required assessments under the WOWS and CIWA protocols. ~~Defendant~~ Bell also failed, with deliberate indifference toward the medical needs of incarcerated people, to ensure that nurses at the Salt Lake County Metro Jail complied with written policies and physicians' orders relating to substance withdrawal, including that all ordered assessments and monitoring of vital signs were completed.

~~79.~~72. Because Lisa was placed on the WOWS and CIWA protocols, written policy and physician orders required that Lisa was to have an assessment, including having her vital signs measured and recorded, twice daily for five days, beginning March 30, 2016.

~~80.~~73. In contravention of written policy, the WOWS and CIWA protocols, and physician orders, no one performed the required assessments for Lisa or measured and recorded Lisa's vital signs during the afternoon or evening of April 1, 2016, or the morning of April 2, 2016, which Defendant Seewer was required to perform or to ensure were performed by another nurse. Had the assessments been performed and had Lisa's vital signs been monitored, any trained medical staff person would have recognized that Lisa was suffering from a serious, perhaps life-threatening, medical condition and Lisa would have been urgently provided, or transported for, diagnosis and emergency treatment for her life-threatening peritonitis. Lisa would have survived had Defendant Seewer not been working in a culture and pursuant to a custom of sloppy, unaccountable, dismissive, and reckless medical monitoring and care, for which Bell was responsible, where Seewer did not even know it was his responsibility to make certain that the CIWA and WOWS assessments of Lisa were performed and that her vital signs were monitored on the afternoon of April 1, 2016.

~~81.~~74. ~~Defendant~~ Bell's active endorsement, encouragement, condonation, and ratification of the unconstitutional custom of failing to perform all required evaluations under the WOWS and CIWA protocols includes ~~Defendant~~ Bell's failure to take any corrective action after learning that Defendant Seewer failed to perform

the WOWS and CIWA evaluations for Lisa Ostler, as he was required to do, on the afternoon of April 1, 2016.

~~82.~~75. As a direct result of Lisa not being evaluated pursuant to the WOWS and CIWA protocols and not having her vital signs measured and recorded, Lisa was denied a medical evaluation, monitoring, diagnosis, and emergency medical treatment, ultimately leading to Lisa's wrongful death.

~~Defendant~~ Bell's Customs Regarding Nurses' Entertainment Activities on the Job

~~83.~~76. As the result of ~~Defendant~~ Bell's failure to provide appropriate supervision and training, nurses and mental health workers at the Salt Lake County Metro Jail routinely spent hours during their shift, while not on break, engaged in personal entertainment such as watching movies, watching YouTube videos, and browsing the internet.

~~84.~~77. ~~Defendant~~ Bell actively endorsed the unconstitutional custom of medical personnel engaging in entertainment activities while on the job. ~~Defendant~~ Bell also failed, with deliberate indifference toward the medical needs of incarcerated people, to ensure that nurses worked while they were at work, which would obviously require that nurses not be allowed to openly and notoriously spend hours a day watching videos, browsing the internet, and otherwise entertaining themselves with personal recreational activities.

~~85.~~78. ~~Defendant~~ Bell failed to supervise nurses to prevent them from spending portions of their shifts engaged in personal entertainment activities.

~~86.~~79. As a direct result of ~~Defendant~~ Bell's endorsement of, and failure to prevent, nurses from spending portions of their shifts engaged in personal entertainment activities, nurses became accustomed to not attending to incarcerated

people's needs and, hence, because of a culture of indifference toward the serious medical needs of incarcerated people, for which Bell was responsible, no nurse provided any form of medical intervention for Lisa's life-threatening medical emergency until Lisa was found unresponsive and not breathing in her cell.

~~Defendant~~ Bell's Customs and Policies Regarding Review of In-Custody Deaths

~~87.~~80. ~~Defendant~~ Bell was responsible, in the case of each in-custody death, to participate in a "morbidity and mortality" review to "determine the appropriateness of custody and medical's emergency response actions surrounding the death" and to "assess the appropriateness of medical care received prior to the death."

~~88.~~81. In complete dereliction of his duties to assure that health services for incarcerated people are accessible, timely, and of appropriate quality, and to identify and remedy practices and policies that contribute to or cause the deaths of incarcerated people, ~~Defendant~~ Bell has ignored and does not even know the circumstances of the deaths of incarcerated people who died in the Salt Lake County Jail while ~~Defendant~~ Bell was the Responsible Health Authority; in fact, he does not even know the names of many incarcerated people who have died during the time he has been the top person responsible for (i) the quality, responsiveness, and timeliness of medical care provided at the Salt Lake County Metro Jail, (ii)

thoroughly investigating the causes of deaths of inmates and whether there were problems in the provision of medical care contributing to the deaths, and (iii) taking measures to prevent unnecessary deaths in the future.

~~89.~~82. Indicative of ~~Defendant~~ Bell's normal practice in the case of in-custody deaths, for at least one year after Lisa's death, ~~Defendant~~ Bell did nothing to obtain information from Defendants Holly Harris, Todd Booth, or Ron Seewer about the circumstances leading up to Lisa's death.

~~90.~~83. Indicative of ~~Defendant~~ Bell's normal, careless, slip-shod practice in connection with in-custody deaths, when ~~Defendant~~ Bell participated in a "morbidity and mortality" review to "determine the appropriateness of custody and medical's emergency response" relating to Lisa's death and "assess the appropriateness of medical care" provided to Lisa, none of the participants were aware of Lisa's cause of death, there had not even been interviews of many important witnesses in possession of highly relevant information, and a purported review of the medical records missed at least six glaring errors and omission in Lisa's CIWA and WOWS assessment records, including the fact that no one had monitored Lisa's vital signs during the approximately twenty-two hours before she was found unresponsive and not breathing, in violation of medical orders and formal jail policies, which led to Lisa's wrongful death.

~~91.~~84. ~~Defendant~~ Bell further actively endorsed and ratified a custom and policy of maintaining no records of communications during the "morbidity and mortality" reviews, undermining even the possibility that corrective actions could be taken in response to the numerous in-custody deaths at the Salt Lake County Metro Jail.

~~92.~~85. Through ~~Defendant~~ Bell's actions and omissions, he actively endorsed, implemented, encouraged, and condoned an unconstitutional custom and culture of deliberate indifference toward the deaths of incarcerated people at the Salt Lake County Metro Jail and toward investigating and gaining knowledge about them so as to recognize problems and resolve them to protect other incarcerated people in the future.

~~93.~~86. Indicative of the culture and unconstitutional custom of deliberate indifference toward the deaths of incarcerated people, Defendant Zachary Frederickson, when he was informed by another incarcerated person that she was concerned Lisa was going to die if she did not receive emergency medical assistance, told that person that Lisa was not going to "die on my watch," but had failed to ensure that a nurse evaluated Lisa, even though two nurses physically came to the housing unit during Frederickson's shift before Lisa was found unresponsive and not breathing.

~~94.~~87. As a direct result of the unconstitutional custom and culture of deliberate indifference toward the deaths of incarcerated people, all staff at the Salt Lake County Metro Jail, including all housing officers, control room operators, nurses, and supervisors, failed to medically intervene, or ensure that someone medically intervened, in response to Lisa's obviously life-threatening medical emergency until she was found unresponsive and not breathing in her cell.

~~95.~~88. ~~Defendant~~ Lofgreen was at all material times the Chief Deputy Sheriff and Commander at the Salt Lake County Metro Jail and was responsible for (a) the management, supervision, and training of all officers at the Salt Lake County Metro Jail, (b) ensuring compliance with all official policies applicable at the Salt Lake County Metro Jail, and (c) ensuring that operations, policies, procedures, and customs at the Salt Lake County Metro Jail protected the constitutional rights of incarcerated people, including access to adequate and reasonable medical care.

~~Defendant~~ Lofgreen's Customs and Policies Regarding Instructions to "Ignore" All Communications from a Particular Incarcerated Person

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~~96.~~89. In at least March and April of 2016, it was the unconstitutional custom at the Salt Lake County Metro Jail that housing officers could instruct a central control room operator to "ignore" communications from a cell, including ringing of

an emergency bell and conversations over an intercom, which was commonly understood to mean an instruction that the central control room operator was to communicate to the housing officer only *new* information being reported by the person in that cell and to otherwise ignore communications from that cell. ~~Defendant~~ Lofgreen condoned and ratified that custom, and permitted it to continue, in violation of her duties to ensure timely and adequate medical responses to urgent, serious medical conditions of incarcerated people. ~~Defendant~~ Lofgreen failed, with deliberate indifference toward the medical needs of incarcerated people, to ensure that central control room operators adequately and timely communicated information about the medical needs of incarcerated people to a housing officer and to ensure that housing officers adequately and timely communicated that information to a nurse, both of which would most obviously require that, absolutely, neither housing officers nor central control room operators could decide to "ignore" communications from a cell.

~~97.~~90. As a direct result of that custom, on April 1, 2016, a housing officer instructed Scott Sparkuhl, a central control room operator, to "ignore" Lisa's cell.

~~98.~~91. On the night of April 1, 2016, into the morning of April 2, Lisa communicated to Scott Sparkuhl through the emergency button and intercom in her cell approximately one to two times per hour, for a total of approximately sixteen

communications throughout Scott Sparkuhl's eight-hour graveyard shift. In those communications, Lisa repeatedly informed Scott Sparkuhl that Lisa was in pain and needed medical help. As a direct result of the instruction he received to "ignore" Lisa's cell, Scott Sparkuhl only contacted a housing officer one or two times about Lisa throughout the night and otherwise did not relay any information to anyone about Lisa's repeated communications about her pain and her urgent need for medical help.

~~99.~~92. Also because Scott Sparkuhl was instructed to ignore Lisa's cell, Scott Sparkuhl ignored communications from at least two other incarcerated people in the same unit where Lisa was located, who expressed their concerns about either Lisa's need for medical treatment or the amount of noise Lisa was making.

~~Defendant~~ Lofgreen's Customs and Policies Regarding Failures to Log and Maintain Thorough and Accurate Information

~~100.~~93. ~~Defendant~~ Lofgreen actively endorsed and implemented a policy and custom at the Salt Lake County Metro Jail that housing officers were not allowed to record information in their logs about the medical complaints of incarcerated people. ~~Defendant~~ Lofgreen also failed, with deliberate indifference toward the medical needs of incarcerated people, to ensure that housing officers recorded all

relevant and necessary information in their logs, including information relating to the medical complaints of incarcerated people. As a result of that policy and custom:

(a) Defendant Booth failed to note anything about Lisa's abdominal pain, obvious distress, and urgent pleas for medical help other than that Lisa did not take her lunch tray because she was "sick" and that Defendant Seewer "examined" Lisa, who was "complaining of pain."

(b) Defendant Harris failed to log anything at all about Lisa, even though Lisa's condition was so severe and obvious that she was screaming, moaning, and crying out in pain all night, begging for medical help, and at least three or four incarcerated people spoke with Defendant Harris about their concerns that Lisa needed emergency medical intervention.

(c) Defendant Frederickson failed to log anything about Lisa's horrific abdominal pain, obvious distress, and urgent pleas for medical help other than that Lisa "refused breakfast," "has not eaten since she arrived in the unit yesterday," and "confirmed that she doesn't want to eat and also reports that she is bleeding vaginally."

(d) Because Defendants Booth, Harris, and Frederickson failed to log critical information about Lisa's emergency medical condition and urgent pleas for medical intervention, staff at the Salt Lake County Metro Jail on April

1 and April 2 of 2016, including nurses, housing officers, sergeants, and commanders, were unable to properly intervene to ensure that Lisa received emergency medical evaluation and treatment or referral for treatment.

~~101.~~94. Policy and custom at the Salt Lake County Metro Jail required that housing officers communicate to their supervising sergeants and a member of the Health Services staff about each instance in which an incarcerated person did not take a meal.

~~102.~~95. ~~Defendant~~ Lofgreen actively endorsed and implemented an unconstitutional policy and custom of deleting those records as soon as the incarcerated person did not refuse a meal tray, which could have been because the incarcerated person died or because the incarcerated person took the meal tray and did not eat any of the meal. ~~Defendant~~ Lofgreen also failed, with deliberate indifference toward the medical needs of incarcerated people, to ensure that accurate records, including emails from housing officers, reflecting the missed meals of incarcerated people were maintained and preserved.

~~103.~~96. As a result of that custom and policy, staff at the Salt Lake County Metro Jail failed to maintain accurate records relating to Lisa's missed meals, depriving nurses, housing officers, and their supervisors of accurate

information about the duration and severity of Lisa's life-threatening medical emergency.

~~Defendant~~ Lofgreen's Customs Regarding the Ignoring of Medical Complaints

~~104.~~97. At least during March and April of 2016, it was the unconstitutional custom at the Salt Lake County Metro Jail, which was condoned, encouraged, ratified, and actively endorsed by ~~Defendant~~ Lofgreen, that housing officers could ignore the signs and symptoms of abdominal pain and emergency requests for medical help made by incarcerated people. ~~Defendant~~ Lofgreen also failed, with deliberate indifference toward the medical needs of incarcerated people, to ensure that housing officers informed medical personnel of all emergency requests for medical help and to ensure that housing officers did not fail to disclose in their communications with nurses all relevant information about an incarcerated person, including that an incarcerated person experienced signs and symptoms of abdominal pain.

~~105.~~98. As a result of, and reflecting, that unconstitutional custom, housing officers were provided no training whatsoever to recognize or appropriately respond to life-threatening abdominal conditions. ~~Defendant~~ Lofgreen knowingly failed to provide that training and ratified the decisions of her subordinates to not provide that training, all of which reflects the deliberate indifference of ~~Defendant~~

Lofgreen and Defendant Salt Lake County toward the constitutional rights and medical needs of incarcerated people.

~~106.~~99. Also as a direct result of that unconstitutional custom:

(a) Defendant Booth failed to do anything for Lisa from approximately 3:30 p.m. on April 1, 2016, through the end of his shift at approximately 10:00 p.m. on April 1, 2016, even though Lisa was exhibiting obvious signs of extreme abdominal pain and distress and was desperately pleading for emergency medical help.

(b) A housing officer instructed at least one central control room operator, Scott Sparkuhl, to ignore Lisa's cell, and at least one central control room operator in fact did ignore calls from Lisa about her abdominal pain and urgent need for medical attention as well as calls from other incarcerated people about Lisa.

(c) Defendant Harris failed to do anything for Lisa for the entirety of her shift, from approximately 10:00 p.m. on April 1, 2016, until approximately 6:00 a.m. on April 2, 2016, other than tell Defendant Frederickson, at the end of Harris's shift and the beginning of Frederickson's shift, that Lisa had been crying and screaming all night

and constantly asked to see a nurse, which Defendants Harris and Frederickson failed even to note in their shift logs.

(d) Defendant Frederickson failed, from approximately 6:00 a.m. through approximately 8:00 a.m. on April 2, 2016, to communicate over the radio or otherwise that a nurse needed to immediately respond to Lisa's obvious and extreme abdominal pain and distress.

(e) When Lisa desperately sought help from Defendant Frederickson for Lisa's horrific abdominal pain and reported to him that she was "bleeding," Defendant Frederickson baselessly, erroneously, and with deliberate indifference to Lisa's life-threatening abdominal condition assumed that Lisa was experiencing "vaginal bleeding," despite the fact that Lisa had not experienced vaginal bleeding, and thus would not have reported "vaginal" bleeding.

(f) Defendant Frederickson, in conformity with the customs and policies in place at the Salt Lake County Metro Jail, which were actively endorsed and ratified by ~~Defendant~~ Lofgreen, failed to disclose to either Defendant Tucker or Nurse Colby James that (1) Lisa displayed obvious signs and symptoms of extreme abdominal pain and distress; (2) Defendant Frederickson was briefed at the beginning of his shift that Lisa had been

crying and screaming all night and had been constantly pressing her emergency button all night long asking for a nurse; or (3) another incarcerated person informed Defendant Frederickson that she was worried Lisa was going to die and that no medical personnel had come to help Lisa.

~~Defendant~~ Bell's and ~~Defendant~~ Lofgreen's Customs and Policies Regarding the Failure to Train Housing Officers to Recognize and Respond to Abdominal Pain

~~107.~~100. ~~Defendant~~ Bell was responsible for ensuring that all staff at the Salt Lake County Metro Jail were properly trained so that people incarcerated at the Salt Lake County Metro Jail would receive quality, accessible, unrestricted, and timely health services. ~~Defendant~~ Bell personally reviewed and authorized the training provided to housing officers regarding CPR and first aid, which together constituted the only training housing officers received about recognizing signs and symptoms of serious medical conditions and responding to emergency medical conditions. ~~Defendant~~ Lofgreen was responsible for ensuring that all housing officers and their supervisors were properly trained so that people incarcerated at the Salt Lake County Metro Jail would receive adequate, reasonable, and timely health services.

~~108.~~101. ~~Defendants~~ Bell and Lofgreen, with deliberate indifference, each failed to adequately train, or ensure the adequate training of, housing officers at the Salt Lake County Metro Jail to recognize signs and symptoms of serious, life-threatening abdominal conditions and adequately respond to life-threatening abdominal medical conditions.

~~109.~~102. ~~Defendants~~ Bell and Lofgreen ratified the decisions of subordinates, who were delegated the responsibility of training housing officers, to provide no training whatsoever to housing officers to recognize and adequately respond to life-threatening abdominal medical conditions.

~~110.~~103. As a result of ~~Defendant~~ Bell's and ~~Defendant~~ Lofgreen's deliberately indifferent failure to ensure housing officers were trained to recognize and adequately respond to life-threatening abdominal medical conditions, Defendants Booth, Harris, and Frederickson callously failed to provide an appropriate emergency-level response to Lisa's obvious signs of extreme abdominal pain and desperate pleas for help, leading to the failure by housing officers, nurses, and jail doctors to provide Lisa the timely evaluation and treatment to which she was constitutionally entitled, ultimately leading to Lisa's wrongful death.

~~Defendant~~ Bell's and ~~Defendant~~ Lofgreen's Customs Regarding the Delegation of Responsibilities Among Housing Officers and Nurses

~~111.~~104. ~~Defendants~~ Bell and Lofgreen, with deliberate indifference toward the serious medical needs of incarcerated people, each perpetuated and ratified an unconstitutional custom at the Salt Lake County Metro Jail that housing officers, with no medical training, were expected or allowed to use their own discretion to determine whether the medical complaints of an incarcerated person were sufficiently serious to necessitate the housing officer to immediately notify a nurse about the medical complaints so the nurse would immediately come to and evaluate the incarcerated person.

~~112.~~105. That custom was in direct contravention of policy at the Salt Lake County Jail that housing officers are to contact a nurse about each and every instance in which an inmate requests immediate medical assistance.

~~113.~~106. That custom was also in contravention of written policy that all matters of medical and nursing judgment are the sole responsibility of Health Services personnel.

~~114.~~107. As a result of that custom, Defendants Booth, Harris, and Frederickson, who were medically untrained and, specifically, untrained to recognize the signs and symptoms of serious abdominal medical conditions, each made their own determination, based on no medical training or knowledge whatsoever and without any medical evaluation or assessment, that the many

requests for medical help made by Lisa did not require the housing officer to call a nurse about Lisa's medical condition and to get a nurse to come to and evaluate Lisa, even though she was exhibiting obvious signs of extreme abdominal pain and distress, she was communicating that she was suffering severe pain, and she was desperately pleading for emergency medical help, which custom led to Lisa not receiving timely evaluation and treatment, to which she was constitutionally entitled and which ultimately led to Lisa's wrongful death.

~~115.~~108. With deliberate indifference toward the medical needs of incarcerated people, ~~Defendants~~ Bell and Lofgreen each actively endorsed, promoted, and condoned a custom at the Salt Lake County Metro Jail that housing officers, with no medical training, made medically baseless determinations as to whether an incarcerated person's medical complaint constituted a medical emergency and that nurses relied on those medically baseless determinations instead of going to see and evaluate the incarcerated person to determine if further evaluation, monitoring, diagnosis, or treatment was required. ~~Defendants~~ Bell and Lofgreen each failed, with deliberate indifference toward the medical needs of incarcerated people, to ensure that nurses, not housing officers, made all determinations about whether incarcerated people were suffering from medical emergencies.

~~116.~~109. That custom was in contravention of written policy that all matters of medical and nursing judgment are the sole responsibility of Health Services personnel.

~~117.~~110. As a result of that custom, Defendants Booth, Harris, and Frederickson each made their own determination, based on no medical training or knowledge whatsoever and without any medical evaluation or assessment, that Lisa would not receive an emergency medical evaluation, a medical diagnosis, or treatment, or a referral for a medical diagnosis or treatment, even though Lisa was exhibiting obvious signs of extreme abdominal pain and distress and was desperately pleading for emergency medical help.

~~118.~~111. Also as a result of that custom, Defendant Tucker and Nurse Colby James, who are nurses with medical training, education, and certification, each requested, and left it to, Defendant Frederickson, a housing officer with no medical knowledge, training, or expertise, to determine whether it *appeared to Defendant Frederickson* that Lisa was having a medical emergency in the hours and minutes before Lisa became unresponsive and not breathing. Likewise, if, as she maintains (but which is not reflected or corroborated by any evidence, including the medical records, which have no notation of Lisa's vital signs during the entire approximately twenty-two hours she was in Unit 8C), Defendant Holly Harris called

a nurse about Lisa, as a result of the custom described in paragraph 115, the nurse left it to Defendant Harris, a housing officer with no medical knowledge, training, or experience, to determine whether it appeared to Defendant Harris that Lisa was experiencing a medical emergency during the evening and early morning hours before Lisa became unresponsive and was not breathing.

~~119.~~112. The custom sanctioned by ~~Defendants~~ Bell and Lofgreen that housing officers were to determine whether an incarcerated person is experiencing a medical emergency led to Lisa not receiving the timely and efficacious evaluation, diagnosis, and treatment to which she was constitutionally entitled, and ultimately leading to Lisa's wrongful death.

~~120.~~113. As high-ranking officials and administrators of the Salt Lake County Metro Jail, ~~Defendants~~ Bell and Lofgreen each had a constitutional duty to provide necessary medical treatment to inmates.

~~121.~~114. ~~Defendant~~ Bell failed to remedy serious incompetence and serious deficiencies in the health care system at the Salt Lake County Metro Jail, including deficiencies in training and procedures, that prevented the diagnosis and treatment of Lisa.

~~122.~~115. ~~Defendant~~ Lofgreen failed to remedy serious incompetence and serious deficiencies in the policies, practices, customs, and training given to housing officers, their supervisors, and central control room operators with respect to their role in ensuring that incarcerated people received adequate, timely, and reasonable health care.

~~123.~~116. At all times material hereto, ~~Defendant~~ Bell and Defendant Salt Lake County followed, established, and implemented a policy and custom of failing to train or adequately supervise its officers and nurses who they were responsible for supervising at the Salt Lake County Metro Jail.

~~124.~~117. At all times material hereto, ~~Defendants~~ Lofgreen and Defendant Salt Lake County followed, established, and implemented a policy and custom of failing to train or adequately supervise housing officers and their direct supervisors.

~~125.~~118. The policies and customs of ~~Defendants~~ Bell, Lofgreen, and Defendant Salt Lake County constituted and reflected deliberate indifference to the serious medical needs and constitutional right of Lisa to receive proper and necessary medical care for her obviously serious, life-threatening medical condition while detained in the Salt Lake County Metro Jail. Those policies and customs also led to the infliction of punishment on Lisa, including the disregard of her serious medical condition and locking her down and refusing medical observation, with the

intent to make her withdraw from drugs cold-turkey (when drug withdrawal is itself a serious medical condition), without any medical observation, evaluation, or treatment, in violation of her due process rights under the United States and Utah Constitutions.

~~126.~~119. ~~Defendants~~ Bell and Defendant Salt Lake County caused Lisa to be denied medical treatment for her serious medical condition insofar as they developed, adopted, implemented, condoned, administered, and failed to remedy policies, practices, patterns, customs, and a widespread culture of callousness and deliberate indifference toward the serious, potentially life-threatening medical needs of incarcerated people, which were followed by the Nurse Defendants and Guard Defendants in their conduct described above, that (1) denied nurses and other jail personnel the ability or authority to obtain a physician's care for detainees; (2) permitted nurses and other jail personnel to conceal the existence of serious physical ailments from physicians; (3) depended on nurses to recognize and treat serious physical ailments; (4) enabled nurses to fail or refuse to provide medical care and to prevent detainees from receiving medical treatment from physicians; (5) created excessive delays in the provision of medical treatment by physicians; (6) permitted prison medical personnel to provide improper or inadequate treatment to seriously ill detainees; (7) failed to provide for or effectuate competent, timely, and responsive

medical treatment for detainees; (8) allowed and caused nurses to provide no evaluation of abdominal pain when abdominal pain was disclosed; (9) encouraged nurses to ignore complaints of abdominal pain by inmates who were placed on a withdrawal protocol; (10) caused the failure to transition medical care and monitoring when an inmate is transferred from a quarantine unit to another housing unit; (11) permitted nurses to fail to perform essential job functions and instead spend multiple hours per shift watching videos on the internet and engaging in other personal and recreational activities entirely unrelated to the nurses' essential job functions; (12) allowed nurses to defer to or allow medically untrained housing officers to determine whether an inmate is experiencing a medical emergency; (13) encouraged and permitted nurses to instruct inmates, directly or through housing officers, to complete a paper medical request form to seek medical help, even when the inmates' symptoms may indicate a medical emergency, and to otherwise ignore the inmates' requests for urgent medical help; (14) allowed nurses to fail to monitor and record the vital signs of inmates, even when in contravention of physician orders, protocols, and written policy applicable at the Salt Lake County Metro Jail; (15) allowed nurses to fail to determine, and fail to inquire about, an inmate's relevant medical history before determining that the inmate is "cleared" to remain in a housing unit with no further medical monitoring, evaluation, diagnosis, or treatment

until at least the next day; and (16) allowed the falsification, deletion, and alteration of portions of inmates' medical records and the failure to note all relevant information in those medical records.

~~127.~~120. ~~Defendants~~ Bell, Lofgreen, and Defendant Salt Lake County caused Lisa to be denied medical treatment for her serious medical condition insofar as they developed, adopted, implemented, condoned, administered, and failed to remedy policies, practices, patterns, customs, and a widespread culture of callousness and deliberate indifference toward the serious, potentially life-threatening medical needs of incarcerated people, which were followed by the Nurse Defendants and Guard Defendants in their conduct described above, that (1) permitted jail personnel to improperly or inadequately make, or fail to make, referrals for treatment by competent medical professionals to seriously ill detainees; (2) provided grossly inadequate training, or no training at all, to housing officers pertaining to the recognition of life-threatening medical situations, including life-threatening abdominal conditions, in contravention of written policy; (3) allowed jail staff to fail to instruct inmates during the intake and booking process how to request emergency medical assistance; (4) encouraged and permitted jail personnel to instruct inmates to complete a paper medical request form to seek medical help, even when the inmates' symptoms may indicate a medical emergency, and to otherwise

ignore the inmates' requests for urgent medical help; (5) encouraged and permitted jail personnel to treat an inmate's request for medical help as an emergency only if the inmate is excessively bleeding, having a seizure, or not breathing; (6) allowed housing officers to withhold from nurses vital information about an inmate's request for medical help, such as, in Lisa's case, that she was suffering from extreme abdominal pain, was in obvious distress, was screaming and crying out throughout the night, and repeatedly begged to see a nurse, among other information; and (7) allowed medically untrained housing officers to determine whether an inmate is experiencing a medical emergency.

~~128.~~121. The policies and customs developed, adopted, implemented, and administered by ~~Defendants~~ Bell, Lofgreen, and Defendant Salt Lake County denied Lisa and other inmates access to necessary medical care and demonstrate deliberate indifference to Lisa's and other inmates' serious medical needs in violation of the Fourteenth Amendment to the United States Constitution.

~~129.~~122. ~~Defendant~~ Bell knew, and reasonably should have known, that the policies, customs, patterns, practices, culture, failures to train, failures to supervise, and failures to carry out his responsibilities described in paragraphs ~~56–49–8794~~, ~~107–119~~100–112, 11~~4~~21, ~~123~~116, and ~~125~~118–~~127–~~120 above would

cause employees at the Salt Lake County Metro Jail to deprive incarcerated people of their constitutional right to adequate and reasonable medical care.

~~130.~~123. As a direct result of the policies, customs, patterns, practices, culture, failures to train, failures to supervise, and failures to carry out responsibilities described in paragraphs ~~56~~49–~~94~~87, ~~107~~100–~~119~~112, ~~121~~114, ~~123~~116, and ~~125~~118–~~127~~ 120 above, employees at the Salt Lake County Metro Jail deprived Lisa of her constitutional right to adequate and reasonable medical care, causing her wrongful death.

~~131.~~124. ~~Defendant~~ Bell is responsible, due to his affirmative conduct, and, at minimum, his failures to take corrective action, for each of the policies, customs, patterns, practices, culture, failures to train, failures to supervise, and failures to carry out his responsibilities described in paragraphs ~~56~~49–~~94~~87, ~~107~~100–~~119~~112, ~~121~~114, ~~123~~116, and ~~125~~118–12~~07~~ above, which affirmatively link ~~Defendant~~ Bell's conduct, and failures to act, to the violations of Lisa's constitutional rights.

~~132.~~125. ~~Defendant~~ Lofgreen knew, and reasonably should have known, that the policies, customs, patterns, practices, culture, failures to train, failures to supervise, and failures to carry out her responsibilities described in paragraphs ~~96~~89–11~~2~~9, 11~~5~~22, 11~~7~~24, ~~125~~118, and 12~~07~~ above would cause employees at the

Salt Lake County Metro Jail to deprive incarcerated people of their constitutional right to adequate and reasonable medical care.

~~133.~~126. As a direct result of the policies, customs, patterns, practices, culture, failures to train, failures to supervise, and failures to carry out responsibilities described in paragraphs ~~96~~89 ~~119~~112, ~~122~~115, ~~124~~117, ~~125~~118, and 120~~7~~ above, employees at the Salt Lake County Metro Jail deprived Lisa of her constitutional right to adequate and reasonable medical care, causing her wrongful death.

~~134.~~127. ~~Defendant~~ Lofgreen is responsible, due to her affirmative conduct, and, at minimum, failures to take corrective action, for each of the policies, customs, patterns, practices, culture, failures to train, failures to supervise, and failures to carry out her responsibilities described in paragraphs ~~96~~89–112~~9~~, ~~122~~115, ~~124~~117, ~~125~~118, and ~~127~~ 120 above, which affirmatively link ~~Defendant~~ Lofgreen's conduct, and failures to act, to the violations of Lisa's constitutional rights.

~~135.~~128. As a result of the unconstitutional policies, customs, patterns, practices, culture, failures to train, failures to supervise, and failures to carry out their responsibilities described in paragraphs ~~56~~49 ~~94~~87, ~~96~~89–112~~9~~, and 114~~21~~ ~~127~~120, ~~Defendants~~ Bell, Lofgreen, and Defendant Salt Lake County established a deeply flawed system of delivering medical care at the Salt Lake County Metro Jail.

That flawed system and those who established it were deliberately indifferent to the medical needs of incarcerated people, particularly those who were identified as being at risk for substance withdrawal. Under that flawed system, it was inevitable that Lisa's life-threatening medical condition would be ignored until Lisa was essentially dead. That flawed system: (a) caused housing officers to ignore and fail to communicate to nurses that Lisa was suffering obvious symptoms of a life-threatening emergency and was desperately pleading to see a nurse for many hours; (b) caused nurses to fail to intervene and to rely on medically untrained housing officers to determine whether Lisa was having a medical emergency, which the housing officers failed to do; and (c) caused nurses to violate written policies, protocols, and physician orders by failing to assess Lisa, including measuring and recording her vital signs, for more than twenty-two hours before she was found unresponsive and not breathing.

~~136.~~129. The presence of gross deficiencies in the medical care system at the Salt Lake County Metro Jail, which led to the failures to provide or to obtain from a competent medical provider medical treatment and care of Lisa's severe, life-threatening medical condition, and the failure of ~~Defendants~~ Bell, Lofgreen, and Defendant Salt Lake County to remedy those deficiencies, demonstrated deliberate disregard for a known or obvious risk that was very likely to result in the violation

of the constitutional rights of Lisa and other pretrial detainees held at the Salt Lake County Metro Jail. Consequently, those failures evidence deliberate indifference to Lisa's and others' serious medical needs by Bell and Salt Lake County.

~~137.~~130. Indicative of the culture, policies, procedures, and customs permitted, condoned, and perpetuated by ~~Defendants~~ Bell, Lofgreen, and Defendant Salt Lake County, which led to the grossly deficient and indifferent medical care system at the Salt Lake County Jail:

- Carlos Umana, a mentally ill inmate, was allowed to die of starvation and dehydration after spending four months in custody at the Salt Lake County Metro Jail.
- Alexa Hamme, 25 years old, was found unresponsive in her cell at the Salt Lake County Metro Jail and died after the failure to attend to her serious medical needs.
- Lindsey Goggin died as a result of severe dehydration while being held at the Salt Lake County Metro Jail.
- Dustin Bliss was found unresponsive in a holding cell in the booking area of the Salt Lake County Metro Jail and died, never having received adequate medical treatment at the Salt Lake County Metro Jail.

- Meagan Deadrich was 27-weeks pregnant when her baby died and she had to have her uterus removed, all because jail nurses brushed off her complaints of bleeding and simply told her that bleeding during pregnancy is normal.
- Scott Osterkamp fell off a top bunk and broke his arm, then jail staff refused to provide medical assistance for several days as he turned yellow and became incoherent, notwithstanding repeated calls to jail staff by his former wife who pleaded for medical assistance for Mr. Osterkamp, and, because of the delay in treatment, Mr. Osterkamp died after finally being transferred to a hospital.
- Angie Turner died of a stroke after pleading for help for weeks for her excruciating headaches while housing officers ridiculed her complaints about her headaches and her slurred speech and used profanity to insult her for seeking medical help.
- Daniel Davis was murdered by another inmate, who had been expressing to others his rage toward Mr. Davis and his desire to kill him, but never received any mental health services.
- David Walker repeatedly expressed to many his extreme anxiety and fears, but he was never treated by nursing or mental health staff, leading him to commit suicide.

The deaths of detainees at the Salt Lake County Metro Jail have contributed to Utah having the highest rate of county inmate deaths per capita in 2016, with at least eleven inmates dying in county jails in 2015 and twenty-three in 2016.

~~138.~~131. As a direct and proximate result of the wrongful conduct and deliberate indifference of the Defendants, (1) Lisa consciously suffered severe and excruciating physical, emotional, and mental pain prior to her death; (2) Lisa's emergency medical condition, which could have been successfully treated had Defendants not been deliberately indifferent to her serious medical needs, and the pain and suffering she endured as a result of it, became far worse, leading to her premature death and her loss of the enjoyment of life and of the love, affection, and consortium of her parents and children and being able to enjoy the delight and pleasure of parenting her beloved children; (3) medical, funeral, and cremation expenses for Lisa were incurred; (4) Lisa and her Estate lost substantial earnings based on the probable duration of Lisa's life had her serious medical condition been appropriately and constitutionally addressed and treated; and (5) Lisa and her Estate suffered other damages recognized at law, for which Defendants are liable to Plaintiff Calvin Donald Ostler, as personal representative of the Estate of Lisa Marie Ostler, for the benefit of Lisa's heirs, in an amount that shall be proven at trial.

~~139. Prior to her death, Lisa was a loving mother to C.K., E.L.K., and L.M.O. and a loving daughter of Plaintiffs Cal and Kim and was a source of companionship, joy, happiness, service, love, affection, guidance, and counsel to her parents and children, who have now sustained substantial damages for her wrongful death. As a direct and proximate result of the wrongful conduct and deliberate indifference of the Defendants, the minor surviving children of Lisa—C.K., E.L.K., and L.M.O.—have been deprived of their inheritance and financial support, the companionship, joy, happiness, service, love, affection, guidance and counsel that would have been enjoyed by them had Lisa not died as a result of the extraordinary neglect and deliberate indifference of Defendants, by reason of which Plaintiffs are entitled to receive from Defendants damages in an amount that will be proven at trial. Cognizant of the holding of *Berry v. City of Muskogee*, 900 F.2d 1489 (10th Cir. 1990) as well as the ruling of this Court on Defendants' motion to dismiss the individual Plaintiffs' claims, Plaintiffs respectfully submit that the award of such damages to the surviving parents and children of Lisa, in the nature of a wrongful death action, is necessary and appropriate to fulfill the remedial and deterrence purposes of 28 U.S.C. § 1983.~~

~~140.~~132. Plaintiff is~~s, and each of them, are~~ entitled to recover from and against the Defendants, jointly and severally, all damages sustained as a result of the

Defendants' wrongful conduct and deliberate indifference, including but not limited to the damages described above and, in addition, all reasonable attorneys' fees and costs incurred in this action, pursuant to 42 U.S.C. §§ 1983 and 1988.

~~141.~~133. Plaintiff~~s~~ is ~~are~~ further entitled to recover from and against the Defendants, except Salt Lake County, punitive damages, in an amount determined at trial, for the Defendants' willful, wanton, deliberate, reckless, and callous indifference toward Lisa's federally protected rights, which proximately caused the extreme, worsening, excruciating pain and suffering experienced by Lisa and her tragic and unnecessary death.

SECOND CLAIM FOR RELIEF
(Survival ~~and Wrongful Death~~ Action~~s~~ for Violations of the Utah Constitution, Article I, Sections 7 and 9)

For ~~their~~ his Second Claim for Relief, Plaintiff~~s~~ complains against the Defendants and allege as follows:

~~142.~~134. Plaintiff~~s~~ repeats and incorporates by this reference the allegations set forth in paragraphs 1 through ~~141~~ 133 above.

~~143.~~135. By their acts and omissions, as described above, Defendants deprived Lisa of her rights guaranteed by Article I, Section 7 of the Utah Constitution, which provides that "[n]o person shall be deprived of life, liberty or

property, without due process of law," including their deliberately indifferent treatment of, and failure to treat, Lisa and their unlawful punishment of Lisa.

~~144.~~136. By their acts and omissions, as described above, Defendants deprived Lisa of her rights guaranteed by Article I, Section 9 of the Utah Constitution, which provides that "[p]ersons arrested or imprisoned shall not be treated with unnecessary rigor."

~~145.~~137. The only remedy for these violations of the Utah Constitution is under the common law, and because of the repugnance of Defendants' conduct and omissions and the strong interests of the State of Utah in discouraging similar future conduct and omissions, no special factors counsel hesitation by this Court in providing or fashioning an appropriate remedy for the violations of Lisa's State constitutional rights in this case.

~~146.~~138. Lisa suffered flagrant violations by Defendants of her clearly established constitutional rights.

~~147.~~139. No existing remedies redress Lisa's pain, suffering, and unnecessary death. That is particularly true where different standards apply under the Due Process Clause of the Federal Constitution and the Unnecessary Rigor Clause of the Utah Constitution and it cannot be known until a jury verdict is returned whether a federal remedy will adequately redress the injuries and damages

alleged herein. ~~Further, no existing remedies under federal law are currently available to redress the losses sustained by Lisa's parents and three minor children as a result of Defendants' unconstitutional conduct and omissions.~~

~~148.~~140. Equitable relief, such as an injunction, was and is wholly inadequate to protect Lisa's rights or redress her pain, suffering, and unnecessary death ~~or the losses sustained by Lisa's parents and three minor children~~ as a result of Defendants' unconstitutional conduct and omissions.

~~149.~~141. The Guard Defendants and the Nurse Defendants intentionally denied and delayed access to medical treatment for Lisa, resulting in her extreme pain, suffering, and death.

~~150.~~142. The conduct and omissions of the Defendants toward Lisa were an abuse to the extent that they cannot be justified by necessity and were needlessly harsh, degrading, and dehumanizing treatment of Lisa.

~~151.~~143. The conduct and omissions of the Guard Defendants and Nurse Defendants toward Lisa, and their ability to engage in such conduct and omissions under the constitutionally deficient policies, customs, patterns, practices, training, and supervision of ~~Defendants~~ Lofgreen, Bell, and Defendant Salt Lake County, was treatment that was clearly deficient and unjustified, constituting unnecessarily rigorous treatment of Lisa in violation of Article I, section 9 of the Utah Constitution.

~~152.~~144. As a direct and proximate result of the wrongful conduct, the deliberate indifference, and unnecessarily rigorous treatment by the Defendants, (1) Lisa consciously suffered severe and excruciating physical, emotional, and mental pain prior to her death; (2) Lisa's emergency medical condition, and the pain and suffering she endured as a result of it, became far worse, leading to her premature death and her loss of the enjoyment of life and of the love, affection, and consortium of her parents and children and being able to enjoy the delight and pleasure of parenting her beloved children; (3) medical, funeral, and cremation expenses for Lisa were incurred; (4) Lisa and her Estate lost substantial earnings based on the probable duration of Lisa's life had her serious medical condition been appropriately and constitutionally addressed and treated; and (5) Lisa and her Estate suffered other damages recognized at law, for which Defendants are liable to Plaintiff Calvin Donald Ostler, as personal representative of the Estate of Lisa Marie Ostler, for the benefit of Lisa's heirs, in an amount that shall be proven at trial.

~~153. Prior to her death, Lisa was a loving mother to C.K., E.L.K., and L.M.O. and a loving daughter of Plaintiffs Cal and Kim and was a source of companionship, joy, happiness, service, love, affection, guidance, and counsel to her parents and children, who have now sustained substantial damages for her wrongful death. As a direct and proximate result of the wrongful conduct, deliberate~~

~~indifference, and unnecessarily rigorous treatment of Lisa by the Defendants, Lisa's parents and the minor surviving children of Lisa—C.K., E.L.K., and L.M.O.—have been deprived of their inheritance and financial support, the companionship, joy, happiness, service, love, affection, guidance and counsel that would have been enjoyed by them had Lisa not died as a result of the extraordinary neglect, deliberate indifference, and unnecessarily rigorous treatment of Defendants, by reason of which Plaintiffs are entitled to receive from Defendants damages in an amount that will be proven at trial.~~

~~154. Pursuant to Utah's wrongful death statute, Utah Code § 78B-3-106, C.K., E.L.K., L.M.O., Cal Ostler, and Kim Ostler, as heirs of Lisa, are each entitled to recover all damages that may be just under the circumstances for Defendants' wrongful acts or neglect that caused Lisa's wrongful death.~~

~~155. The violations of Lisa's rights under the Utah Constitution as described above constitute "wrongful acts" within the meaning of the Utah wrongful death statute, Utah Code § 78B-3-106. Those "wrongful acts" caused Lisa's death.~~

~~156.~~145. Plaintiff~~s~~ ~~are~~ is entitled to recover from and against the Defendants, jointly and severally, all damages sustained as a result of the Defendants' wrongful conduct and deliberate indifference, including but not limited

to the damages described above and, in addition, all reasonable attorneys' fees and costs incurred in this action, pursuant to Utah Code § 78B-3-104(3).

~~157.~~146. Plaintiff~~s~~ is ~~are~~ further entitled to recover from and against the Defendants, except Salt Lake County, punitive damages, in an amount determined at trial, for the Defendants' willful, wanton, deliberate, reckless, and callous indifference and disregard toward Lisa's constitutionally protected rights, which proximately caused the extreme, worsening, excruciating pain and suffering experienced by Lisa and to her tragic and unnecessary death.

THIRD CLAIM FOR RELIEF
(Violations of the Due Process Clauses of the Fifth and Fourteenth Amendments to the United States Constitution; the Equal Protection Clause of the Fourteenth Amendments to the United States Constitution; the Due Process Clause of Article I, § 7 of the Utah Constitution; the Uniform Operation of Laws Clause of Article I, § 24 of the Utah Constitution; and the Open Courts Clause of Article I, § 11 of the Utah Constitution)

For ~~their~~ his Third Claim for Relief, Plaintiff~~s~~ alleges as follows:

~~158.~~147. Plaintiff~~s~~ repeats and incorporates by this reference the allegations set forth in paragraphs 1 through ~~157~~ 146 above.

~~159.~~148. Plaintiff~~s~~ challenges the constitutionality of Utah Code § 78B-3-104 (the "Bond Statute"), which places an unreasonable and oppressive burden on people injured or heirs of people killed by wrongful acts of law enforcement officers and deprive people with limited financial resources access to the courts. The right of injured parties who seek access to the courts for violation of their rights is guaranteed by the Due Process and Equal Protection Clauses of the Fifth and Fourteenth Amendments to the United States Constitution, the Due Process Clause of Article I, § 7 of the Utah Constitution, the Open Courts Clause of Article I, § 11 of the Utah Constitution, and the Uniform Operation of Laws Clause of Article I, § 24 of the Utah Constitution.

~~160.~~149. The Bond Statute requires a person filing an action against a law enforcement officer to post a bond before the action is filed, in an amount determined

by the court, to cover all estimated costs and attorneys' fees the officer is likely to incur in defending the action. Utah Code § 78B-3-104.

~~161.~~150. The Bond statute provides no guidance as to how the Court is to determine the amount of the bond required by the Bond Statute. The Bond Statute prevents the filing of "an action against a law enforcement officer … unless the [plaintiff] *has* posted a bond in an amount determined by the court." (Emphasis added). The Bond Statute provides no guidance as to how a plaintiff may obtain a determination of the amount of the bond prior to filing the complaint, or at any time.

~~162.~~151. The Bond Statute places an unreasonable and discriminatory burden on Plaintiff~~s~~ and, at the same time, protects a small and specific class of people. Under the Bond Statute, access to money alone determines whether Plaintiff~~s~~ in this action, and similarly situated plaintiffs in other actions, get into court at all.

~~163.~~152. Plaintiff~~s~~ contends that, both on its face and as applied to them, the Bond Statute violates the Due Process and Equal Protection Clauses of the Fifth and Fourteenth Amendments to the United States Constitution; the Due Process Clause of Article I, §7 of the Utah Constitution; the Open Courts Clause of Article I, § 11 of the Utah Constitution; and the Uniform Operation of Laws Clause of Article I, § 24 of the Utah Constitution.

~~164.~~153. Accordingly, declaratory relief pursuant to 28 U.S.C. § 2201(a) and Rule 57 of the Federal Rules of Civil Procedure is appropriate.

~~165.~~154. Pursuant to Rule 5.1(a), Federal Rules of Civil Procedure, Plaintiff~~s~~ has ~~have~~ served notice of the constitutional question on the Utah Attorney General.

~~166.~~155. Pursuant to DUCivR 24-1, Plaintiff~~s have~~ has served notice on the Clerk of the Court of Plaintiff~~s~~'s constitutional challenge.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff~~s~~ pray~~s~~ for relief on ~~their~~ his claims for relief against Defendants as follows:

Under ~~their~~ his First Claim for Relief, Plaintiff~~s~~ demand~~s~~ judgment against Defendants, jointly and severally, as follows:

1. For an award of compensatory damages, including all special and general damages, the amount of which will be established at trial, with pre-judgment interest on all special damages.

2. For an award of punitive damages against all Defendants, except Salt Lake County, in an amount to be established at trial;

3. For an award of reasonable attorneys' fees and costs, pursuant to 42 U.S.C. § 1988; and

4. For such other and further relief as the Court deems proper.

Under ~~their~~ his Second Claim for Relief, Plaintiff~~s~~ demands judgment against Defendants, jointly and severally, as follows:

1. For an award of compensatory damages, including all special and general damages, the amount of which will be established at trial, with pre-judgment interest on all special damages.

2. For an award of punitive damages against all Defendants, except Salt Lake County, in an amount to be established at trial;

3. For an award of reasonable attorneys' fees and costs, pursuant to Utah Code § 78B-3-104(3); and

4. For such other and further relief as the Court deems proper.

Under ~~their~~ his Third Claim for Relief, Plaintiff~~s~~ respectfully requests the Court to enter judgment as follows:

1. To enter a declaratory judgment that Utah Code § 78B-3-104, facially and as applied to Plaintiff~~s~~, violates the Due Process Clauses of the Fifth and Fourteenth Amendments to the United States Constitution and Article I, § 7 of the Utah Constitution, and 42 U.S.C. § 1983;

2. To enter a declaratory judgment that Utah Code § 78B-3-104, facially and as applied to Plaintiff~~s~~, violates the Equal Protection Clause of the Fourteenth

Amendment to the United States Constitution and the Uniform Operation of Laws Clause of the Utah Constitution in Article I, § 24;

3. To enter a declaratory judgment that Utah Code § 78B-3-104, facially and as applied to Plaintiff~~s~~, violates the Open Courts Clause of the Utah Constitution;

4. For reasonable attorneys' fees as provided by 42 U.S.C. § 1988 and by Utah law; and

5. For such other and further relief as the Court deems just and appropriate.

DEMAND FOR JURY

Plaintiff~~s~~ hereby demands a trial by jury on all ~~their~~ his claims, except those under the Third Claim for Relief, and have submitted the jury fee.

DATED this 5th ~~_____~~day of November~~_____~~ 2019~~.~~:

LAW OFFICES OF ROCKY ANDERSON

_____

Ross C. Anderson
Attorney for Plaintiff~~s~~

Plaintiff's~~'~~ Address:
1094 W. Greasewood Drive
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