IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLORADO

Civil Action No. 07-cv-01814-WDM-MJW

DEBBIE ULIBARRI;
ESTATE OF SHAWN FRANCISCO VIGIL;
COLORADO CROSS-DISABILITY COALITION, a Colorado Corporation;
COLORADO ASSOCIATION OF THE DEAF, a Colorado Corporation;
ROGER KREBS;
SARAH BURKE;

Plaintiffs,

v.

CITY & COUNTY OF DENVER, INCLUDING ITS SHERIFF DEPARTMENT, AND ITS POLICE DEPARTMENT;
ALVIN LACABE, in his official capacity as Manager of Public Safety for the City & County of Denver, and in his individual capacity;
WILLIAM LOVINGIER, in his official capacity as the Director of Corrections and Undersheriff for the City & County of Denver, and in his individual capacity;
RON D. FOOS, in his official capacity as Division Chief for the County Jail Division for the City & County of Denver, and in his individual capacity;
GARY WILSON, in his official capacity as Division Chief for the Pre-Arraignment Detention Facility Division, and in his individual capacity;
GERALD R. WHITMAN, in his official capacity as Chief of Police, and in his individual capacity.

Defendants.

PLAINTIFFS' COMBINED RESPONSE TO DEFENDANTS' MOTIONS FOR SUMMARY JUDGMENT

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Plaintiffs, Debbie Ulibarri on behalf of herself and as Personal Representative of the Estate of Shawn Francisco Vigil, Colorado Cross-Disability Coalition, Colorado Association of the Deaf, Roger Krebs, and Sarah Burke by and through their attorneys, Paula Greisen and Laura Schwartz of King & Greisen, LLC; Amy Robertson of Fox & Robertson P.C.; and Carrie Ann Lucas and Kevin W. Williams of the Colorado Cross-Disability Coalition, hereby submit their Combined Response to Defendants' Motions for Summary Judgment found at Dkt. ##197 and 198.[1]

INTRODUCTION

The overwhelming evidence in this case shows that the Denver Sheriff Department ("DSD") failed Mr. Vigil at every step of his incarceration. Mr. Vigil, who had been deaf since childhood and communicated primarily through American Sign Language (ASL), had an English proficiency of approximately a second grade level. At no time during his incarceration was a sign language interpreter ever brought in to assist Mr. Vigil with communication with the DSD deputies or to complete a mental health assessment. The evidence shows that the DSD had no policies with respect to accommodating deaf inmates and had no written suicide prevention policies. During his incarceration, the deputies failed to take the critical steps necessary to prevent his suicide by failing to make rounds as required, failing to make any attempt to communicate with him, and failing to properly observe Mr. Vigil despite the fact that there were

[1] Defendants filed two motions for summary judgment. Dkt. #197 moves to summarily dismiss all Plaintiffs' claims except the claims against the Defendants in their individual capacities. That motion is Dkt. #198. Because the motions substantially overlap, both factually and legally, Plaintiffs are filing a Combined Response and discussing all civil rights claims in one section of the brief and all of the state claims in a separate section.To aid this court, Plaintiffs used pinpoint citations to Defendants' motions to identify the source of Defendants' arguments.

numerous indicators that he was at high risk for suicide. Instead, Mr. Vigil was isolated in his cell, and in a world where he was unable to communicate any of his mental health needs.

Upon his arrival at the Pre-Arraignment Detention Facility ("PADF"), he had a 15 second medical screening by a nurse, without the assistance of a sign language interpreter. The nurse failed to make an adequate assessment of his mental health status and recommended that he be housed in a single cell.

When Mr. Vigil arrived at the Denver County Jail ("DCJ"), despite the policy that a thorough classification intake be performed in order to assess his suicide risk, the intake officer failed to obtain the services of a sign language interpreter. Instead, the intake deputy expected Mr. Vigil to read and answer a classification intake form that far exceeded his English comprehension abilities. Despite the demonstrably wrong answers that Mr. Vigil allegedly provided, the intake officer took no further steps to ensure effective communication with Mr. Vigil. In addition, the intake officer failed to make any of the required observations, which included an assessment of whether Mr. Vigil was disabled, anxious, withdrawn, depressed, confused or suicidal. Because Mr. Vigil was deaf, he was assigned to segregation housing in the special management unit. He was then allegedly sent for a mental health screening which was admittedly a critical step in the process of assessing his risk for suicide. Despite the importance of this screening, however, no mental health assessment was ever performed on Mr. Vigil. It is clear from the medical assessment form that the only information that medical personnel obtained from Mr. Vigil, his blood pressure and his temperature, was that which did not require Mr. Vigil to communicate with the staff.

That no sign language interpreter was ever provided to Mr. Vigil during his intake or medical assessment was consistent with the fact that the Denver jail did not have any policies or

procedures that required the use of an interpreter, or required that the jail staff take any steps to ensure effective communication with deaf inmates. Despite the fact that inmates who are deaf are routinely held at the DCJ, there is no evidence that a sign language interpreter has ever been brought into the jail to assist with communication with those inmates. Although the medical staff was required to follow the policies and procedures of the DSD, there were no such policies or procedures in place to mandate effective communication, despite the fact that as of 2005, the American with Disabilities Act had been in effect for well over a decade. Ultimately, it was the responsibility of the DSD deputies to ensure that the mental health assessment had been performed before Mr. Vigil was taken to the housing unit - but again, this policy was not followed and Mr. Vigil was taken to the special management unit without any assessment of his risk of suicide.

During his stay at DCJ, there is no evidence that Mr. Vigil had any communication with the deputies, Deputy Pablo and Deputy Pacheco, who were charged with his care in the housing unit. At no time was Mr. Vigil ever provided any accommodations, never provided a sign language interpreter ("SLI"), provided a closed-captioned television, or told of his ability to access a TTY, and never monitored for whether he posed a risk of suicide. Deputy Pacheco admitted that he was unable to assess the risk of suicide posed by Mr. Vigil because he was deaf, and therefore could not communicate with him. In the course of his stay, Mr. Vigil's cell assignment was changed six times in a one-month period, further increasing his isolation and inability to form relationships, resulting in him finally being placed alone, in the next to the last cell in the row, far away from the officer's cage.

Despite the testimony from DSD supervisors that that making and documenting rounds and that communication with inmates were critical to prevent inmate suicides, there was virtually

no attempt to communicate with Mr. Vigil and there was no evidence shows that rounds were routinely made. In fact, the logbook for Mr. Vigil's housing unit shows that rounds were routinely not documented during the time of day that Mr. Vigil committed suicide for multiple days preceding his suicide. DSD supervisors testified that the deputies were expected to know the high risk periods for suicide, such as after receiving bad news such as learning of the potential length of a sentence, first-time arrest, and special events such as birthdays. They also testified that the deputies should know the warning signs for inmate suicide, such as if an inmate felt isolated or secluded, had no visitors, exhibited a change in eating or sleeping habits, or felt rejected by jail staff or dehumanized by their incarceration. Deputy Pacheco, however stated he had not had any suicide prevention training in the approximately five years prior to Mr. Vigil's suicide and did not know what the high risk periods were for inmate suicides and did not know the warning signs that an inmate may commit suicide.

In addition to the failure to conduct rounds, the deputies charged with Mr. Vigil's care did not make any efforts to communicate with him, did not know that he had been to court and learned of a potential lengthy jail sentence, did not know this was a first time arrest, and did not know that he had a birthday while incarcerated, which he spent alone as he had no visitors. Although the defense expert testified that inmates in segregated special housing, such as Mr. Vigil, should have been trained that this type of housing increases the risk of a feeling of isolation for the inmate, the deputies were not trained on this fact. The deputies also did not know whether Mr. Vigil had a change in eating or sleeping habits during his incarceration, never brought in a sign language interpret to communicate with him, and never offered him access to the TTY or provided him closed-captioned television. The evidence does show, however, that Mr. Vigil sat in his cell and drew a picture of himself crying.

The evidence also shows that during 2005, when Mr. Vigil was incarcerated, the Denver jail experienced extreme overcrowding, reaching 150% of its capacity, requiring make-shift housing units in the gym and yard areas. Despite this significant increase in the number of inmates at the jail, there was no significant increase in the number of deputies or medical staff at the jail. During this time, there was a 177% increase in assaults on staff, a 120% increase in the number of critical incidents requiring the use of force, a 96% increase in nurse practitioner visits. As a result of the increase in the number of inmates, there was over 50% more hours in officer overtime than was budgeted for the year. A DSD supervisor admitted that this type of increase in officer hours can lead to officer fatigue which, in turn, can increase the danger that warning signs of suicide by an inmate may go unnoticed.

The overwhelming evidence in this case shows that the DSD failed to protect Mr. Vigil's federally protected rights throughout every phase of his incarceration. By failing to adopt policies to accommodate deaf inmates, failing to adequately train its deputies on suicide prevention, by isolating Mr. Vigil, failing to provide him any effective means to communicate with the deputies or medical staff, failing to perform a mental health assessment on him and failing to properly observe him for the risks or warning signs of suicide, the actions and inaction of the DSD culminated in the tragic suicide of Mr. Vigil.

The evidence demonstrates that Defendants failed to make any efforts to accommodate Plaintiff Roger Krebs -- who is also deaf . Mr. Krebs, who was arrested after an altercation with security guards at the Denver Greyhound station. Despite being in handcuffs in the security office, Denver Police never attempted to get an interpreter for Mr. Krebs. Mr. Krebs, who was injured during a scuffle with the security guards, and did not understand that the police had cited and arrested him. Mr. Krebs was transported to a hospital where the hospital provided him with

an interpreter. It was then that Mr. Krebs learned he was under arrest. After emergency treatment, Mr. Krebs was transported to the PADF, and despite his repeated requests, an interpreter was not permitted to accompany him. He continued to request an interpreter, but his requests were ignored. Mr. Krebs remained in jail overnight, isolated and without any way to communicate with his jailers. Late the next day Mr. Krebs was taken to court to be arraigned. Despite multiple requests for an interpreter, he was not provided with an interpreter. Ultimately, Defendants informed him that if he wanted an interpreter for his arraignment, he would have to remain detained at the PADF for an additional three days until an interpreter could be provided, but that if he pled guilty without an interpreter, he would be released immediately. Faced with those choices, Mr. Krebs pled guilty to all charges.

Plaintiff Sarah Burke -- who is deaf and diabetic – was home cooking dinner for her family when Denver police officers arrived at her home to perform a welfare check on her children. Ms. Burke had just taken her fast acting insulin, and was preparing to serve dinner. She invited the police officers into her home. Despite multiple requests by Ms. Burke and her husband, the police officers refused to provide an interpreter or write their questions for the adults. Instead the police insisted on using Ms. Burke's eight-year-old son to interpret. After running a name check, the police arrested Ms. Burke for what they characterized as "contempt of court." Ms. Burke and her husband, not understanding what the police were referring to, continued to request an interpreter. The police, despite spending nearly three hours in Ms. Burke's home, never attempted to contact an interpreter. Ms. Burke tried to explain that she had diabetes, had taken insulin, and needed to eat, but the officers ignored her request. The police then handcuffed her -- thus restricting her ability to communicate -- and refused to permit her to bring her medication or her pager. Ms. Burke was transported to a police station where her

repeated requests for an interpreter and for food were ignored. Eventually Ms. Burke was transported to the PADF where her ordeal continued.

Ms. Burke asked her jailers to provide an interpreter, and when they ignored her, she begged for them to write to her. They ignored those requests, and spoke verbally to her. She requested medical attention, but was not provided with medical attention for hours. Ms. Burke was severely hypoglycemic, and needed medical attention, but her pleas were ignored.

Eventually when taken to a medical officer, Ms. Burke wrote down that she needed to eat and that she had taken her insulin hours earlier. The medical officer correctly noted her history, but only checked her blood sugar after Ms. Burke became insistent. The medical officer then gave Ms. Burke additional insulin, and no food, further increasing her hypoglycemia. Ms. Burke was released at approximately 2:00 in the morning, but because Defendants did not have an operating TTY device and had not permitted her to bring her pager, she was unable to contact her husband to pick her up. Still feeling desperately ill and disoriented with low blood sugars, Ms. Burke started walking toward a light rail station to go home, but discovered train service did not start for another two hours. Ms. Burke -- ill and confused -- accepted a ride from a stranger who attempted to assault her. Though she managed to escape, she was afraid to report the incident to police based on her experiences of the previous twelve hours.

Defendants now seek to dismiss all of Plaintiffs' claims against all Defendants by refusing to acknowledge overt material factual disputes coupled with misstatements of the applicable law while making some nineteen different legal arguments.

I. PLAINTIFFS' RESPONSE TO DEFENDANTS' STATEMENT OF "UNDISPUTED" FACTS

As a threshold matter, Defendants' "Statement of Undisputed Facts" is fundamentally flawed – many of the 217 "undisputed facts" are anything but, and the misstatements are

substantive. If they were otherwise, Plaintiffs would be agreeing that disabled arrestees and inmates leave their rights outside the squad car and at the jail doors.

Nonetheless, Plaintiffs have parsed each factual allegation as follows:

A. Shawn Vigil at PADF and Attendance at Court Hearings

1. Undisputed.

2. Undisputed.[2] However, Plaintiffs' identifying this factual allegation as undisputed in part does not constitute acceptance of the affidavit relied upon by Defendants as supporting the allegation.

3. Undisputed.

4. Undisputed.

5. Disputed. Plaintiffs agree that Bates No. 000127,[3] attached to Defs.' Ex. A-6 *contains* the information attributed to it by Defendants but do not concede that Nurse Costin, the author of this document, was able to effectively communicate with Shawn Vigil, and thus could not have attained the information from him such as the denial of "current or past mental health problems, medications, or alcohol or drug abuse." For the same reasons, Plaintiffs also dispute that Mr. Vigil "claim[ed] negative for all medical problems . . . ." Mr. Vigil was only able to effectively communicate through the use of American Sign Language ("ASL"). There is no record evidence establishing that Mr. Vigil was able to effectively communicate by lip reading or writing. In fact, Mr. Vigil's reading and writing skills were somewhere between the first and

[2] The fact that Plaintiffs do not dispute a fact recited by Defendants does not mean that Plaintiffs agree that the evidence on which Defendants rely is admissible.

[3]Defendants did not include Bates Number prefixes in their motions for summary judgment. For clarification, all documents disclosed or produced by Defendants include the prefix "Debbie Ulibarri 00XXX 07-cv-01814-WDM-MJW." Documents disclosed or produced by Plaintiffs' carry the prefix "P".

second grade levels. Ex. 1, Andrews Dep. 30:6–15. He was also unable to finger spell. *Id*. at 56:20 – 57:8.[4] If a hearing person is attempting to communicate with a deaf person whose only means of effective communication is through the use of American Sign Language ("ASL"), a sign language interpreter must be used. Ex. 2, Kosinski Dep. 24:24 – 25:2, 32:6-16. Nurse Costin, testified during his deposition that he never asked for a sign language interpreter to communicate with any deaf inmate, which necessarily includes Mr. Vigil. Ex. 3, Costin Dep. 77:20 – 78:5. Nurse Costin testified that if an inmate answered the ten questions on the assessment form in the negative, he routinely took no longer than 12 – 15 seconds to complete his medical assessment. *Id.* at 41:4-11.

6. Undisputed.

7. Disputed in part. Defendant's factual allegation misstates Nurse Costin's deposition testimony. Nurse Costin testified that psychiatric nurses were only available for referrals from medical nurses during the daytime. Defs.' Ex. A-11 at 57:16 – 58:1. Plaintiffs also deny that Costin had the ability to effectively communicate with Mr. Vigil regarding his mental health status without an interpreter and because Costin preferred to move through his medical assessments as quickly as possible—in 12 to 15 seconds, Ex. 3, Costin Dep. 41:4-15, it would have been impossible for him to have sufficient time to complete a thorough assessment.

8. Disputed in part. This factual allegation is admitted to the extent that Nurse Costin testified at his deposition that he would refer an incoming inmate to a psychiatric nurse for additional mental health screening if the inmate's appearance or conduct were indicative of

[4] "Finger -spelling is a system of communication made up of 26 hand shapes that correspond to the 26 letters of the alphabet, and so you actually spell out the words on your fingers, like J, E, A, N, four hand shapes that spell the name Jean, and so finger-spelling is commonly used to spell out words that don't have signs, like names of cities or food or, you know, brand names of food or cars and things of that nature." Ex. 1, Andrews Dep. 56:25– 57:8.

potential mental health issues. Again, psychiatric nurses were only available during daytime hours. Defs.' Ex. A-11 at 57:16 – 58:1.

9. Undisputed.

10. Disputed in part. While Nurse Costin testified as alleged by Defendants, the medical assessment form prepared by Nurse Costin prepared in regard to Mr. Vigil in 2005, Defs.' Ex. A-6, Crum Aff. Ex. 1, Bates No. 000127, unambiguously states that Nurse Costin decided to house Mr. Vigil alone because of his deafness. "Is deaf. Does not read lips. Does communicate by writing. Claims negative for all medical problems, and writing. Housed alone for this reason." *Id*.

11. Disputed in part. As drafted by the Defendants, this factual allegation leaves the reader with the mistaken impression that Nurse Costin decided to house Shawn Vigil alone because of concerns for Mr. Vigil's safety. As stated above, Nurse Costin's actual testimony is that he does not know why he housed Mr. Vigil alone, and the form completed by Costin at the time of the assessment states he was housed alone because of his deafness. *Id*. In fact, Nurse Costin also testified that he may have deferred to a Denver sheriff in making the housing decision. Ex. 3, Costin Dep. 124:21– 125:8.

12. Undisputed.

13. Undisputed. The bond amount, however, is irrelevant to the issues to be decided on summary judgment.

14. Disputed. Paragraph 8 of Ms. Kosinski's Affidavit does not speak to Mr. Vigil's court appearances. It is paragraph 9. Moreover, paragraph 9 contains no indication of how Ms. Kosinski is able to provide an affidavit about court appearances that occurred in August 2005.

Defendants have produced no documents evidencing that Ms. Kosinski was at Mr. Vigil's hearing.

15. Disputed in part. Plaintiffs do not dispute that Defs.' Ex. A-1, Bates No. 001678 contains the date found in this factual allegation. However, again, it is paragraph 9, not paragraph 8 of Ms. Kosinski's Affidavit that discusses Mr. Vigil's court appearances.

16. Undisputed.

17. Undisputed.

B. Shawn Vigil at the Denver County Jail

18. Undisputed.

19. Undisputed to the extent this is the routine procedure. Disputed to the extent it suggests Mr. Vigil received a routine screening.

20. Disputed in part. Plaintiffs do not dispute that Mr. Vigil met with Deputy Sheriff Randy Coleman or that Deputy Coleman was a classification officer. Plaintiffs do dispute that Mr. Vigil and Deputy Coleman worked "together" in completing the "Denver County Jail Classification Intake Questionnaire" for Mr. Vigil. *See* Defs.' Ex. A-12, Coleman Dep. 62:9–19 and Ex. 25, Bates No. P000646. In his deposition, Deputy Coleman testified that he treated all deaf inmates exactly the same during the classification process, that is, he had those inmates read the questions on the Intake Questionnaire and that he would mark down the answers. *Id.* 62:9 – 63:16. During his interviews with deaf inmates, Deputy Coleman made no effort to determine whether the inmates have the ability to read and understand the questions and how they were supposed to answer those questions. *Id.* at 59:16-24. Moreover, as discussed in Plaintiffs' separate section of undisputed facts, Pls.' Add'l Facts Nos. 155-63, there are multiple factual concerns about the accuracy and completeness of the responses documented in the

Questionnaire. Coleman did not obtain a sign language interpreter to assist Mr. Vigil. As Mr. Vigil could not complete the form, he could not assist Coleman. Ex. 1, Andrews Dep. 59:19-25, 61:5-18. In fact, the form was seriously incomplete and inaccurate. *See* Pls.' Add'l Facts Nos. 157-59.

21. Disputed. Plaintiffs agree that Exhibit 25 to the Coleman Deposition, Defs.' Ex. A-12, contains the information attributed to it by Defendants but do not concede that Deputy Coleman, the author of this document, was able to effectively communicate with Shawn Vigil and thus, could not have attained the information from him such as that he "had never attempted suicide; that he did not request any special accommodations; that he was not taking any medication; that he saw a doctor at the city jail, that he did not ask to see the medical staff at the County jail; and that he had never been in the Denver County Jail before." *See supra* Paragraph 20.

22. Disputed in part. Plaintiffs do not dispute that the Classification Intake Questionnaire has a section for "observations by deputy sheriff." However, Coleman failed to properly complete that portion of the intake form to determine if Mr. Vigil was "injured, disabled, sick, anxious, withdrawn, hostile, depressed, under the use of alcohol/drugs, aggressive, confused suicidal." To the extent Defendants suggest that Coleman simply did not observe any of these conditions, the allegation is disputed. For example, Coleman knew that Mr. Vigil was deaf and also testified at his deposition that a deaf inmate is disabled. Yet, Coleman did not circle "disabled" on the Intake Questionnaire. Ex. 4, Coleman Dep. 65:18-23 and Ex. 25 (Defs.' Ex. A-12). Further, Sgt. John Romero testified that the intake form was incomplete. Ex. 5, Romero Dep. 91:6-11.

23. Undisputed.

24. Undisputed.

25. Disputed in part. Coleman's deposition testimony was that he would have the inmates *read* the Classification Intake Questionnaire, not merely that he *showed* the inmate the questionnaire. Ex. 4, Coleman Dep. 49:3-23.

26. Disputed in part. Again, as written, this factual allegation is misleading because it leaves the impression that Mr. Vigil signed his Classification Intake Questionnaire only because he agreed with everything written on it. As is undisputed, in addition to Coleman's failure to completely fill out the form, there are at least two facts with which Mr. Vigil would have disagreed had he understood the questions: Mr. Vigil was disabled by virtue of being deaf, and he was a United States citizen. Ex. 4, Coleman Dep. 69:1-9.

27. Disputed in part. This factual allegation omits key testimony from this portion of Coleman's deposition. Coleman's deposition testimony was that inmates were provided with the inmate handbook and expected to read and understand it but were given no other orientation about the policies and procedures at the Denver County Jail. Defs.' Ex. A-12, Coleman Dep. 29:21-25 – 30:1-7.

28. Undisputed. Although Vigil was apparently taken to the medical unit, the medical assessment was incomplete, and no mental health assessment was performed. Deputy Coleman coded Mr. Vigil as requiring placement in Administrative Segregation because he was "physically handicapped." Defs.' Ex. A-12, Coleman Dep. 48:4-12; Ex. 4, Coleman Dep. Ex. 18 at 15 (Bates No. P000033) Section IV(E)(3)(2) ("Special Needs Inmates- X07A");[5] Ex. 4, Coleman Dep. 37:20-38:11 and Ex. 11, Bates No. P000633 (documenting Mr. Vigil's Classification as an X07A). The conclusion that Mr. Vigil was housed alone at Denver County

[5] Although the date on this Post Order is "1/2006," Deputy Coleman testified that the same codes were in effect in 2005. Ex. 4, Coleman Dep. 48:4-12.

Jail is also borne out by Division Chief Foos' report to Major Deeds about Mr. Vigil's death where he states that "Inmate Vigil was housed in Administrative Segregation (Special Management) commensurate with his physical limitations." Foos admitted that his physical limitation was because he was deaf. Ex. 6, Foos Dep. 110:22-111:5; Ex. 23 at 1.

29. Disputed in part. All inmates that were deemed physically handicapped were automatically designated X07A and placed in Administrative Segregation, including deaf inmates such as Shawn Vigil. Plaintiffs also dispute that housing deaf inmates in segregation "improves inmate morale." Mr. Vigil was placed in Administrative Segregation solely because of his deafness. See Ex. 4, Coleman Dep. 78:19. This factual allegation fails to distinguish between the classification goals and procedures at the Denver County Jail. During his 30(b)(6) deposition about the classification of inmates by the Denver Sheriff's Department, Major Deeds testified to this effect. Ex. 7, Deeds Dep. 17:4-12. Major Deeds went on to describe the classification procedures at the Denver County Jail as more "objective" than those at the PADF and are intended to classify those inmates who will be incarcerated for longer periods of time. There are no codes for special management inmates at the PADF. *Id.* at 17:24 – 18:8. Nonetheless, Mr. Vigil was housed alone at the PADF. Defs.' Ex. A-12.

30. Disputed in part. Sgt. Romero's supporting Affidavit ignores Defendants' own documents which expressly state that inmates with "physical handicaps" are to be housed in Administrative Segregation. *See supra* ¶ 20. There is also no record support for the contention that Mr. Vigil, apart from Defendants' policies regarding "physical handicaps," was "unable to live in the general population . . . ."

31. Disputed. The overwhelming evidence is that Mr. Vigil was housed by himself in the Special Management Unit because he was deaf. Ex. 6, Foos Dep. 110:22 – 111:5; Ex. 8,

Pablo Dep. 126:12-15; Ex. 5, Romero Dep. 31:1-21. Nurse Costin's documentation unambiguously states that he housed him alone because of his deafness. Defs.' Ex. A-6, Costin Dep. Ex. 1, Bates No. 000127. Deputy Sheriff Coleman did not even complete the paperwork on Mr. Vigil but was operating under a classification system that automatically called for placing inmates with "physical handicaps" in Administrative Segregation.

32. Undisputed.

33. Disputed in part. The description of privileges afforded to inmates in Administrative Segregation may have been true for some of those inmates but not for Mr. Vigil. He had no access to a telephone he could use. In fact, when Deputy Coleman prepared Mr. Vigil's Classification Intake Questionnaire, he wrote that Mr. Vigil was "Deaf" on the same line of the form entitled "Phone Call" and checked the "No" box asking whether Mr. Vigil had had access to a telephone. Defs.' Ex. A-12. Moreover, the Inmate Handbook, makes no reference to disabled inmates in its promise of non-discriminatory treatment:

> You can expect your treatment to be non-discriminatory with regard to sex, religious beliefs, sexual preference, race, color, creed, national origin, political opinion or political affiliation.
>
> Ex. 8, Pablo Dep. Ex. 9, 2004 Denver County Jail Inmate Handbook at 2 (Bates No. U000209).

Furthermore, although the Inmate Handbook contains a section detailing how inmates can communicate within the jail, there is no mention of the TDD or TTY telephones purportedly available for deaf or hard of hearing inmates. *Id.* at 26-28 (Bates Nos. U000221 and 222). Furthermore, the inmate privileges described by Defendants in this factual allegation are only contained in the Inmate Handbook, which Mr. Vigil would not have been able to read or understand without substantial assistance—which he never received. Dr. Jean Andrews, Plaintiffs' expert witness on effective communication and Mr. Vigil's impairment, testified in

her deposition that Mr. Vigil would have found the Handbook "incomprehensible unless he had an interpreter to explain all the concepts . . . ." Ex. 1, Andrews Dep. 45:17-25.

34. Disputed. There were no closed-captioned televisions in Building 6 in 2005. Moreover, the Deputy Sheriff who worked in Building 6 was confident that closed captioned televisions were not available in 2005, when Mr. Vigil was imprisoned. Moreover, that television is not visible to inmates in Building 6 when they are in their cells. Ex. 8, Pablo Dep. 109:15 – 110:9. Romero also testified that he was not aware of any accommodations provided to Shawn Vigil. Ex. 5, Romero Dep. 174:7-25.

35. Disputed. Romero's deposition testimony was that he knew of no accommodations provided to Shawn Vigil. *Id*. In fact, according to the deposition of Deputy Pablo who worked at the Denver County Jail in Building 6 where Mr. Vigil was housed, none of the telephones in Building 6 were TDD or TTY telephones. Ex. 8, Pablo Dep. 171:23 – 172:9. In fact, the only TTY or was located in the sergeant's office. *Id*. at 172:10-15. The sergeant's office is a small office just off of the main hallway on the opposite side of the corridor and down the hall from the cell house where Mr. Vigil was housed. Ex. 9, McCarten Decl. ¶ 14. Thus, without someone telling him, Mr. Vigil had no way of knowing that such a telephone existed. As written, this factual allegation places the burden on the deaf or hard of hearing inmate to ask for a TDD telephone --- without providing that inmate knowledge of the telephone' s existence. Moreover, Pablo did not know how a deaf inmate would know of the TTY's availability. Ex. 10, Pacheco Dep. 51:3-6.

36. Disputed in part. While it may be true in general that inmates in Administrative Segregation were not isolated from other inmates, there is no evidence that Shawn Vigil had an ability to interact in a meaningful way with other inmates or had access to a television. *See, e.g.,*

Pls.' Add'l Fact No. 37. Merely because deaf inmates in Building 6 were allowed to co-mingle with the other inmates it is questionable whether Mr. Vigil was able to have any effective interaction with those inmates because he had no meaningful way of communicating with them. There is also no evidence that Mr. Vigil interacted with the tier clerks. Ex. 5, Romero Dep. 176:22 – 177:18. Deputy Sheriff Pablo has no memory of Mr. Vigil's communicating with anyone. Ex. 8, Pablo Dep. 147:24 – 148:3. In fact, during the investigation, Pablo stated that he did not understand how another inmate could communicate with Mr. Vigil—because of Mr. Vigil's deafness. Ex. 20, Recorded Statement, at 15:20-22, Notably, the Defendants' factual allegations that Mr. Vigil was surrounded by other inmates and, on occasion, and jail staff, is not evidence that Mr. Vigil did communicate with anyone. Ex. 6, Foos Dep. 154:4-16 (admitting that he has no knowledge that Mr. Vigil interacted with anyone while incarcerated at DCJ). There was never a sign language interpreter, be it jail staff or another inmate, and that was the only means by which Mr. Vigil had to effectively communicate with anyone. Ex. 1, Andrews Dep. 69:20 – 70:18. Finally, Plaintiffs move to strike paragraph 15 of Sgt. Romero's affidavit for lack of personal knowledge.

37. Disputed. See response to ¶ 36, *supra*. Without an interpreter, Mr. Vigil could not effectively communicate with anyone. Because Romero did not work in Building 6, he has no personal knowledge that anyone had personal interaction or effective communication with Mr. Vigil. Neither Deputy Sheriff Pablo nor Deputy Sheriff Pacheco recalled having any interaction with Mr. Vigil. Ex. 8, Pablo Dep. 127:5- 13, 130:21- 24, 132:10-13; Ex. 20, Pacheco Recorded Statement at 25:6-18 ("He was a deaf guy . . . so he didn't communicate very well . . . He never . . . really gave us a note for anything."). Indeed, Deputy Sheriff Pablo did not recall witnessing Mr. Vigil interacting with any other jail staff, including nursing staff when

making rounds. Ex. 8, Pablo Dep. 133:24 – 134:1, 140:16-22. Furthermore, there is no evidence that the deputies made their two rounds an hour as required. *See* Pls.' Add'l Fact No. 142; *see also* Ex. 8, Pablo Dep. 139:25 – 140:15 (testifying that if an inmate is not receiving medication, he and the nurse do not stop at the cell but only make sure the inmate is still "breathing"). Plaintiffs also move to strike paragraph 16 of Sgt. Romero's affidavit for lack of personal knowledge.

38. Disputed. Because Romero did not work in Building 6, he has no personal knowledge that any of the nurses had personal interaction or effective communication with Mr. Vigil. Further, factual allegation 38 speaks only in general terms and not about Mr. Vigil's actual interaction with nursing staff—the relevant issue. This omission can only be intentional because Defendants are unable to point to anyone who effectively communicated with Mr. Vigil while he was housed at the Denver County Jail. As to the specifics in the allegation, Deputy Sheriff Pablo testified that no sign language interpreter was provided during nursing rounds to aid in communication between the nurses and Mr. Vigil. Ex. 8, Pablo Dep. 139:7 – 140:4. Importantly, Deputy Sheriff Pablo also testified that if an inmate was not to receive medication, the nurse did not stop at the cell and only did a quick check to make sure that the inmate was "breathing." *Id*. at 139:25 – 140:7. There is also no evidence that of meaningful contact with Mr. Vigil during the nursing segregation rounds. Further, it has already been established that Mr. Vigil did not have the ability to read and understand the Inmate Handbook; therefore, without an interpreter, he had no way of knowing how to send a kite or otherwise communicate with medical staff. Ex. 1, Andrews Dep. 45:22-25. Plaintiffs also move to strike paragraph 17 of Sgt. Romero's affidavit for lack of personal knowledge. Sgt. Romero's Affidavit also conflicts with a published, albeit undated, policy describing the nature of the medication rounds:

"The medical staff will make rounds in each building three times a day for the purpose passing medication, talking to inmates who may have medical problems that were not preciously noted, and observing inmates who are taking medication." Ex. 21, Lucas Decl. Ex. 1 (Bates No. U000112).

39. Disputed. Defendants have identified no objective guidelines for selecting Deputy Sheriffs to work in Special Management at the Denver County Jail. Ex. 6, Foos Dep. 40:7-9. All that has been provided by Defendants is anecdotal information about the desired qualities in those sheriffs, such as that found in Paragraph 10 of Sgt. Romero's Affidavit. Further, these deputies received no special training to work in Special Management. Ex. 6, Foos Dep. 39:23-25; Ex. 8, Pablo Dep. 65:17-23, Ex. 10, Pacheco Dep. 9:1-9.

40. Disputed. Capt. Michael Than, a 30(b)(6) witness, knew of no such deputies. Ex. 11, Than Dep. 17:18-21. Moreover, both Pablo and Pacheco were unaware of the existence of such sheriffs. Ex. 8, Pablo Dep. 107:12-14, Ex. 10, Pacheco Dep. 48:13-24, 50:12-23. There is also no evidence that any jail staff in Building 6 communicated with Mr. Vigil in writing. Plaintiffs also move to strike paragraph 11 of Sgt. Romero's affidavit for lack of personal knowledge and as an undisclosed expert opinion.

41. Disputed in part. Plaintiffs do not dispute that all deputy Sheriff's were expected to know and follow all policies promulgated by the Denver Sheriff's Department, including suicide prevention. The difficulty however, with this factual allegation is that Defendants are entirely unable to identify the written policies and procedures that were actually in effect in 2005. Even now, nearly a year after the close of formal discovery, Defendants cannot point to the effective dates of assorted written policies on suicide prevention. For example, the 30(b)6) witness designated by Defendants, Captain Michael Than, to testify about suicide prevention

training at the DCJ, identified some risk periods and events for suicides,[6] but was unable to testify about suicide prevention *training* beyond that provided by the Academy during a sheriff's initial training period. "So I can't answer exactly what training is provided at the DCJ facility." Ex. 11, Than Dep. 31:22 – 32:18. Similarly, although Captain Than was able to testify about some indicia of impending suicide he was once again unable to identify any training beyond that from the Academy during the relevant time period. *Id*. at 41:6-9.

42. Disputed. First, according to deposition testimony by Sauer, the Administrative Review Board ("ARB") met weekly. Ex. 12, Sauer Dep. 22:8-10. Yet, Defendants have produced no documentation that inmates were asked on September 5, 2005, whether they wanted to meet with the ARB - despite Sergeant Romero's deposition testimony that the ARB met weekly, even during holiday weeks. Ex. 5, Romero Dep. 110:6-12, 21-25. It is also difficult to credit Defendants' allegation that Deputy Line asked every inmate in Special Management two questions every week. The first question on the forms provided by Defendants asks "Are you having any problems?" In each and every document provided by Defendants in disclosure and in discovery shows all inmates always answering "No." to this question for a one-month period. Defs.' Ex. A-5 at Bates Nos. 001316, 001326, 001329, 001333, 001447, 001342, 001350, and 001359. It strains the reliability of Defendants' allegation that no inmate housed in Special Management in the month of September 2005 had no problems but nonetheless wanted to meet with the ARB. Moreover, Sergeant Romero testified that sometimes inmates would answer

[6] These rules include the fact that suicide is the number one cause of death in jails, "that making rounds and logging those rounds were essential to help prevent an increased risk of suicide," "that most suicides in jail can be prevented," "that communication with the inmates is an important line of defense to preventing the risk of suicide," and that risk factors for suicide include being arrested for the first time, depression, sentencing, holidays, loss of a loved one, family matters, birthdays, anniversaries, feelings of isolation, or facing a potentially lengthy period of incarceration. Ex. 11, Than Dep. 21:9 – 22:10, 24:14 – 25:1, 25:14 – 27:2, 33:10-14.

"Yes" to this question. In fact, during his deposition Sergeant Romero testified that if the response to this first question was always "No," that would be indicative of a problem. Ex. 5, Romero Dep. 133:21-25, 134:24 – 135:5. Thus, the documents prepared by Deputy Line are inherently untrustworthy. Additional evidence of the unreliability of Deputy Line's documentation is found in Sergeant Romero's deposition testimony, where he stated that the classification officer was supposed to fix any reported problems while he was questioning the inmate, where possible. *Id.* at 123:13-15. This testimony is an implicit recognition that inmates in Special Management sometimes had problems and that the universal negative responses to Question Number 1 were not accurate representations of the inmates' answers. Plaintiffs also move to strike paragraph 19 of Sgt. Romero's affidavit for lack of personal knowledge, as an undisclosed expert opinion, and because it constitutes inadmissible hearsay.

43. Disputed. Because Sergeant Romero was not present when Deputy Line made his rounds, he has no personal knowledge of Deputy Line's practices. Furthermore, as Deputy Line reported "No" with respect to every inmate's response when asked if he was having a problem, what is reported on the contact sheet by Deputy Line is unreliable. Moreover, there is no evidence that Deputy Line was able to effectively communicate with Mr. Vigil without a sign language interpreter. Plaintiffs also move to strike paragraph 20 of Sgt. Romero's affidavit for lack of personal knowledge, as an undisclosed expert opinion, and because it constitutes inadmissible hearsay

44. Undisputed.

45. Disputed. Because Sgt. Romero was not present on August 28, 2005, he has no personal knowledge about the ARB proceedings on that date. Ex. 5, Romero Dep. 141:22 – 142:8. Plaintiffs disagree with the first sentence of this factual allegation because there is no

memorandum, or cover page, summarizing why some inmates were not seen by the ARB during the week of August 28, 2005. Sergeant Romero also has no independent recollection of the ARB proceedings for that week. *Id.* at 121:14 – 122:18. Plaintiffs also dispute that Mr. Vigil declined to meet with the ARB during the week of September 18. There is a handwritten notation, "Declined ?" next to Mr. Vigil's name which suggests the ARB did not know why Mr. Vigil did not appear. Pls.' Add'l Fact No. 185. The only evidence of this assertion is of dubious value since it includes a question mark. Plaintiffs also move to strike paragraph 20 of Sgt. Romero's affidavit for lack of personal knowledge, as an undisclosed expert opinion, and because it constitutes inadmissible hearsay.

46. Disputed. Because Sergeant Romero has already testified that he had no independent recollection of the week of August 28, 2005, he has no personal knowledge of that purported weekly review. Ex. 5, Romero Dep. 141:22 – 142:8. As Sergeant Romero was not at the ARB the week of September 18, 2005, he has no personal knowledge that the ARB reviewed Mr. Vigil's classification and housing records on a weekly basis. The forms submitted by the ARB showed no review of his classification. Plaintiffs move to strike paragraph 19 of Sgt. Romero's affidavit for lack of personal knowledge.

47. Undisputed.

48. Undisputed.

49. Disputed in part. Elsewhere in Defendants' Motions for Summary Judgment, at ¶ 38, Defendants affirmatively stated, through Sgt. Romero's Affidavit, that nurses made rounds to the cells "three times each day" and were accompanied by a deputy on all of the rounds. Here, however, Defendants are now averring that the medication rounds were made "two or three times per day . . . ." Plaintiffs dispute that nurses "communicated" with inmates during rounds.

Deputy Sheriff Pablo testified that if an inmate was not taking medication, such as Mr. Vigil, the nurse did not stop at the cell and would just make sure the inmate was "breathing." Ex. 8, Pablo Dep. 139:25 – 140:7. Furthermore, while this statement is supported by the Affidavit of Peter Crum, M.D., nowhere in his Affidavit, other than his title as Medical Coordinator and Responsible Position for the Denver Sheriff's Department, is there a basis for his personal knowledge regarding how he knows what rounds nurses make in Special Management. His Affidavit does not state that he has reviewed medical records were accompanied the nursing staff on their rounds. *See* Defs.' Ex. A-6, Crum Aff. Plaintiffs also move to strike paragraph 14 of Dr. Crum's affidavit for lack of personal knowledge, as an undisclosed expert opinion, and because it conflicts with testimony provided pursuant to Rule 30(b)(6).

50. Disputed in part. As with all purported communications with Mr. Vigil at the Denver County Jail, the record is devoid of evidence as to how these nurses effectively communicated with him in order to complete a "subjective assessment" of him. *See also* Response to ¶ 49, *supra*. Plaintiffs also move to strike paragraph 15 of Dr. Crum's affidavit for lack of personal knowledge and because it conflicts with testimony provided pursuant to Rule 30(b)(6)

51. Disputed in part. Plaintiffs do not dispute that Mr. Vigil was seen during the weekly segregation rounds. However, this factual allegation suffers from the same flaw as all other documents allegedly reporting on Mr. Vigil's responses—there is no evidence of effective communication because there was no sign language interpreter. And, contrary to Defendants' assertion, there is no documentary evidence that the nurses observed no problems with Mr. Vigil. In the Problem Oriented Records completed by the nurses on their segregation rounds, only the box next to "No Complaints" is checked. None of the comment sections contains any

information—not even Mr. Vigil's deafness is identified. *See* Defs.' Ex. A-6, Crum Aff., Ex. 1 at Bates Nos. 000128-130. The only time a nurse completed a Problem Oriented Record had to do with Mr. Vigil's suicide. *Id.* at Bates No. 000131. In addition, Plaintiffs also move to strike paragraph 16 of Dr. Crum's affidavit because it includes inadmissible hearsay.

52. Disputed. While nursing staff may have "seen" Mr. Vigil, there is no evidence that anyone at the Denver County Jail, including the nursing staff, was able to, or made the effort, to engage Mr. Vigil in effective communication. *See also* Response to ¶ 49, *supra*. Plaintiffs also move to strike paragraph 16 of Dr. Crum's affidavit for lack of personal knowledge, as an undisclosed expert opinion, and because it conflicts with testimony provided pursuant to Rule 30(b)(6).

53. Disputed. While Dr. Crum may well have been the Medical Director when Mr. Vigil committed suicide, the barren medical records and other medical information concerning Mr. Vigil are an inadequate basis for Dr. Crum to form an opinion as to whether Mr. Vigil may have been suicidal or shown any signs of suicidal risk. Multiple factors and behaviors that can be indicative of an impending suicide attempt but missing from the medical records include Mr. Vigil's youth; the seriousness of his criminal charges; the significant amount of prison time he was facing; turning age twenty-three (23) while incarcerated; the utter lack of a way to effectively communicate with his jailers, the medical staff, or by telephone with his family; the picture he drew and kept in his cell that depicted himself in a brick room with tears falling down his face. For these reasons, Plaintiffs move to strike paragraph 19 of Dr. Crum's affidavit for lack of personal knowledge and as an undisclosed expert opinion.

54. Disputed. Ms. Ulibarri's deposition testimony squarely states that her son indicated to her when she was saw him at the courthouse that the deputies did not understand

what he was trying to communicate and that she called the jail to find out why he was not calling home from the Denver County Jail. Ex. 13, D. Ulibarri Dep. 75:21 – 76:6, 78:7 – 79:3. During that telephone call, whoever spoke with Ms. Ulibarri told her they did not have the equipment that would enable Mr. Vigil to call home. *Id.* at 80:11-23. While Ms. Ulibarri may not have characterized her telephone conversation as a complaint, *id*. at 80:24 – 81:3, she did notify the jail that she was concerned because her son was deaf and he had no way to communicate with her or the rest of his family by telephone. *Id.* at 83:4 – 84:2. Moreover, Ms. Ulibarri's deposition testimony relied upon Defendants ignores other significant testimony by Ms. Ulibarri: when asked whether her son, Shawn Vigil, ever complained to her about conditions at the jail, she asked opposing counsel quite simply, "How could he?" *Id.* at 127:22-24. Again, when opposing counsel asked a long series of questions about whether Mr. Vigil ever complained to her about particular problems he was having at the jail, she responded "No," but and then pointed out that he had no way of communicating with her. *Id.* at 130:13-18. Although not a lawyer, Ms. Ulibarri got right to the heart of the matter.

55. *See* response to ¶ 54, *supra*. Additionally, Mr. Vigil sent a letter to his mother from the Denver County Jail that showed a sad face. *Id.* at 118:24 – 119:8. Ms. Ulibarri reasonably interpreted this as indicating that her son was depressed during his incarceration. *Id.*

56. *See* response to ¶ 54, *supra*.

57. *See* response to ¶ 54, *supra*.

58. *See* response to ¶ 54, *supra*.

59. *See* response to ¶ 54, *supra*.

60. Disputed. *Id.* at 94:11-19.

61. Disputed in part. Again, Mr. Vigil had no meaningful way of communicating with his mother or the remainder of his family while he was incarcerated because he had no access to a telephone and was functionally illiterate in the English language. Therefore while it is technically accurate to state that Mr. Vigil did not discuss suicide with her while he was in jail, it is disingenuous to suggest that he had the means to do so. *See* for example, Ex. 2, Kosinski Dep. Exs. 39-44, for an example of Mr. Vigil's writing abilities.

62. Disputed in part. Plaintiffs do not dispute that Mr. Vigil never indicated prior to going to jail that he was considering suicide. The remainder of the factual allegations in ¶ 62 are strongly disputed. *See* response to ¶ 53, *supra* for a summary of the risk factors and warning signs indicating that Mr. Vigil was at high risk for committing suicide.

63. Disputed. *See* response to ¶ 54, *supra,* for a summary of Ms. Ulibarri's deposition testimony stating that she contacted the Denver County Jail, a division of the Denver Sheriff's Department to find out why her deaf son was not calling her.

64. Disputed in part. Because Mr. Vigil was unable to communicate with Ms. Ulibarri while incarcerated, other than hurried meetings in the courthouse, she had no viable means of knowing that her son was a suicide risk and could not, therefore, have notified anyone of information she did not have-- through no fault of her own.

65. Disputed in part. *See* response to ¶ 64, *supra*.

66. Disputed in part. Again, Defendants omitted significant testimony by Ms. Ulibarri. While Mr. Vigil did communicate by writing notes, his mother described his notes is "very difficult to understand." Ex. 13, D. Ulibarri Dep. 37:23-24. She also testified that people who were not familiar with Mr. Vigil or his writing would have even more difficulty than his family members did in understanding his intent in communicating. *Id.* at 37:23 – 38:4, 45:9 –

46:4. *See also* Ex. 1, Andrews Dep. 36:18-20; Ex. 14, Brandon Ulibarri Dep. 33:9 – 34:7 (demonstrating how Shawn Vigil made-up some of his own hand signs to communicate with his family).

67. Disputed. Although it is correct that Mr. Vigil's brother testified that he communicated with family members by visual signs and the use of writing, this type of "preferred means" of communication only suggests that when he was with his family, that was the means of communication he had to rely on as no one in his family perform ASL. *See also* response to ¶ 66, *supra*. Jean Andrews testified on the other hand that Mr. Vigil's school records show that the most effective means to communicate with Shawn Vigil was ASL, and this was the preferred means to effectively communicate with Mr. Vigil. Ex. 1, Andrews Dep. 78:7-9. Mr. Vigil also communicated with hearing persons by pointing or making simple signs. Ex. 13, D. Ulibarri Dep. 44:6 – 45:16.

68. Disputed in part. *See* response to ¶ 67, *supra*.

69. Disputed in part. It is important to note that Brandon Ulibarri, Shawn Vigil's brother, did not live with Shawn Vigil for most of his life and visited with Shawn on one occasion prior to Mr. Vigil's incarceration. Ex. 14, B. Ulibarri Dep. 14:4, 18:3-5. Therefore, Brandon Ulibarri had had little opportunity to interact with his older brother, Shawn Vigil, for many years prior to Shawn Vigil's suicide.

70. Disputed in part. Brandon Ulibarri's complete testimony was that he and other family members communicated by writing notes back and forth with Shawn Vigil because the hearing family members knew little about signing. *Id.* at 29:2-5. Simply seizing on one word in Brandon Ulibarri's deposition, as Defendants have done here with the use of "effective," is misleading about Shawn Vigil's ability to communicate effectively in exchanging notes with his

family or with anyone else. Brandon Ulibarri also testified, as does his mother, about the many difficulties in understanding Shawn Vigil's notes:

> Q. Did he ever have any problem writing his notes?
>
> A I mean, sometimes he was hard to understand because his vocabulary wasn't the same as ours, you know.
>
> Q. When you say, "Vocabulary," we're talking about notes now. Are you talking about when he writes?
>
> A. Well, yeah, his understanding of what a word -- like, some things he'd write -- it would be, like, backwards. Like, when he writes, it don't really make sense so you've got to kind of read it over and over so it will make sense, and sometimes he'll point to, like, over here and over here and he'll put it together and make sense . . . .

Id. at 29:20 – 30:6*; See also* response to ¶ 69, *supra*.

71. Disputed in part. Plaintiffs do not dispute that this is the text of Brandon Ulibarri's deposition testimony. However, it must be remembered that Mr. Ulibarri left the home at age eight (8) and did not return for 10 years, approximately two (2) years after Mr. Vigil's death. *See also* responses to ¶¶ 69 and 70, *supra*.

C. The Morning of the Suicide.

72. Disputed. Mr. Vigil was not found hanging in his cell at 8:55 a.m. Inmate Wilson was not informed that he had a visitor until 8:55 a.m. According to Deputy Sheriff Pablo's written statement, made on the day Mr. Vigil was discovered, inmate Wilson did not notify the deputies about Mr. Vigil's situation until 9:03 am. Ex. 8, Pablo Dep. Ex. 13 at Bates Nos. P000666-P000667 (Incident Report by Deputy Pablo). Furthermore, one document relied upon by Defendants for this assertion, Bates Nos. P000592, contains the statement that "Sergeant Moore states that at approximately 9:03 a.m. Inmate Marvin Wilson, Bk#1429124, informed Deputy David Pacheco and Deputy Robert Pablo that Inmate Shawn Vigil was hanging

in his cell."[7] The only document that says Mr. Vigil was found hanging at 8:55 a.m. was the summary portion of the Internal Affairs investigation which does not comport with any of the deputy statements in that report. Furthermore, Pacheco's contemporaneous written statement states that he found Mr. Vigil hanging at 9:05 a.m. Ex. 21, Lucas Decl. Ex. 2 (Bates No. P000610).

73. Undisputed. However, it should be noted that as written, makes it appear that Inmate Wilson had a choice of deputies to notify. This is incorrect; there were only two deputies on this side of Building 6, the A, B., and C tiers. Ex. 21, Lucas Decl. Ex. 3, Bates Nos. U000041-000042 (Daily Assignment Roster for 9/27/05).

74. Disputed. According to Deputy Sheriff Pacheco's written statement, he notified medical and his supervisors at approximately 9:05 am, not 9:03 am. Ex. 21, Lucas Decl. Ex. 4 (Bates Nos. P000608-609). This is also the report that was signed off on by Pacheco's supervisors. *Id*.

75. Undisputed.

76. Undisputed.

77. Disputed. The documents show that the ambulance was called for at 9:08 AM, not 9:05 am. Ex. 21, Lucas Decl. Ex. 2 (Bates No. P000610). The Denver Fire Department paramedics did not arrive at Building 6 until 9:15 am. *Id*.

78. Undisputed.

79. Undisputed.

[7] Plaintiffs do not understand why Defendants are not using the deposition transcripts of the two deputies in charge of Building 6 when Mr. Vigil hanged himself.

80. Disputed in part. The logbook shows only that medications were passed out. There is no indication that the nurses went to every cell in Building 6. Ex. 10, Pacheco Dep. Ex. 16 at Bates Nos. U001107 (Observation Logbook of Building 6).

81. Undisputed.

82. Disputed in part. The log book for that morning shows that "chow" was started but no ending time is provided. *Id*. at Bates No. U001107. There is no evidence that Major Deeds was present at that time and had any personal knowledge as to what occurred.

83. Disputed. The log book indicates that the juveniles were sent to the yard at 0800, and that the juvenile returned from the yard and showers at 0845. Ex. 8, Pablo Dep. Ex. 14.

84. Disputed. The logbook does not indicate that any rounds were made at 8:25 a.m. Id. at Bates No. U001109. Deputy Pacheco also testified that if a round was not documented, he could not verify that it was made. Ex. 10, Pacheco Dep. 116:11-25.

D. Denver Sheriff Department Internal Affairs Bureau Investigation.

85. Undisputed.

86. Undisputed.

87. Disputed in part. Plaintiffs do not dispute that this allegation accurately summarizes Major Deeds' deposition testimony; however, they believe that the scope of the investigation should have been much wider and included what accommodations were provided to Mr. Vigil, and why no accommodations were provided.

88. Disputed in part. Plaintiffs do not dispute that this was Major Deeds' deposition testimony. They disagree that all relevant witnesses were interviewed, that the interviews were complete and that all relevant evidence was collected and reviewed and that an objective review of the evidence was conducted. The Office of the Independent Monitor ("OIM"), through

Richard Rosenthal, notified the Denver Sheriff's Department of a number of flaws in the investigation, including but not limited to inquiries about whether Mr. Vigil presented as a suicide risk and requested additional information about the risk of suicide posed by Mr. Vigil:

> I am concerned, however, that the investigation did not cover one key area of inquiry: was anyone in the Denver Sheriff's Department aware of the possible suicide risk posed by the inmate?
>
> Inmate Marvin Wilson, who discovered and reported the attempted suicide, was interviewed. However, written documentation of this interview is not contained in the investigation report. Inmate Wilson was asked about the prior demeanor of Mr. Vigil and noted "he seemed to be happy." This was an excellent area of inquiry. It would be helpful for effective review and audit, however, if this information is documented in the reports.
>
> The two inmates on either side of Mr. Vigil were also interviewed. It does not appear, however, that either of these inmates were asked any questions about whether Mr. Vigil appeared to be a suicide risk . . . . Also, I did not note any documentation of any attempt to interview Mr. Vigil's most recent cellmate.
>
> I also noted that there is no written documentation of any questions asked of the interviewed Deputies or medical staff who had contact with Mr. Vigil as to whether he appeared to be a suicide risk. I would be specifically interested in seeing the nurse who conducted the "segregation rounds" with Mr. Vigil interviewed about her contacts with Mr. Vigil.
>
> Ex. 6, Foos Dep. Ex. 30 at Bates No. P000587 (Memo from Rosenthal to Horner).

There is no evidence that any investigation was done regarding the OIM's request for additional information.

89. Undisputed. Plaintiffs note, however, they have received no documentation that it falls to the Division Chief to determine at the conclusion of an Internal Affairs Bureau ("IAB") investigation whether all policies and procedures for the Denver Sheriff's Department were followed.

E. PADF Routine in 2007 (Arrests and Detention of Plaintiffs Krebs and Burke)

90. Disputed as to collecting medical information. Undisputed as to other facts. Captain Michael Than was the 30(b)(6) designees on the topic of the training provided to Denver Sheriff Deputies regarding inmates who have diabetes since 1993. Ex. 15, Robertson Decl. Exs. 4-6. Than did not know whether the deputies were trained regarding how they would know whether an inmate/detainee had diabetes. Ex. 11, Than Dep. 66:19 – 67:25. Plaintiffs also move to strike paragraph 4 of Maj. Wilson's affidavit for lack of personal knowledge.

91. Disputed. Deeds, the Rule 30(b)(6) designee on the provision of medical services at the PADF, testified that although there was a policy in effect that detainees should be seen within one half hour of their arrival, on a busy day it could take more than one half hour before an inmate was seen. Ex. 7, Deeds Dep. 48:15 – 49:15. Plaintiffs also move to strike paragraph 5 of Maj. Wilson's affidavit for lack of personal knowledg

92. Undisputed.

93. Undisputed.

94. Undisputed.

95. Undisputed. Sarah Burke and Briana McCarten found the TTYs inoperable. Ex. 16, Burke Dep. 44:10 – 45:10, Ex. 9, McCarten Decl. ¶¶ 7, 13. Plaintiffs also move to strike paragraph 9 of Maj. Wilson's affidavit for lack of personal knowledge.

96. Disputed. Roger Krebs asked for and was denied access to any technology that would allow him to make a telephone call. Ex. 17, Krebs Decl. ¶ 10. Plaintiffs also move to strike paragraph 10 of Maj. Wilson's affidavit for lack of personal knowledge.

97. Undisputed as to the presence of a videophone.

98. Undisputed.

99. Disputed. Krebs Decl. ¶ 12; *see also supra* ¶ 37.

100. Disputed. At the PADF, Mr. Krebs asked for an interpreter during the booking process. Ex. 18, Roger Krebs Dep. 75:7-9, 75:18, 79:25 – 80:16. Mr. Krebs continued to ask the deputies at the PADF for an interpreter. He was never provided with an interpreter. *Id*. at 80:19-25. When Sarah Burke stated that she wrote on paper that she had diabetes and needed to see a doctor, the officer ignored the message and spoke verbally to her, and she could not understand what he was saying. Ex. 16, Sarah Burke Dep. 37:20 – 38:4. When Ms. Burke wrote notes to the medical officer, the officer refused to write back, and instead spoke verbally to Ms. Burke, which she could not understand. *Id*. at 39:7-11. Plaintiffs also move to strike paragraph 14 of Maj. Wilson's affidavit for lack of personal knowledge and as an undisclosed expert opinion.

101. Undisputed.

F. Roger Krebs is Arrested by the Denver Police Department and Placed in the Custody of the Denver Sheriff's Department.

102. Undisputed.

103. Undisputed.

104. Undisputed.

105. Disputed. Mr. Krebs testified that he didn't understand what the security guard was saying. Ex. 18, Roger Krebs Dep. 61:2-8. The security guard then grabbed Mr. Krebs's Sidekick (pager device). *Id.* at 13-15. The security guard proceeded to choke Mr. Krebs, and Mr. Krebs then bit the security guard. *Id.* at 16-23. The security guard then pushed Mr. Krebs and broke his ankle. *Id.* at 61:24 – 62: l-3. The security guard then pounded Mr. Krebs head repeatedly. *Id.* at 62:4-11.

106. Undisputed.

107. Disputed in part. Plaintiffs do not dispute that the police officer noticed Mr. Krebs's hands or that the police officer asked for a handcuff key. Plaintiffs dispute that the police officer instructed the security guard to loosen the handcuffs; rather, the police officer released the handcuffs. Ex. 18, Krebs Dep. 65:10-15.

108. Undisputed.

109. Undisputed in part. The police officer observed Mr. Krebs's injured foot only after Mr. Krebs took off his shoe to show the officer his injured foot. Ex. 18, Krebs Dep. 68:16-22.

110. Disputed. Mr. Krebs testified that he could not understand the arresting police officer. Ex. 18, Krebs Dep. 66:2 – 67:10.

111. Undisputed.

112. Undisputed.

113. Undisputed.

114. Undisputed.

115. Undisputed.

116. Undisputed.

117. Undisputed.

118. Undisputed.

119. Disputed. Mr. Krebs did not understand what happened in court. Ex. 18, Krebs Dep. 88:24 – 89:8.

120. Disputed. *Id*.

121. Undisputed.

122. Undisputed.

123. Disputed. Mr. Krebs did not understand what happened in court. Ex. 18, Krebs Dep. 88:24 – 89:8.

124. Undisputed.

125. Undisputed.

126. Undisputed.

127. Undisputed.

128. Undisputed.

129. Disputed. Mr. Krebs does not communicate with his boss every day. Ex. 18, Krebs Dep. 49: 8-10. Mr. Krebs uses interpreters to communicate with his boss. *Id.* at 48:6-8. Mr. Krebs occasionally uses notes to communicate with his boss, but frequently does not understand the notes. He also uses a fellow employee to interpret conversations with his boss. *Id.* at 49:8-18.

130. Disputed in part. Mr. Krebs also communicates with coworkers using sign language. *Id*.

131. Disputed. Mr. Krebs employer provides sign language interpreters, and written communication. *Id*. at 48:6-8 – 49: 8-18.

132. Undisputed.

G. Sarah Burke.

133. Undisputed.

134. Undisputed.

135. Undisputed.

136. Undisputed.

137. Undisputed.

138. Undisputed.

139. Undisputed.

140. Undisputed.

141. Undisputed.

142. Undisputed.

143. Disputed in part. Plaintiffs do not dispute that the police officers relied on Ms. Burke's eight-year-old son to interpret. Plaintiffs dispute that the police officers communicated with Ms. Burke in writing. Ex. 16, Burke Dep. 29:24 – 31:2.

144. Disputed. Ms. Burke and her husband repeatedly requested a sign language interpreter. *Id.* at 25:8-20; 29:13-23; 30:2-6.

145. Disputed in part. Plaintiffs do not dispute that it is the officer's perception that he had effective communication but deny that effective communication occurred. Ex. 16, Burke Dep. 25:21 – 24; 28:23 – 31:2.

146. Disputed. Ms. Burke got that the officers used the word "contempt" but did not know what this meant. *Id.* at 25:21 – 24; 30:7-12.

147. Undisputed.

148. *See* Plaintiffs' response to ¶ 145, *supra*. Plaintiffs do not dispute that Ms. Burke was compliant, but deny that effective communication occurred.

149. Disputed. Officer Merino testified that he cannot recall whether he allowed Ms. Burke to bring her medications with her when she was arrested. Ex. 19, Joseph Merino Dep. 27:25 – 28:2.

150. Undisputed.

151. Undisputed.

152. Undisputed.

153. Disputed. About three and a half hours after arriving at PADF, Ms. Burke was taken to a person she believed to be a medical officer. Ex. 16, Burke Dep. 38:11-24.

154. Undisputed that the document so states.

155. Undisputed.

156. Disputed in part. Plaintiffs do not dispute that this is what is recorded in the document. Plaintiffs disputed that Ms. Burke's blood sugar was 377. Ex. 16, Burke Dep. 39:7-18. Plaintiffs do not dispute that Ms. Burke received an insulin injection but dispute that Ms. Burke received a sack lunch. *Id.* at 40:9-21.

157. Disputed. *Id*.

158. Disputed. Ms. Burke was told that she would have to wait until the next scheduled meal to receive food. *Id*.

159. Undisputed.

160. Disputed. Ms. Burke was not offered a TTY until after her release. Ex. 16, Burke Dep. 43:15-19; 44:8-16.

161. Undisputed.

162. Undisputed.

163. Undisputed.

164. Disputed in part. Ms. Burke also communicates with hearing people using a sign language interpreter. *Id.* at 14:15 – 15:l.

165. Disputed in part. See Plaintiffs' response to ¶ 164, *supra*.

H. Purported Accommodations for Deaf and Hearing Impaired Inmates.

166. Disputed in part. While interpreter services may be available to Denver's police and sheriff's departments, there is no record that a sign language interpreter was provided to any of the Plaintiffs while in Defendants' custody. Moreover, Defendant Denver Sheriff's Department has produced no evidence that it has ever availed itself of the interpreter services. .

167. Undisputed.

168. Undisputed.

169. Disputed in part. Plaintiffs do not dispute that TDDs existed at the DCJ and PADF but dispute that they were working. Ex. 9, McCarten Decl. ¶¶ 7, 13.

170. Disputed in part. Admit that the videophones were installed in 2008. Deny that the technology became available in 2007.

171. Disputed. Ex. 9, McCarten Decl. ¶ 5.

172. Undisputed.

173. Undisputed.

174. Undisputed.

175. Undisputed.

176. Undisputed.

177. Undisputed.

178. Disputed in part. Plaintiffs admit that Defendants retained Michael W. Haley as an expert witness regarding acceptable practices in the management and care of inmates. Plaintiffs also do not dispute the contents of Ex. A-20. Plaintiffs object, however, to Ex. A-20 because Defendants failed to authenticate the documents it contains.

179. *See* response to ¶ 178, *supra*, regarding Defendants' failure to authenticate Ex. A-20.

180. *See* response to ¶ 178, *supra*, regarding Defendants' failure to authenticate Ex. A-20.

181. *See* response to ¶ 178, *supra*, regarding Defendants' failure to authenticate Ex. A-20.

182. *See* response to ¶ 178, *supra*, regarding Defendants' failure to authenticate Ex. A-20.

183. *See* response to ¶ 178, *supra*, regarding Defendants' failure to authenticate Ex. A-20.

I. Alvin LaCabe.

184. Plaintiffs were limited to ten depositions. In the absence of the ability to cross examine this witness, Plaintiffs dispute this assertion.

185. *See supra* ¶ 184.

186. *See supra* ¶ 184.

187. *See supra* ¶ 184.

188. *See supra* ¶ 184.

189. *See supra* ¶ 184.

190. *See supra* ¶ 184.

J. William Lovingier.

191. *See supra* ¶ 184.

192. *See supra* ¶ 184.

193. *See supra* ¶ 184.

194. *See supra* ¶ 184.

195. *See supra* ¶ 184.

196. *See supra* ¶ 184.

197. *See supra* ¶ 184.

K. Ron D. Foos.

198. Undisputed.

199. Undisputed.

200. Undisputed.

201. Undisputed.

202. Undisputed.

203. Undisputed.

204. Undisputed.

205. Undisputed.

206. Undisputed.

207. Undisputed

L. Gary Wilson.

208. *See supra* ¶ 184.

209. *See supra* ¶ 184.

210. *See supra* ¶ 184.

211. *See supra* ¶ 184.

212. *See supra* ¶ 184.

213. *See supra* ¶ 184.

214. *See supra* ¶ 184.

215. *See supra* ¶ 184.

216. *See supra* ¶ 184.

217. *See supra* ¶ 184.

II. PLAINTIFFS' STATEMENT OF ADDITIONAL DISPUTED OR UNDISPUTED FACTS

A. Shawn Vigil

1. Mr. Vigil Was Prelingually Deaf

1. At the age of two (2), Mr. Vigil became ill with a serious infection that resulted in his deafness. Ex 1, Jean Andrews Dep. 37:8-10. Because of his youth, he was prelingually deaf which means "he did not fully acquire language before he became deaf." *Id*. at 56:7-19.[8] He did not use amplification. Ex22, Educational Records of Shawn Vigil, Bates Nos. P000426-427, 310, and 343.

2. Deaf and hard of hearing persons differ widely in their abilities to communicate and understand, and Mr. Vigil was no exception. Each deaf person must be evaluated on a case-by-case basis to determine the best means for effective communication. Ex 1, Andrews Dep. 13:1-24.

3. For example, spoken and written English are substantially different from American Sign Language ("ASL"). ASL does not have a direct connection to the grammar of the English language. ASL is a three dimensional language that possesses its own grammatical rules and syntax. It includes regional dialects and can convey abstract concepts. An English sentence can be conveyed with a single sign, and in other circumstances, an English word can take several signs to convey. Ex.23, Jean Andrews Decl. at ¶ 3.

[8] Dr. Andrews is a Professor of Deaf Studies/Deaf Education at Lamar University. Ex. 1, Jean Andrews Dep. 4:14 – 5:3.

4. Mr. Vigil attended the Colorado School for the Deaf and the Blind ("CSDB) from 1987, when he was age six (6), through 2004 when he was age 21. He graduated from high school and also attended post-secondary classes at CSDB for vocational training. His reported intellectual functioning (non verbal IQ) was in the low borderline range. Ex 1, Andrews Dep. 58:6-16; Ex. 22, Educational Records of Shawn Vigil at Bates Nos. P000308.

5. Mr. Vigil's teachers at CSDB did not believe he could use written English to effectively communicate. Ex 1, Andrews Dep. 38:24 – 39:7; Ex. 22, Educational Records of Shawn Vigil at Bates Nos. P000304, 307, 308, 310, 315, 342, 347, 352, and 331.

6. Mr. Vigil could not use speech reading or lip reading. Ex 1, Andrews Dep. 32:18 – 33:2; Ex. 22, Educational Records of Shawn Vigil at Bates Nos. P000426-427. Speech reading and lip reading are essentially the same—they both depend on the deaf or hard of hearing person's ability to understand English words and grammar patterns, something Mr. Vigil never learned. Ex 1, Andrews Dep. 55:16 - 56:4; Ex 2, Kosinski Dep. 55:9-17.

7. Because he was prelingually deaf, he did not have the opportunity to learn to speak or understand English in the way that hearing people do. Mr. Vigil was substantially limited in the major life activities of hearing and speaking with his primary method of communication through American Sign Language. Mr. Vigil also did not have the ability to use intelligible speech. Further, because of his limited English comprehension skills, lip reading, reading notes or writing notes were not truly effective modes of communication for Mr. Vigil. Therefore, the only effective means available to Mr. Vigil for communicating with the hearing world were through an interpreter, TTY telephone or a relay service. Ex 1, Andrews Dep. 75:18 – 77:2, 78:4-19.

8. Mr. Vigil was also substantially limited in the major life activity of learning, as evidenced by intellectual testing and his Stanford Achievement Test results when he was 19 years old. Those tests show that Mr. Vigil was reading at the same level as a hearing child who was in the second grade in the third month of school. Mr. Vigil had an intellectual disability as evidenced by intellectual testing performed by the Colorado Department of Education. It is also suspected, based on testing, that Mr. Vigil suffered from a learning disorder which hindered his ability to move forward in his education. Ex 1, Andrews Dep. 30:19 - 31:9.

9. While in school at CSDB, Shawn Vigil received counseling services at CSDB as part of his educational and residential life programs. Ex 22, Educational Records of Shawn Vigil at Bates Nos. P000305, 343, and 331.

10. In 1999, Mr. Vigil's school records indicate that communication was quite difficult for him: "Please note that Shawn have [sic] difficulty with communication due to his limited vocabulary. He does communicate mostly in American Sign Language but with many gestures and facial expressions. Shawn needs processing time to understand what is being said to him." *Id*. at P000308.

11. Mr. Vigil's school records show that his persistent inability to understand communications often caused problems for him. *Id*. at P000311.

12. Mr. Vigil continued to struggle with emotional issues throughout his time at the school: Shawn can be inconsistent in his behavior and interactions. Even though his emotional outbursts have decreased, he still will react impulsively and become physically Violent; especially when he feels there is no way out." *Id*. at P000310.

13. While in school, Mr. Vigil was prone to angry outbursts, and at one point was required to meet daily with a counselor as a check on his emotional status. *Id*. at P000305.

14. In 2000, the school referred Mr. Vigil for a mental health evaluation to determine whether he required medication for "depression, anger and impulse control." *Id*. Unfortunately, his school records contain no further information about whether Mr. Vigil was evaluated by mental health. He was still seeing a counselor in 2001. *Id*. at P000322.

15. In February 2004, Mr. Vigil was once again evaluated and expressed a need for additional emotional/social counseling services. *Id*. at P000331.

2. Mr. Vigil's Incarceration at the PADF

16. On August 17, 2005, after being arrested and charged by the Denver Police Department, Mr. Vigil was held at the Denver Pre-Arraignment Detention Facility ("PADF"). Exhibit A-7, Affidavit of Gary Wilson, Affidavit Ex. 1, Bates No. U000001. By statute, the Denver Sheriff's Department is responsible for operating the PADF and DCJ. C.R.C. § 30-10-511.

17. On August 17, 2005, Nurse Robert Kelly Costin conducted a medical assessment on Mr. Vigil. Exhibit A-6, Affidavit of Peter Crum, Affidavit Ex. 1, Bates No. U000127. The nurses at the PADF were required to follow the policies and procedures of the Denver Sheriff Department, Ex. 3, Costin Dep. 29:11-14, but the DSD provides no formal training to the medical staff with respect to the policies and procedures. *Id*. at 30:12-17. Nurse Costin is also the nurse at the PADF that performed the medical assessment on Emily Rice, the woman who died at the PADF in February 2006 after she was not given a proper medical assessment by Costin. Deposition of Kelly Costin in the Matter of Estate of Emily Rice v. City and County of Denver, et al, 07-CV-01571 at 12:3-11.

18. Costin was disciplined by the Board of Nursing for a "substandard" medical evaluation of Ms. Rice upon intake. Ex. 3, Costin Dep. 19:22-25 – 20:1-6. Drs. Joseph E. Paris

and Robert Greifinger both submitted expert reports in that case and opined that Nurse Costin was deliberately indifferent to Ms. Rice's serious medical needs. Ex 25, Paris Report at 9; Ex 25, Griefinger Report at 3-4, ¶ 28.

19. In October 2006, the National Commission on Correctional HealthCare (NCCHC) cited PADF for having insufficient continuing education for nurses and found that there were serious continuing problems in the custom and practices at the PADF with intake screening, and there was continued non-compliance with health assessments. *See* Greifinger Report at 5 ¶¶ 37, 38.

20. Nurse Costin was fired from the PADF and Denver Health's employment in November 2008 after he failed to perform a proper assessment of another inmate who had a liver laceration from a motor vehicle accident. Ex 3, Costin Dep. 7:9 – 8:9; 11:7-21; 21:14-22.

21. At the time of his deposition in the instant case, he was facing disciplinary action by the Board of Nursing for that incident. *Id*.

22. Chief Foos testified that he had concerns about Nurse Costin's performance and professionalism and was not the type of person to be trusted with carrying out the duties of the Denver Sheriff Department. Ex 6, Foos Dep. 185:7-16.

23. It was Nurse Costin's practice to complete a medical assessment in *12 to 15 seconds*. Ex. 3, Costin Dep. 41:4-11. Nurse Costin habitually rushed through the medical assessments of the incoming inmates because he felt pressured by jail personnel, jail supervisors and his coworkers. *Id*. at 139:12-20. Defendants' own expert, Michael Haley, testified that 15 seconds would not have been an adequate amount of time to conduct the medical assessment intake screening at the PADF, Ex. 26, Haley Dep. 31:1 – 32:2, and that he would be concerned

that any medical professional who felt rushed to complete such an assessment may not be as thorough as needed. *Id*. at 32:23 – 33:18.

24. It was Nurse Costin's practice to read the series of 10 questions to any inmate he was assessing. Ex. 3, Costin Dep. 41:13-14.

25. The documentation prepared by Nurse Costin stated that Mr. Vigil could not read lips but that he could communicate in writing. Defs.' Ex. A-6, Affidavit of Peter Crum, Affidavit Exhibit 1, Bates No. U000127. Nurse Costin made this decision about Mr. Vigil's language abilities without having any knowledge of his English skills or cognitive deficits. In fact, Nurse Costin testified that he believed Mr. Vigil to be proficient in the English language; otherwise, he would not have written down that Mr. Vigil could communicate in writing. Ex. 3, Costin Dep. 120:24 – 121:23. During his deposition, Nurse Costin admitted that he had no recollection of Mr. Vigil's medical assessment. *Id*. at 119:10-12.

26. Nurse Costin did not use a sign language interpreter when evaluating Mr. Vigil. *Id*. at 77:20 – 78:5, 162:20 – 163:1.

27. Although somewhat equivocal on the issue, Nurse Costin housed Mr. Vigil alone because of his deafness. *Id*. at 123:14-21.

28. Sometime during Mr. Vigil's detention at the PADF, another inmate assisted Mr. Vigil in calling his grandparents' house. That inmate used a regular telephone, not a TTY telephone. Ex. 13, Debbie Ulibarri Dep. 102:23 – 103:18.

29. Mr. Vigil was able to use a TTY or TDD telephone to communicate with his family, who kept one of these telephones at his grandmother's house. *Id*. at 87:2-4, 100:1-6.

30. From the PADF, Mr. Vigil called his grandmother's house once. *Id*. at 95:24 - 96:9. (Although Ms. Ulibarri's testimony at this point in the deposition was that Mr. Vigil called

home twice while he was at the PADF, she later clarified that he made one TTY telephone call home. *Id*. at 103:2-6. The other call was made to Ms. Ulibarri by another inmate on Mr. Vigil's behalf. *Id*. at 103:10-12.)

3. Mr. Vigil's Classification

31. On August 25, 2005, Defendants transferred Mr. Vigil from the PADF to the Denver County Jail ("DCJ"). Defs.' Ex. A-5, Affidavit of Sgt. John Romero, ¶ 4 and Affidavit Exhibit 1, Bates No. U000880.

32. When Mr. Vigil arrived at the DCJ, he was housed in Building 6 which held inmates that required special management based upon assessments by classification officers.

33. Classification officers relied upon a Post Order entitled in making those assessments. Ex.27, Denver Department of Safety, COJL Post Order, Building 6 at 1, §§ I.A.(1-7). Denver County Jail housed inmates in Building 6 for a variety of reasons, including: physical or emotional disabilities, sexual orientation, security issues, protective custody, or administrative segregation. *Id*. at 15-16, §§ E, F.

34. Mr. Vigil was classified as X 07A. Ex. 28, List of Housing Assignments for Shawn Vigil, Bates No. P000633. This classification is reserved for inmates with drug or alcohol addictions, emotionally or mentally disturbed inmates or "physically handicapped" inmates. *Id*. at 15, § IV.E.3.

35. Inmates in Building 6 were allowed out of their cells for exercise a maximum of 45 minutes, Ex.27, Post Order at 8-9, §§ V.I.1, were not allowed contact visits, only video visits, *id*. at 18, § A, "Visits," were barred from attending any function where the general population was also allowed, *id*., and were not allowed to leave the building for religious services. Instead, Building 6 inmates were required to send a kite to the chaplain who would then have a one-on-

one meeting. *Id*. at 9, § V.K. The Post Order does not indicate how a deaf or hard of hearing inmate was to communicate with the chaplain.

36. The Post Order contains no instructions for deputies about the need to accommodate deaf or hard of hearing inmates who needed to make personal or legal telephone calls. Ex.27, Post Order at 20, § E.

37. Although the programs and services available to inmates incarcerated at the Denver County Jail in 2005, including pre-trial detainees such as Mr. Vigil, included: GED; drug and alcohol counseling; religious services and life skills. Ex. 6, Foos Dep. 73:19 – 74:5. The Post Order for Building 6 significantly limited the opportunities of any inmate in that building because they were not allowed to interact with inmates in the general population. Post Orders at 18 § A.

38. Building 6 holds six tiers, with the A, B, and C tiers stacked on top of each other on one side of the building and the D, E, and F tiers stacked on top of each other on the opposite side of the building. The A tier is on the bottom, with the B tier on top of the A tier, and the C tier on top of the B tier. Ex. 8, Pablo Dep. 15:12 - 17:9; Ex. 29, Drawing by Deputy Sheriff Pablo.

39. The officer's cage is located on the A tier, *id*., and is approximately 30 yards, or 125 feet, from cell A-17. Ex. 8, Pablo Dep. 18:11 – 19:2; Ex. 10, Pacheco Dep. 68:18-22.

40. During his 30(b)(6) deposition, Sergeant John Romero testified that because of Mr. Vigil's classification, he needed to be as close to the officer's cage as possible. Ex. 5, Romero Dep. 44:12-17.

41. Nonetheless, Mr. Vigil was moved multiple times during his month-long incarceration at Denver County Jail. From September 21, 2005 until the day of his suicide

attempt six days later, Mr. Vigil was held in Cell A17, which is the seventeenth cell away from the cage on the first floor of Building 6. Ex. 10, Pacheco Dep. 90:4-7; Ex. 28, List of Housing Assignments for Shawn Vigil, Bates No. P000633; Ex. 30, Declaration of Briana McCarten at ¶ 8. *See also* Ex. 31, for pictures of Mr. Vigil's cell at the time of his suicide.

42. The inside of Cell A-17 is not visible from the officer's cage. Ex. 10, Pacheco Dep. 69:8-10. All that a sheriff in the cage could see of the A tier was the hallway down the corridor that ran in front of the 18 cells on that tier. Ex. 32, Mark Richard Pogrebin Dep. 147:10-12, 21-23.

43. Despite being disabled, deaf and hearing impaired inmates should have received the same privileges as any other inmate with the X 07 A classification. *Id*.

B. Training

1. <u>Training Provided to DSD Deputies Regarding Inmates Who Are Deaf or Have Diabetes</u>

44. Captain Michael Than, along with Lorrie Kosinski, were the 30(b)(6) designees on the topic of the training provided to Denver Sheriff Deputies regarding inmates who are deaf or hard of hearing or have diabetes since 1993. Ex. 33, Fed.R.Civ.P. 30(b)(6) Designation. Captain Than testified that Lorrie Kosinski only provided training to the deputies at the Training Academy, which is the "pre-service" training. Ex. 11, Than Dep. 9:6-25; and 58:5-9.

45. The documents produced by the DSD regarding the training provided at the Academy show that Ms. Kosinski did not begin to provide a two-hour training on "Deaf and Hearing impaired" issues until April 14, 2004. Ex. 34, Bates Nos. U001549–1577. The document provided as an attachment to her affidavit regarding the training that she provided to DSD deputies, [Defs.' Ex. A-4 (Part 1) (Doc. # 197-6), Exhibit 1], is not dated and there is no verification regarding when the material in that document was provided to DSD deputies.

46. Even assuming that Ms. Kosinski has been providing training at the Academy since the early 1990's as stated in her affidavit, no evidence regarding the content of that training has been produced in this case. Kosinski did testify that in the past she trained for a full day, and at some time that changed to two hours. Kosinski did not know why the training time had been reduced, or when the training time had been reduced. Ex. 2, Kosinski Dep. 36:15-24.

47. There have been occasions where people that Kosinski has trained have simply disregarded her training. Ex. 2, Kosinski Dep. 33:5-14. In addition, she is not surprised that deputies do not recall information from her trainings accurately because she believes that people remember what they want to remember, not necessarily what they are told. *Id.* at 23:21-24:11.

48. Kosinski does not specifically train on ADA requirements, but simply mentions ADA requirements during her trainings. *Id.* at 39:14-16

49. Kosinski would like more time for her training sessions at the pre service academies. *Id.* at 36:10-14. As a result of the time constraints, recruits no longer conduct role play, an effective form of adult education. *Id.* at 37:24 – 38:10.

50. Kosinski has never seen what recruits are tested on, *id.* at 54:12-15, and has no input into the testing that is given the recruits. *Id.* at 53:20-23.

51. The training provided by Kosinski is that an interpreter should be provided for optimum effective communication with people who are deaf. *Id.* at 50:22-25. She testified that a sign language interpreter should be brought in when obtaining medical information or assessing a person's risk of suicide. *Id*. at 61:3-18.

52. After the training at the Academy, there is no other training by the Denver Sheriff's Department to its deputies regarding sign language, deaf culture, or deaf community issues. Ex. 11, Than Dep. 16:11-14, 17:24 – 18:21; Ex. 2, Kosinski Dep. 21:7-9. Kosinski

believes the city should be conducting ongoing quarterly refresher training on dealing with deaf individuals. *Id.* at 51:21 – 52:9, 54:6-11.

53. Than was also the Rule 30(b)(6) designee with respect to the sign language training provided to Department of Safety employees and admitted that none of the deputy sheriffs are trained in American Sign Language by the DSD, there are no certified ASL deputies at the DSD, there are no lists of DSD deputies that know ASL, and the DSD does not rely on its deputies to perform ASL services to inmates or detainees who are deaf. Ex. 11, Than Dep. 17:7-21.

54. Than does not know what the deputies were trained to do if an inmate was deaf and not having much interaction with deputies. Ex. 11, Than Dep. 37:14-17.

55. Than did not know what training the deputies had as of 2005 regarding which accommodations were available at the Denver County jail to ensure that the deputies had effective communication with deaf inmates, *id*. at 39:7-12, 39:22 – 40:2, and was not aware of any such training that occurred at the Training Academy. *Id*. at 40:12-15.

56. Than did not know whether the deputies were trained prior to October 2005 that they could not rely on written communication when trying to obtain medical information from a deaf inmate. *Id*. at 60: 9-15.

57. Than did not know whether the deputies would have been trained that they could not expect deaf inmates to be able to understand documents such as inmate handbooks, medical forms and legal forms, *id*. at 60:16-21, and did not know whether the deputies were trained prior to October 2005 that they could not rely on written communication when trying to obtain medical information from a deaf inmate. *Id*. at 60:9-15.

58. Than did not know if deputies have ever received training regarding where a deaf inmate's preferred means of communication should be recorded. *Id*. at 60:22 – 61:4.

59. Than was unaware of any training the DSD deputies had with respect to providing sign language interpreters to deaf inmates prior to October 2005. *Id*. at 58:5-9. Although he testified that there were "procedures" in place at the PADF, he could not state when the procedures were implemented. *Id*. at 58:18-23, 59:4-6. Than admitted that he did not know what training the deputies had as of 2005 regarding which accommodations were available at the PADF to ensure that the deputies had effective communication with deaf inmates. *Id*. at 39:7-12, 39:22 – 40:2.

60. Sergeant John Romero, the Rule 30(b)(6) designee regarding the provision of disability related accommodations to the individual Plaintiffs, has never had any training on the English proficiency of individuals who have been deaf since birth or early childhood, Ex. 5, Romero Dep. 90:14-17, and he has never received training on whether deaf individuals who primarily communicate through American Sign Language should be expected to read and understand forms such as the classification intake form that was used at the DCJ. *Id*. at 90:23 – 91:5; and Defs.' Ex. A-12, Denver County Jail Classification Intake Questionnaire, Deposition Ex. 25 (Bates No. P000646).

61. Although the American with Disabilities Act was effective in 1990, Romero believed that the Americans with Disabilities Act became law around 2004. The deputies were given a briefing on a disk which provided that inmates with disabilities had a right to go to populated areas. This information did not change how deputies performed their jobs in working with deaf inmates but meant only that they paid more attention to them to see if they would have any issues out in the general population. Ex. 5, Romero Dep. 31:18 – 33:8.

2. Training of Deputies Charged with Mr. Vigil's Care

62. Two DSD deputies, Deputy Robert Pablo and Deputy David Pacheco, were routinely assigned to Mr. Vigil's living unit and were the two deputies assigned to Mr. Vigil's living unit in the special management unit on the morning that he committed suicide, September 27, 2005. Ex. 8, Pablo Dep. 53:4-9; Ex. 10, Pacheco Dep. 74:25 – 75:3.

a. *Deputy Sheriff Pablo*

63. Pablo started working at the Denver County jail in March 1994. Ex. 8, Pablo Dep. 11:24 – 12:1. He went to the training academy in March 1994 for 11 weeks, *id*. at 12:15 – 13:5. DSD failed to produce any records regarding the training he received.

64. The only training Pablo received regarding dealing with deaf inmates was when he went to the training academy in 1994. Ex. 8, Pablo Dep. 9:4 – 10:14; 98:13 – 99:2. He received no training on the general topic of the American with Disabilities Act. The only training that he remembers from the Academy was that he was given handouts with hand signs and that the instructor said that "the best tool is pen or pencil and paper." *Id*. at 10:16 – 11:4.

65. Pablo could not recall whether he had ever received training regarding the availability of sign language interpreters at the DCJ in 2005, Ex. 8, Pablo Dep. 106:14 – 107:11, and did not know if there was any documentation regarding what he should do if he received a request for a sign language interpreter. *Id*. at 106:4-7.

b. *Deputy Sheriff Pacheco*

66. Deputy Pacheco graduated from the Training Academy in April 2001, and started working at the DCJ the same month. Ex. 10, Pacheco Dep. 6:22 – 7:6.

67. The only training Pacheco ever received on how to communicate effectively with the deaf/hearing impaired was a class at the Academy in 2000 where he was taught to

communicate with pen and paper and to let deaf inmates use the TTY machine. Ex. 10, Pacheco Dep. 48:25 – 49:15.

68. As of 2005, Pacheco had not had any training on any policies at the DCJ on dealing with people who are deaf or hearing impaired. Ex. 10, Pacheco Dep. 53:12-16.

c. *Deputy Sheriff Coleman*

69. Deputy Coleman, the classification officer who performed the intake classification on Mr. Vigil, graduated from the training academy in July 1998, Ex. 4, Coleman Dep. 7:22 – 8:2, and could not recall any training he had received on how to deal or communicate with deaf inmates. *Id*. at 50:12-16.

C. Policies Regarding Accommodations for Deaf Inmates

70. Approximately three percent of the population is deaf or hard of hearing, according to National Center for Health Statistics. Ex. 23, Dr. Jean Andrews Decl. at ¶ 4.

1. PADF

71. Deeds was the Rule 30(b)(6) designee on the provision of sign language interpreters to inmates at the PADF, and on the policies and procedures relating to suicide prevention, inmates with disabilities and sign language interpreters. Ex. 33.

72. At the PADF, the only policy regarding communicating with deaf inmates was that a deputy could call an interpreter, that a deputy could communicate by writing to the deaf inmate, or that one of the deputies who knew sign language could be called. Ex. 7, Deeds Dep. 22:9-21. Deeds admitted, however, that no sign language interpreter had ever been provided to assist with communication with a detainee at the PADF. *Id*. at 14:22-25. In addition, although Deeds testified that Captain Than would have the list of DSD deputies who could perform sign

language to communicate with an inmate, *id*. at 19:16 – 20:7, Than testified that there were no such deputies. See, ¶ 53, infra.

73. There was no policy at the PADF regarding how deaf inmates would be informed of the availability of accommodations for effective communication at the PADF, *id*. at 28:2-13, and Deeds did not know if Mr. Vigil was ever offered or provided a sign language interpreter or any other accommodation at the PADF. Ex. 7, Deeds Dep. 28:17-23.

74. Deeds did not know if any accommodations were ever offered to Roger Krebs or Sarah Burke at the PADF. Ex. 7, Deeds Dep. 28:24 – 25:15.

75. There is no documented policy about how the PADF arranges an interpreter for a court hearing for a deaf detainee. The practice would be that if a deaf detainee needed an interpreter for a court appearance, it would be arranged at the PADF booking desk and the control center would be notified. *Id*. at 65:21-25; 66:3-10.

2. DCJ

76. There was no policy in effect at the DCJ regarding communicating with deaf inmates in 2005. Ex. 7, Deeds Dep. 21:23 – 22:3.

77. In 2005, the only accommodation available at the county jail to ensure effective communication with deaf inmates was an on-call interpreter, Lorrie Kosinski, if needed for effective communication with a deaf inmate. Ex. 5, Romero Dep. 22:18 – 23:7. However, at that time, there was no written policy in existence anywhere that explained Ms. Kosinski's availability. *Id*. at 26:16-19.

78. The Inmate Handbook in effect in August 2005 did not provide any information regarding available accommodations to inmates with disabilities and did not mention the availability of TTY phones. Ex. 35.

a. *Deputy Pablo*

79. There are no policies at the Denver County jail with regard to communicating with deaf or hearing impaired inmates, Ex. 8, Pablo Dep. 97:23 – 98:3, and he does not know what type of accommodations the jail provided to individuals with hearing impairments. *Id*. at 98:9-12.

80. Pablo has never been aware of any policies at DCJ that mandated when an interpreter needed to be brought in to assist a deaf or hearing impaired person, Ex. 8, Pablo Dep. 107:20 – 108:1, and was unaware of a sign language interpreter ever being brought in for deaf inmates. *Id*. at. 108:2-10.

81. Pablo did not know of any policy in 2005 that required jail personnel to keep notes regarding their communication with the deaf or hearing impaired inmates, or any notes that were passed between the deputies and deaf inmates. Ex. 8, Pablo Dep. 111:10-14; 112:5-11.

82. Pablo was unaware of any policy regarding how often deaf inmates should be seen by the medical staff. Ex. 8, Pablo Dep. 112:12-19.

83. It was only a couple of years ago (from 2009) that DSD put in a closed-captioning television outside of the officers' cage but it is not visible to the inmates when they are in their cells. Ex. 8, Pablo Dep. 109:7-25. He does not know how the inmates would be aware of the availability of the closed-captioned television. *Id*. at 111:1-4.

84. There are twelve (12) telephones available for use by inmates in Cellhouse 6 and the phones were available to the inmate a majority of the day. Ex. 8, Pablo Dep. 30:17-25; 31:12-16. The inmates in general population did not have to ask permission to use the phones. *Id*. at 31:21 – 32:13.

85. The primary means that inmates are informed about the policies and procedures of the jail is through the inmate handbook or through verbal discussions with the deputies. Ex. 8, Pablo Dep. 95:17-22.

86. The only way an inmate would know about the availability of KITES is from the inmate handbook or if the deputies would verbally inform them. Ex. 8, Pablo Dep. 89:16-24; 91:8-19.

87. The handbook reflected in Ex. 35 was in effect in August and September 2005. Ex. 8, Pablo Dep. 96:19-21.

b. *Deputy Pacheco*

88. During Pacheco's first four years of employment at DCJ, he dealt with between five (5) and twenty (20) deaf inmates, Ex. 10, Pacheco Dep. 54:2-12, and he did not bring in a sign language interpreter to communicate with any of those deaf inmates. *Id*. at 54:16-19. He never communicated with some of these inmates because they could not communicate with pen or paper or "they just didn't try to get any attention for any reason." Id. at 55:7-10.

89. Pacheco was not aware of any policies regarding communicating with deaf or hearing impaired inmates at the DCJ. Ex. 10, Pacheco Dep. 48:8-12. He didn't know how deaf inmates were informed of the availability of the TTY machine, *id*. at 50:24 – 52:1, and, if an inmate didn't know that a TTY machine was available, Pacheco admitted that the inmate might not ask to use it. *Id*. at 51:23 – 52:1.

90. Pacheco has never known of any policies or procedures for obtaining a sign language interpreter, *id*. at 56:13-19, or any DSD policy that requires an interpreter to be brought in to communicate with a deaf inmate. *Id*. at 56:20 – 57:5.

91. Pacheco has never been aware of any policies or practices at the DCJ that required the deputies to keep notes regarding their communications with deaf inmates, *id*. at 59:10-20, or that required documenting the preferred means of communication of the deaf inmates *Id*. at 52:20 – 53:11. Pacheco did not know where he would look to see the inmate's preferred means of communication. *Id*. at 52:20 – 53:2.

92. Pacheco did not know if there was any policy in effect in 2005 regarding whether deaf inmates should be housed in a cell alone. *Id*. at 60:8-11.

93. Romero did not know of any policy in 2005 requiring the deputies at DCJ to obtain a sign language interpreter to assist with the intake of deaf inmates. Ex. 5, Romero Dep. 63:15-20.

D. Accommodations Provided to Shawn Vigil, Sarah Burks and Roger Krebs

94. Romero was the Rule 30(b)(6) designee regarding what accommodations were provided to Shawn Vigil, Sarah Burke and Roger Krebs. Ex. 33. Romero could not identify any accommodations that were provided to any of these Plaintiffs at either the PADF or DCJ. Ex. 5, Romero Dep. 170:3-13; 170:16-20; 171:1-5; and 174:23 – 175:1.

95. There was no evidence that a sign language interpreter had ever been brought in to assist the medical staff at Denver County Jail to ensure effective communication with deaf inmates. Ex. 5, Romero Dep. 63:8-13. Deputy Pacheco confirmed that a sign language interpreter was never called in to assist Mr. Vigil to communicate with the nurses. Ex. 10, Pacheco Dep. 74:21-24.

E. Suicide Prevention Training and Policies

96. Kosinski was a Rule 30(b)(6) designee for the policies related to suicide prevention. Ex. 33, Fed.R.Civ.P. 30(b)(6) Designation. The training material provided by Ms.

Kosinki in her affidavit, [Doc# 197-6, Exhibit A-4 (Part 1), Exhibit 1], show that she did not provide any training related to suicide prevention and the deaf inmate.

97. Than was also a Rule 30(b)(6) designee for the provision of training on suicide prevention at the DCJ. *Id*.

98. Than did not know whether the Denver Sheriff Department had a suicide prevention and intervention program in effect in 2005, Ex. 11, Than Dep. 43:2-11, could not identify any written suicide prevention and intervention program in effect in 2005, *id*. at 42:20-23, and he could not provide any information about any such program. *Id*. at 43:2-8.

99. The deputies that worked in the special management unit did not receive any special training regarding suicide prevention. Ex. 11, Than Dep. 31:22-25; Ex. 6, Foos Dep. 39:23-25; Ex. 10, Pacheco Dep. 17:6-11; Ex. 8, Pablo Dep. 65:6-23.

100. The inmates that are in special management are often assigned to administrative segregation or protective custody, Ex. 11, Than Dep. 28:19-22, and being placed in administrative segregation can affect an individual's mental status and make a person feel more isolated or more secluded. *Id*. at 31:15-21. Mr. Vigil was assigned to administrative segregation and housed by himself in cell 17B on the A tier of the special management unit during the last week of his incarceration. Ex. 8, Pablo Dep. 119:24 – 120:4, 136:18-23; and Ex. 28.

101. Prior to October 2005, the deputies did not receive any specific training regarding the prevention of suicide with respect to deaf inmates, nor did they receive any training regarding what warning signs a deaf inmate may exhibit if the inmate was suicidal. Ex. 11, Than Dep. 41:2-9.

102. Deputies did not receive training that housing a deaf inmate in administrative segregation may increase the inmate's feelings of isolation, Ex. 11, Than Dep. 42:15-19, whether

deaf inmates should be housed alone, *id*. at 41:14-18, or whether deaf inmates should be placed in cells where the inmate was visible to the officers in the cage. *Id*. at 41:24 – 42:3.

103. The DSD deputies did not receive training that they should make extra efforts to communicate or interact with deaf inmates to prevent the risk of suicide, Ex. 11, Than Dep. 42:4-8, or whether deaf inmates may have a harder time forming relationships if their cell assignments were frequently changed. *Id*. at 42:9-14.

104. Although deputies were trained that if an inmate is feeling isolated or secluded, it can increase the risk of suicide by the inmate, Ex. 11, Than Dep. 27:3-6, there has never been any special training to the deputies that suicide is more likely to occur in the special management area. *Id*. at 28:2-6. Defense expert, Michael Haley, stated that the deputies should have been trained on the fact that housing an inmate in a single-cell unit in a special housing unit could increase the risk of suicide but was not aware of any such training given to DSD deputies. Ex. 26, Haley Dep. 280:8 – 281:3. Deputy Pacheco did not know whether housing a deaf inmate in a cell by themselves could increase a feeling of isolation and did not know if an increased feeling of isolation could increase the danger of suicide. Ex. 10, Pacheco Dep. 73:1-14.

105. Although it would be harder for inmates in the jail to form friendships if their cell assignments were changed frequently, Ex. 10, Pacheco Dep. 44:16 – 45:2, Shawn Vigil's housing assignment at the DCJ was changed 6 times during the one month period of his stay, resulting in him being placed alone in a cell that was next to the last cell farthest away from the officer's cage on Tier A of Building 6. Ex. 28. Chief Foos testified most suicides in jail occur by hangings and that as a part of the safety and security at DCJ, the jail would "take every step possible to remove or eliminate know and obvious places where an inmate might hang themselves." Ex. 6, Foos Dep. 127:16-24.

106. In 2005, Chief Ronald Foos was the division Chief at the Denver County Jail and was responsible for facility operations, the safety and security of the inmates and the jail staff, and the overall physical management of the DCJ in 2005. Ex. 6, Foos Dep. 30:18 – 31:2.

107. Chief Foos testified that deputies that worked in the special management unit should know what factors in the jail environment increased the risk of inmate suicide, such as increasing the isolation of an inmate, Ex. 6, Foos Dep. 88:4 – 89:2, officer insensitivity, *id*. at 89:3-7, feeling dehumanized by their incarceration, *id*. at 89:16-20, and a very authoritarian environment or feeling of loss of control by an inmate. *Id*. at 87:18-24.

108. The only formal training that Deputy Pacheco ever received regarding suicide prevention was at the academy, Ex. 10, Pacheco Dep. 60:20 – 61:5, and he did not know what factors in the jail environment have an impact on suicide risk, *id*. at 62:3-6, did not know whether the risk of suicide was higher if an inmate felt isolated or was in seclusion in the jail, *id*. at 61:25 – 62:2; and 73:1-14, and did not know whether feeling dehumanized by incarceration, officer insensitivity, or rejecting attitudes by jail staff could increase the risk of inmate suicide. *Id*. at 62:7-10, 14-22.

109. Than could not verify whether the deputies were trained that it could increase the risk of suicide if an inmate was feeling dehumanized or experiencing a very authoritarian environment or a loss of control. Ex. 11, Than Dep. 33:5-9, 24-25 – 34:4.

110. Foos also testified that the deputies should have known the high-risk periods for inmate suicide included "the time immediately after booking, after receiving bad news, court, or after suffering some type of humiliation or rejection" as stated on the DSD Post Order regarding Suicide Prevention. [Doc # 197-8, Exhibit A-5, Exhibit 6, p. 31]. Ex. 6, Foos Dep. 84:9-13; 89:3-25.

111. Pacheco, however, did not know the high risk period for inmate suicides, Ex. 10, Pacheco Dep. 61:23 – 62:2, whether there was a higher risk that someone will commit suicide if they are incarcerated, *id*. at 61:6-9, or whether receiving bad news would be a high risk period for an inmate suicide. *Id*. at 63:9-12. He did not believe that rejection by the jail staff or feeling humiliated by jail staff or deputies could trigger a suicide risk. Ex. 8, Pablo Dep. 116:3-5, 13-16.

112. Although Than stated that deputies were trained that if an inmate learned that they were facing a substantial jail or prison time, that the information could increase the risk of suicide, Ex. 11, Than Dep. 33:10-14, he did not know whether the classification deputies were trained that if an inmate returned from court and had learned that they would be facing a significant jail time, that they were required to report the inmate to the medical staff. *Id*. at 33:15-20. Pacheco did not know whether an inmate finding out that he could be facing significant jail time would create a high-risk period for suicide. Ex. 10, Pacheco Dep. 63:3-8.

113. Than further expected the deputies in the special management building to know that the warning signs for a suicide risk included if there was an unusual behavior, such as changes in eating or sleeping patterns, or if an inmate was being withdrawn, not communicating, not relating or interacting with others, Ex. 11, Than Dep. 93:21 – 94:13, and that if an inmate was not interacting or communicating with deputies, that could be a sign that the inmate was depressed. *Id*. at 34:5-8.

114. Pacheco, however, did not know whether a change in eating or sleeping patterns could be a warning sign for suicide; didn't know whether a person had difficulty dealing with or relating to others that it could be a warning sign for suicide, and did not know if a person being very withdrawn could be a warning sign for suicide. Ex. 10, Pacheco Dep. 64:13-23.

115. Although Chief Foos testified that the deputies in the special management unit should have known that suicides can be prevented if officers are caring and that many inmates just need someone to talk to in order to alleviate the risk of suicide, as stated in Defendants' Exhibit to Summary Judgment, Exhibit 6 to Defs.' Ex. A-5 [Doc 197-8]. Ex. 6, Foos Dep. 94:18-21, 95:5-9; Deputy Pacheco, however, did not agree that suicides could sometimes be prevented if officers were caring and did not know whether suicides could be prevented if inmates had someone to talk to. Ex. 10, Pacheco Dep. 64:24 – 65:1.

F. Suicide Warning Indicators with Shawn Vigil

116. Than testified that the deputies were trained that communication with the inmates is an important line of defense to preventing the risk of suicide. Ex. 11, Than Dep. 22:7-10.

117. However, Pacheco admitted that he could not assess Mr. Vigil's risk of suicide because of the lack of communication with him. Ex. 10, Pacheco Dep. P. 74. Ll. 8-11.

118. Neither Deputies Pacheco or Pablo had any communication with Shawn Vigil or even recall making any attempt to communicate or interact with him. Ex. 10, Pacheco Dep. 69:12-15 and 70:18-20; Ex. 8, Pablo Dep. 127:5-13. According to Deputy Sheriff Pacheco's interview with the IAB, Mr. Vigil "didn't communicate very well" because he was deaf. Ex. 20, 10/10/05 Pacheco interview at 25:6-9. Pacheco further testified that Mr. Vigil never gave any notes to the deputies:

> And he didn't – he happened to talk to use very much, never gave us a note – notes, because a lot of deaf guys will give you notes, you know, just that they want to, you know, go to the library where they want to make a phone call on the TDD where everything is called. He never – he never really gave us a note or anything. He never asked us any questions or anything like that.

Id. at 11-18.

When interviewed by the IAB, Deputy Sheriff Pablo testified that he "did not understand" how another inmate, Inmate Wilson, could communicate with Mr. Vigil "because he is deaf." Ex. 20, IAB interview of Deputy Sheriff Pablo at 15:11-23.

119. Neither Deputy Pacheco or Pablo could recall any other jail personnel at DCJ ever having any contact or communication with Mr. Vigil. Ex. 10, Pacheco Dep. 71:1-2; Ex. 8, Pablo Dep. 133:24 – 134:1.

120. Pacheco had no understanding as to Mr. Vigil's mental health status, Ex. 10, Pacheco Dep. 70:18-23, and did not know if Mr. Vigil was depressed during his stay at DCJ. *Id*. at 71:3-5. The only way that Pacheco would have known if Mr. Vigil was depressed or feeling isolated was if Mr. Vigil had asked to see the psych nurse or another inmate had told him that Vigil seemed a bit lonely or wasn't coming out of his cell. *Id*. at 71:6-13.

121. Similarly, Pablo had no idea what Mr. Vigil's mental status was during his stay at DCJ. Ex. 8, Pablo Dep. 127:14-18. Although Pablo testified that the events that can trigger suicidal thoughts could be the type of charge and sentence that an inmate was facing, their sentencing, no contact from outside people that they've tried to contact, thoughts about the amount of time that they could serve, *id*. at 115:15-20, or spending birthdays alone in the jail, *id.* at 118:21– 119:1, he did not know the type of charge or sentence faced by Mr. Vigil, that Mr. Vigil did not have any visitors while he was at DCJ, *id.* at 133:19-21, did not know whether Mr. Vigil felt isolated or depressed while at DCJ, or even if Mr. Vigil had ever come out of his cell, *id*. at 127:22 – 128:2, 131:6-8, and did not know that Mr. Vigil had a birthday during the time he was incarcerated at the DCJ. *Id*. at 133:15-18.

122. A document found in Mr. Vigil's cell demonstrated that he was spending time calculating the potential length of his jail sentence. Ex. 36. He also drew a picture of a man standing in front of a brick wall, crying. Ex. 37.

123. Although Pablo agreed it was important for the deputies in the special management unit to know those inmates and any special needs they had, Ex. 8, Pablo Dep. 91:22, 25 – 92:11, he testified that the deputies are not told the mental health needs of an inmate, *id*. at 24:4-8, and did not have access to their mental health needs or medical records. *id*. at 26:13-15. There was no place that a deputy could go to determine what mental health issues an inmate had in order to accommodate them. *Id*. at 26:1-23.

124. Although Pablo agreed that changes in eating and sleeping patterns could be a sign of suicide risk, Ex. 8, Pablo Dep. 114:19 – 115:6, there was no policy in 2005 to document whether an inmate had stopped eating meals. *Id*. at 128:3-22. He did not recall whether there was any change in Mr. Vigil's sleeping pattern or whether he ate his food. *Id*. at 128:3-11, 134:2-6. Another inmate, R.D. Coyle, stated that Mr. Vigil had not eaten his breakfast on the morning of the suicide. Ex. 20, Interview of R.D. Coyle at 2:21-24.

125. Neither Deputies Pacheco or Pablo knew what type of charges Mr. Vigil faced or the potential length of sentence length if convicted, Ex. 10, Pacheco Dep. 72:9-15; Ex. 8, Pablo Dep. 132:18-20. Once informed of the nature of the charges, Pablo agreed that the charges Mr. Vigil faced carried substantial jail time. *Id*. at 132:25 – 133:3. It was not the policy in Building 6 for the deputies to be aware of the criminal charges of the inmates. *Id*. at 133:4-14.

126. Pacheco never looked to see what accommodations Mr. Vigil needed, Ex. 10, Pacheco Dep. 71:17-19, he did not know whether Mr. Vigil had a pencil or paper in his cell, *id*.

at 72:1-3, and does not know if anyone else ever provided Mr. Vigil with any accommodations at DCJ. *Id*. at 72:4-8.

127. If Mr. Vigil had wanted to see a psych nurse, Pacheco stated that Vigil would have had to have written a KITE, or a note to him, but he did not know how a person who was not literate in the English language would have communicated that he needed to see a psych nurse. Ex. 10, Pacheco Dep. 73:25 – 74:7.

128. The only accommodation Deputy Pablo provided to Mr. Vigil was that he was "accessible" to Mr. Vigil by being on the tier and making his rounds. Ex. 8, Pablo Dep. 131:24 – 132:8.

129. Pablo did not know if anyone else provided Mr. Vigil with any accommodations at DCJ. Ex. 8, Pablo Dep. 132:14-17.

130. Sign language interpreters were never brought in to assist Mr. Vigil to communicate with medical personnel. Ex. 10, Pacheco Dep. 74:21-24; Ex. 5, Romero Dep. 63:8-14. When the nurses made their rounds in the living units, they did not stop to talk to the inmates who were not receiving medication, they just looked in to see if the inmate was breathing. Ex. 8, Pablo Dep. 139:25 – 140:15.

131. Pablo did not know Vigil's preferred means of communication and has never been aware of any policy in effect at DCJ with respect to documenting a deaf person's preferred means of communication. Ex. 8, Pablo Dep. 126:1 – 127:4.

G. Logbook Documentation and Suicide Prevention

132. Chief Foos expected the deputies in the special management unit to know that "Suicide is the number one cause of deaths in jails; therefore making rounds and logging rounds

are essential." Ex. 6, Foos Dep. 84:9-13; Exhibit 6 to Exhibit A-5 of Defendants' Motion for Summary Judgment, [Doc. 197-8].

133. The logbook is a legal document and it was the deputy's responsibility to ensure that the information in the logbook is an accurate record of events and the time they occur. Ex. 8, Pablo Dep. 64:5-21.

134. Rounds were required to be made every one half hour, Ex. 10, Pacheco Dep. 25:12-15, but there was no policy on *who* was required to document the rounds in the logbook. *Id*. at 27:11-22.

135. Usually when an officer went to do rounds, the other officer would mark it in the logbook that he started to do rounds. Ex. 10, Pacheco Dep. 26:13-15.

136. Another inmate found Mr. Vigil hanging in his jail cell at either 9:03 or 9:05 on the morning of September 27, 2005. Ex.38, Deputy Pacheco DPD Statement dated 9/27/05 (Ulibarri 000174); Ex. 39, Deputy Pablo DSD Statement dated 9/27/05 (Ulibarri 000019).

137. Foos agreed that if there was a pattern during a certain period of the day when deputies were not performing rounds, it could increase the risk of inmate suicide, and the deputies working in the special management unit should have known that. Ex. 6, Foos Dep. 91:5-14.

138. Deputy Pacheco, however, was unaware of this fact. Ex. 10, Pacheco Dep. 63:13-16.

139. The notation "all okay" in the logbook does not verify a round was made at the time indicated. It is impossible to determine what that notation means: it could mean simply that the whole tier was okay; it does not mean that a round was performed. Ex. 10, Pacheco Dep.

80:1-13. In addition, the fact that a count was made in the cell house does not mean that a round was conducted at the same time. *Id*. at 92:1-4.

140. If the logbook did not specifically indicate that a round was made, there was no way to verify at a later date whether a round had actually occurred. Ex. 10, Pacheco Dep. 116:18-25.

141. The logbook for the duration of Shawn Vigil's stay at DCJ is Ex. 40.

142. Even assuming *arguendo* that an "all okay" notation did indicate that a round had been conducted, there is no evidence that rounds were conducted on the following dates and times:

a. On August 27, 2005, no rounds between 8:00 a.m. and 11:30 a.m. Ex. 40 at Bates Nos. U001017-001018.

b. On August 28, 2005, no rounds between 8:00 a.m. and 12:30 p.m. *Id*. at Bates Nos. U001020-001021.

c. On September 1, 2005, no rounds between 7:05 a.m. and 9:00 a.m. *Id*. at Bates Nos. U001034.

d. On September 2, 2005, no rounds between 8:00 a.m. and 9:30 a.m. *Id*. at Bates Nos. U001038.

e. September 4, 2005, no rounds between 7:00 a.m. and 10:00 a.m. *Id*. at Bates Nos. U001043-001044

f. On September 5, 2005, no rounds between 7:00 a.m. and 11:30 a.m. *Id*. at 10, Pacheco Dep. 93:8-10, 94:15-24.

g. On September 6, 2005, no rounds between 8:30 a.m. and 10:00 a.m. *Id*. at 95:1 – 96:1.

h. On September 8, 2005, no rounds conducted between 8:00 a.m. and 10:30 a.m. *Id*. at 96:1-22.

i. On September 9, 2005, no rounds conducted between 7:30 a.m. and 2:00 p.m. *Id*. at 98:1-4.

j. September 10, 2005, no rounds between 8:30 a.m. and 10:00 a.m. *Id*. at 98:5 – 99:14.

k. September 12, 2005, no rounds between 7:00 a.m. and 10:00 a.m. *Id*. at 99:15 – 100:17.

l. September 14, 2005, no rounds between 8:00 a.m. and 10:00 a.m. *Id*. at 100:18 – 101:13.

m. September 15, 2005, no rounds between 8:00 a.m. and 11:00 a.m. *Id*. at 101:14 – 102:7.

n. September 16, 2005, no rounds between 7:30 a.m. and 9:15 a.m. *Id*. at 103:7-21.

o. September 17, 2005, no rounds from 6:20 a.m. until 2:40 p.m. *Id*. at 103:25, 104:21-23.

p. September 18, 2005, no rounds between 7:00 a.m. and 9:00 a.m. *Id*. at 104:25, 105:13-16.

q. September 19, 2005 no rounds between 7:00 a.m. and 10:00 a.m. *Id*. at 105:17 – 106:10.

r. September 20, 2005 no rounds between 6:00 a.m. and 9:00 am. *Id*. at 106:11-13, 107:7-9.

s. September 21, 2005, no rounds between 6:35 a.m. and 10:00 a.m. *Id*. at 107:14-24.

t. September 24, 2005, no rounds between 8:30 a.m. and 10:00 a.m. *Id*. at 108:1-17.

u. September 25, 2005, no rounds between 7:00 am and 3:00 p.m. *Id*. at 108:18 – 109:10.

v. September 26, 2005, no rounds between 7:00 a.m. and 11:30 a.m. *Id*. at 109:11 – 110:9.

w. September 27, 2005 no rounds after 7:30 a.m. *Id*. at 110:10 – 111:1.

143. Chief Foos agreed that rounds were not documented in the logbook during the term of Mr. Vigil's incarceration and that he had no basis for a belief that the rounds were conducted as required. Ex. 6, Foos Dep. 163:20-23; 164:11-14.

H. Defense Expert on Training Lacks Credibility

144. Defendant's expert, Michael Haley, who opined that the deputy sheriffs were adequately trained regarding suicide prevention, is the Warden of the Mobile County Jail which has been the subject of a formal complaint by the Department of Justice for the failure to properly train deputies on suicide prevention. Ex. 41. Specifically, the United States Department of Justice, Civil Rights Division, has found that conditions at Mr. Haley's jail violate the constitutional rights of inmates and that the jail engages in a pattern and practice of subjecting inmates to egregious or flagrant conditions, including in regard to the medical care of inmates and the mental health care of inmates, *inter alia*. *Id*. at 2-3. The report specifically states that Mr. Haley's jail:

a. Has failed to provide adequate assessment, monitoring and housing of suicidal inmates, *Id*. at 23, and has a very serious suicide prevention problem and has a suicide rate twice the national average for a jail of its size, *Id*. at 24;

b. Does not assess properly the severity of an inmate's suicide risk; *Id*. at 24;

c. Improperly monitors suicidal inmates, *Id*.;

d. The nursing assessment was inadequate as it consisted of nothing more than recording the inmates basic vital signs, *Id*.;

e. The mental health services were grossly inadequate to meet the serious mental health needs of inmates, *Id*. at 17;

f. The Department specifically identified problems and deficiencies in intake screening; access to mental health care; assessment, management and treatment of mental illnesses; and suicide prevention, *Id*. at 17; and

g. That the intake process failed to identify and respond to inmates' serious mental health needs, p. 18, noting that the intake forms were often incomplete, completely blank, lacking pertinent information , or contained no information about the inmates' mental health status. *Id*. at 18.

145. The report found that the failure of the jail's mental health services were caused in part by its lack of adequate policies and procedures, as well as its failure to implement policies and procedures that were adequate. *Id.* at 25.

146. The report also details that the jail staff did not supervise inmates adequately, *id*. at 33, and that the deficiencies stemmed in large part from a lack of adequate policies, procedures, training and staffing, *id*. at 34. The report detailed that the jail staff did not receive

adequate training, pointing out the limited pre-service and in-service training received by the officers. *Id.* at 35.

147. Mr. Haley himself has been held in contempt of court on three different occasions for failing to follow court orders regarding the conditions of confinement of inmates when he was the Commissioner of the State of Alabama Department of Corrections, including one case that involved the failure to appropriately accommodate and provide medical treatment to inmates with disabilities. Ex. 26, Haley Dep. 211:8 – 213:18, 277:6-23.

148. Plaintiffs' expert on conditions of confinement, Dr. Mark Pogrebin, opined that the Denver Sheriff Department deputies were not adequately trained regarding suicide prevention, the need to provide accommodations to deaf inmates, and that the actions of the DSD in its treatment of Mr. Vigil increased the danger that he would commit suicide. Specifically, Dr. Progrebin opined that the DCJ did not comply with the American Correctional Association (ACA) standards, or the jail's own standards, with respect to the booking process, the intake process and classification of Mr. Vigil, and physically and emotionally isolated him at the DCJ. Ex. 41b, Expert Reports of Dr. Pogrebin at 1-4. He stated that the jail's lack of policy for special need for deaf inmates to provide basic mental health care, frequent interactions with officers and nurses, and the lack of accommodations increased the danger that he would commit suicide. *Id*. at 4. He opined that the small amount of time provided to the deputies at the training academy regarding the prevention of suicide and the lack of in-service training on suicide prevention resulted in inadequate training of the deputies on this issue. He further opined that the lack of this training coupled with the lack of training on how to communicate with deaf inmates led directly to Mr. Vigil's suicide. *Id*. at 5-6. He concluded the DSD and its jail administrators, by that failure to implement the appropriate policies and procedures, and the failure to provide

adequate training, acted with deliberate indifference to the serious medical and mental health needs of Mr. Vigil. *Id*. at 6. In his supplemental report, Dr. Progrebin again opined that the training on the issues of suicidal inmates and deaf inmates was extremely inadequate, and had the officers been trained properly, it would have prevented the suicide of Mr. Vigil, Supplemental Report at 2. Dr. Progrebin also opined on the lack of knowledge by the jail administration concerning providing appropriate training and policies concerning suicide prevention and the treatment of deaf inmates. *Id*. at. 2-3.

I. Classification

149. Sergeant John Romero was the 30(b)(6) designee regarding the classification of inmates at the DCJ since August 2005. Ex. 33, Fed.R.Civ.P. 30(b)(6) Designation He has been responsible for supervising the deputies who perform the classification intake on inmates since 2004. Romero Affidavit, Defs.' Ex. A-5 ¶2, [Doc. # 197-8, p. 3].

150. There was no training for the classification officers in 2005 other than on-the-job training, Ex. 5, Romero Dep. 76:2-6, and there was no specific training regarding dealing with deaf inmates. *Id*. at 78:8-13. Deputy Coleman could not recall ever receiving any training on how to perform the intake process with deaf inmates. Ex. 4, Coleman Dep. Deposition at 48:16-19.

151. Deaf inmates would be given the X07A code and housed in the special management unit. Ex. 5, Romero Dep. 77:1-20. The only reason that Mr. Vigil was given this code and placed in the special management unit was because he was deaf. Ex. 4, Coleman Dep. 78:14-23.

152. The A, B, and C tiers in the special management unit contained inmates who were in protective custody, homosexual and mental, and administrative segregation. Ex. 10, Pacheco Dep. 8:10-13.

153. In 2005, after arriving at the jail, the inmate would first see the classification intake officer. Ex. 5, Romero Dep. 36:7-12.

154. There were no policies in 2005 requiring Denver Sheriff deputies at the county jail to obtain a sign language interpreter to assist with the intake of deaf inmates. Ex. 5, Romero Dep. 63:15-20. Other deaf people have been through intake in the DCJ, but a sign language interpreter had never been brought in to assist with their communication. *Id*. at 72:1-9.

155. The intake classification deputy, Deputy Coleman, knowing Mr. Vigil was deaf, simply gave the form to Mr. Vigil and expected him to read and complete it. Ex. 4, Coleman Dep. Deposition at 59:8-15; 62:20 – 63:8.

156. The Denver County jail Classification Intake Form for Mr. Vigil was filled out incompletely and inaccurately as shown on Ex.42. Specifically:

157. The answer to the question of whether Mr. Vigil had a disability was marked "No." *Id*.

158. The deputy failed to complete the section of the form entitled "Observation by Deputy" which required the deputy to indicate whether Mr. Vigil was "Injured Disabled Sick Withdrawn Hostile Depressed under the use of Alcohol/Drugs Aggressive Confused Suicidal" or N/A. *Id*.; Ex. 5, Romero Dep. 95:7-14; Ex. 42.

159. Although Mr. Vigil was born in Colorado, there was a "No" indicated where it was asked whether he was a U.S. citizen, Ex. 42.

160. The classification deputy failed to follow policy and complete the types of charges against Mr. Vigil as required in the "Custody Assessment" portion of the intake. *Id*.; Ex. 5, Romero Dep. 95:22 – 96:6.

161. The deputy failed to properly complete the questions regarding verification of Mr. Vigil's identity under the "Morpho System" questions. *Id*. at 100:6-24; Ex. 42.

162. The information obtained from the "observations by the deputy" portion of the intake form is important information. *Id*. at 94:2-10; Ex. 42.

163. The fact that Mr. Vigil indicated "No" to the question of whether he had a disability and "no" to the question "are you a U.S. citizen," when in fact the trip sheet showed he was born here in Colorado, could indicate that Mr. Vigil did not understand the question. *Id*. at 91:17 – 92:10; 96:11-18; Ex. 2, Kosinski Dep. 29:21 – 30:8.

164. When Romero initially reviewed the intake form completed by Deputy Coleman, he did not believe there were any problems with the way the form was filled out other than that the deputy's signature was not legible. Ex. 5, Romero Dep. 86:19 – 87:5

165. When an inmate gives an answer that was clearly wrong, the classification officer should have reviewed that question with the inmate to ensure it was answered correctly. *Id*. at 85:9-14.

166. Officer Coleman wrote the notation "deaf" on the form in response to whether Mr. Vigil had access to a phone but Romero was unaware of any steps Coleman took to provide Mr. Vigil with phone access. *Id*. at 98:3-7; 99:2-12; Ex. 42.

167. In 2005, the intake officer simply gave the inmate a copy of the inmate handbook, did not provide any sort of orientation to the inmate, and did not explain what accommodations

were available at the jail to deaf inmates. *Id*. at 101:2-12; Ex. 4, Coleman Dep. Deposition at 29:21 – 30:11; 52:9-14.

168. After the classification process was done, the inmate would then be taken to the medical for medical and mental health screening. Ex. 5, Romero Dep. 36:7-12.

J. Medical

169. Romero was also the Rule 30(b)(6) designee regarding the provision of medical services and mental health screening to inmates at the DCJ since August 2005. Ex. 33, Fed.R.Civ.P. 30(b)(6) Designation.

170. The medical personnel at the DCJ were expected to follow any relevant policies and procedures of the jail while working there. Ex. 5, Romero Dep. 19:18-22. However, the Denver Sheriff's Department never provided any formal training to the medical staff at the jail regarding its policies and procedures, *id*. at 20:23 – 21:3, never provided any training to the medical staff regarding how the ADA affects how they perform their jobs, *id*. at 31:8-13, never provided any training to the medical personnel regarding how to accommodate inmates who were deaf or what accommodations were available at the jail to allow medical staff to effectively communicate with deaf inmates, *id*. at 19:23 – 20:5; 22:11-17, never provided any training to the medical staff regarding how to identify inmates who posed a risk of suicide, and has ever had any requirement that the nurses who did the medical assessments have any such training. *Id*. at 19:3-22.

171. There was no policy in 2005 regarding how medical staff was to accommodate deaf inmates. *Id*. at 21:19-22.

172. There was no information provided by the Denver Sheriff's Department to the medical staff at the jail regarding the need to ensure effective communication with deaf inmates

during the medical or mental health screening in 2005, *Id*. at 21:4-10, and no policy that required the medical staff to obtain the services of a sign language interpreter when assessing a deaf inmate. *Id*. at 62:18-24.

173. There is no evidence that the sign language interpreter had ever been brought in to assist the medical staff at Denver County Jail to ensure effective communication with a deaf inmate. *Id*. at 63:8-13.

174. There are no policies or procedures at the Denver County Jail requiring medical staff or deputies to ask a deaf inmate about their preferred means of communication, *Id*. at 75:9-12, and no policy that required medical staff or the deputies to keep the written communication they had with deaf inmates. *Id*. at 75:3-8.

175. In 2005, the policy at the jail was that incoming inmates had a medical and mental health screening within two hours of their arrival. *Id*. at 29:10-16.

176. Medical and mental health information was an important part of classifying an inmate. *Id*. at 34:13-20. It would be a pretty serious problem if a health assessment was not completed. *Id*. at 53:10-12.

177. The Denver County Jail Health Assessment form for Mr. Vigil is blank, except for a temperature and blood pressure reading. Ex. 43. These are both items of information that can be obtained without requiring any communication with Mr. Vigil.

178. Although the mental health screening of inmates was vital to evaluation of whether the inmate posed a risk of suicide, Ex. 5, Romero Dep. 35:2-9, no mental health screening was performed on Mr. Vigil. *Id*. at 9:6-25; 61:3-15. Ex. 44.

179. It was the DSD deputies' responsibility to ensure that all inmates were seen by the medical personnel for medical and mental health screenings. The deputy that came to pick up

inmates would have been responsible to make sure the inmate's screenings had been done before taking the inmate to his housing unit. Ex. 5, Romero Dep. 39:18 – 40:3. The deputies, however, were not trained on how to ensure that the medical screening of the inmate actually occurred. Ex. 11, Than Dep. 47:8-11.

K. The Administrative Review Board (ARB)

180. The ARB consists of a panel of classification officers who reviewed inmate housing and classification and heard complaints or concerns from the inmates about their incarceration. The ARB was important to the safety and security of the inmates and the jail staff. Any inmate who asked to be seen by the Board was granted that privilege. Ex. 5, Romero Dep. 106:1-3; 108:1-22.

181. The ARB meets every week, with no exceptions for holiday weeks, Ex. 5, Romero Dep. 110:6-25, and would meet as often during the week as necessary in order to speak to all the inmates who had requested to meet with it. *Id*. at 111:17-20.

182. There is no written procedure as to which of the inmates gets to meet with the board first at the beginning of the week as opposed to the end of the week, Ex. 5, Romero Dep. 112:2-6, and there is no written procedure provided to the housing deputies regarding what procedures they must follow when bringing inmates in for an ARB meeting. *Id*. at 112:9-13.

183. The ARB documents show that Mr. Vigil requested to see the ARB three times during his stay at the Denver County Jail, for the weeks of August 28, September 18, and September 25, 2005. Ex. 45. ARB Documents at Bates Nos. U001316, 1326, 0689 and 0668. The ARB documents for the week of September 5, 2005 were not produced by the DSD in this case so it is unknown whether Mr. Vigil also requested to see the ARB that week.

184. Mr. Vigil was not seen by the ARB in the week of August 28, 2005. *Id*. at Bates No.U000687. Mr. Romero was not present at the ARB that week and did not know why Mr. Vigil was not seen by the ARB that week. Ex. 5, Romero Dep. 122:2 – 123:4.

185. For the week of September 18, 2005, the ARB documents show Mr. Vigil's name with the comment "Declined?" Ex. 45, ARB documents at Bates No. U001338, (this document was not produced as part of the IAB file). On other pages of the ARB documents, the notation "Declined" and "Declined?" as written with respect to other inmates on the ARB docket. *Id*. at Bates No. U000679.

186. The notation "Declined?" indicates that the inmate did not appear for the ARB meeting and that it was unknown whether the inmate had actually declined to meet with the Board. Ex. 5, Romero Dep. 131:7-17.

187. The ARB documents that were submitted to the IAB which was investigating the suicide of Mr. Vigil did not show that Mr. Vigil was listed to see the ARB that week. Ex. 45, ARB Documents at U000672-681. Those records did contain one document dated September 15, 2005 which indicates that Mr. Vigil did not meet with the Board because he was taken to DGH. Ex. 45, at Bates No. U001107; Ex. 6, Foos Dep. 141:1-7.

188. After the deposition of Chief Foos where he was unable to locate evidence that Mr. Vigil declined to meet with the Board during the week of September 18, Ex. 6, Foos Dep. 142:15 – 143:13, a second set of ARB documents were produced in this case that differed from those produced to the IAB. On that second set of documents, there was a new document dated September 18, 2005 with the notation "declined - ?" next to Mr. Vigil's name. Ex. 45, ARB Documents at Bates No. U001338. In this new set of documents, there was a handwritten

change to the document dated September 15, changing the date to September 25, 2005. *Id*. at Bates No. U001352.

189. As the Chairperson of the ARB, Romero testified that it would not be appropriate for anyone to have made changes to the ARB documents after the week of the ARB meeting, suggesting it would compromise the integrity of those documents. Ex. 5, Romero Dep. 115:8-10.

190. In any event, even if Mr. Vigil had been taken to meet with the ARB, there would not have been a sign language interpreter at that meeting. Ex. 12, Daniel Sauer Dep. 48:14-19.

L September 27, 2005

191. On September 27, 2005, Pablo and Pacheco were assigned to the ABC side of cellhouse 6 during the shift that started at 6:00 a.m. Ex. 8, Pablo Dep. 53:1-9.

192. On that day, Pablo was the "observation officer" at the 6:00 a.m. shift. 23, and was responsible for performing rounds but Deputy Pacheco also did rounds. Ex. 8, Pablo Dep. 56:20 – 57:9.

193. Two inmates verified that the deputies did not conduct rounds on the morning of September 27 after breakfast was served at 6:15 a.m. Ex.40 at Bates No. U001109; Ex. 20, Statement of Inmate R.D. Coyle at 4:17-23; Ex. 20, Statement of Inmate Wilson at 6:8-19, 7:12-22.

194. At either 9:03 a.m. or 9:05 a.m., inmate Wilson called out that Mr. Vigil was hanging in his cell. Ex. 10, Pacheco Dep. 76:12-17; Ex. 20, Pacheco Internal Affairs Statement.

195. At the time Inmate Wilson called out regarding Vigil, Pacheco and Pablo were at the cage. Ex. 10, Pacheco Dep. 76:18-21.

196. When deputies arrived at the cell, they saw Mr. Vigil hanging from a bed sheet tied to the vent bar above the toilet at the back of his cell. Ex.46; Ex. 20, Interview of Deputy Sheriff Pacheco on Oct. 10, 2005 at 23:23 – 24:2-7; and Ex. 31, Photos of Mr. Vigil's cell.

197. Mr. Vigil was warm to the touch when he was cut down and the medical staff was able to regain his blood pressure and pulse. He died on October 1, 2005. Ex. 47, Autopsy Report.

198. On October 1, 2005, Mr. Vigil's family removed him from life support. *Id*, at Bates Nos. 000182. The cause of death was complications from ligature hanging. *Id*. at Bates No. 000188.

199. The logbook does not indicate that a round was made after 7:30 that morning. Ex. 40, at Bates No. U001109-1110. Neither Pablo nor Pacheco informed Internal Affairs that they had conducted a round after 8:25 a.m. Statements to IAB by Pablo, Ex. 48, and Pacheo, Ex. 20. Pacheco Interview to IAB, respectively. Pacheco stated that the last time he saw Mr. Vigil was when he did a round at 8:25 a.m., *Id*. at. 6:15-18, which indicates that Pacheco did not perform another round between 8:25 and 9:03 or 9:05, when he was informed that Shawn Vigil was hanging in his cell.

M. Investigation Into Death And Supervision

200. Despite the statement in Chief Foos's report that a comprehensive review of classification was done as a result of Mr. Vigil's death, no such review actually occurred. Ex. 5, Romero Dep. 164:3-12.

201. After a suicide or attempted suicide, there is a departmental procedural review with the command staff, psych and medical staff, Ex. 5, Romero Dep. 199:17-24, but Romero was not aware of any such review following Mr. Vigil's suicide. Id. at 199:25 – 200:1.

202. After the Internal Affairs investigation, Romero did not sit down and look at all the documents and conduct his own investigation as to whether Mr. Vigil was properly classified. Ex. 5, Romero Dep. 200:13-17. Romero was not aware that an investigation was conducted by the Office of Independent Monitor into Mr. Vigil's suicide. He wasn't asked to conduct any follow-up by providing documents or any further information regarding the Office of Independent Monitor's investigation. *Id*. at 62:6-17.

203. There were three deaths within three months span in 2005 (August, September, October), and as a classification officer that concerned Romero, but he didn't know of any changes that were put into place. Ex. 5, Romero Dep. 201:2-24.

204. Romero did not participate or conduct his own investigation into whether there were any issues with classification after the three deaths. Ex. 5, Romero Dep. 202:2-7.

205. The only change made at the Denver County Jail as a result of Mr. Vigil's suicide was that they now ask three questions about suicide – but that change was made in 2008 so it was not just in response to Mr. Vigil's suicide Ex. 5, Romero Dep. 202:16-21.

206. The only change in policy at the Denver County Jail since Mr. Vigil's suicide is the memo regarding access to an interpreter that Romero wrote in May 2009 – but that memo is not a jail policy. Ex. 5, Romero Dep. 204:3-16.

207. Despite an inquiry from the Office of Independent monitor about whether there was any assessment of Mr. Vigil's mental health status or suicide risk prior to the suicide, no follow-up investigation was done. Ex. 5, Romero Dep. 62:6-17; and Ex. 49.

208. None of the deputies were disciplined for the failure to document that rounds were conducted in the logbook. Ex. 6, Foos Dep. 161:15-23.

209. There is no evidence to show that any investigation was conducted into the changes made to the ARB documents after they were produced to the IAB.

N. Staffing

210. In 2005, the number of inmates housed in Mr. Vigil's housing unit in special management, the ABC tier, varied a lot, ranging from 50 to 80, but there were no changes in the number of deputies assigned to work on the tiers, regardless of the increase in number of inmates. Ex. 10, Pacheco Dep. 17:22 – 18:20. There were no special precautions taken when the special management unit exceeded 11 percent of the total population of the jail. *Id*. at 18:21 – 19:1. In 2005, it was the policy that only two deputies were assigned to the ABC tier for every shift, *id*. at 15:14-19; 16:4-6, and there was no increase in the number of deputies that staff the ABC tiers in Building 6 when the number of inmates increases. Ex. 8, Pablo Dep. 68:4-17.

211. The logbook shows an inmate count for the ABC tier for the week of September 20 through September 27, 2005 ranged from 90 to 97 inmates. Ex.40 at Bates No. U001091-1109. On September 27, 2005, the inmate count on the ABC tier was 95. *Id*. at Bates No. U001109.

212. The deputies only get one half-hour break during their 10-hour shift. Ex. 8, Pablo Dep. 86:10-14.

213. Romero, the Rule 30(b)(6) designee on the staffing levels and inmate consensus testified that in 2005, the Denver County Jail was experiencing significant overcrowding, Ex. 5, Romero Dep. 189:24 – 190:2, and that for the months of August, September and October in 2005, the number of inmates ranged between 100 and almost 150 percent of design capacity, *id*. at 188:20 – 189:11, and the juvenile population went up 15 percent. *Id*. at 189:18-21.

214. Because of the overcrowding, the jail had to convert the gym area for inmate housing and had to erect a tent in the yard for housing. Ex. 5, Romero Dep. 191:1-10.

215. During this time, there was a 177 % increase on assaults on staff, Ex. 5, Romero Dep. 192:8-10, and the critical incidents requiring the use of force increased 120 % from the previous year. *Id*. at 192:12-15.

216. The 2005 Annual Report of the Denver Sheriff's Department shows 463 deputies and civilians. Ex. 5, Romero Dep. 185:24 – 186:19, and only three additional deputies were added in 2005 from the previous year. *Id*. at 188:8-11.

217. Because of the increased population of the jail, the officers had to put in more hours, Ex. 5, Romero Dep. 191:11-16, and there was over 50 % more hours in officer overtime in 2005 than what was budgeted. *Id*. at 192:2-5.

218. All of these factors, the increase in the inmate population, an increase in the assaults and incidents requiring the use of force, and more overtime worked by the deputies, can lead to an increase in officer fatigue and the risk of harm to inmates. Ex. 5, Romero Dep. 192:19 – 193:20.

219. An increase in officer fatigue can make officers less attentive to the individual needs of the inmates, Ex. 5, Romero Dep. 196:6-13, and could also increase the danger that warning signs of suicide by an inmate might go unnoticed. *Id*. at 196:14-22.

220. Romero did not know how the strain associated with the increase of inmates, assaults, use of force and officer overtime was addressed by the Denver Sheriff's Department in 2005. Ex. 5, Romero Dep. 196:23 – 197:3.

221. During this time Romero did not know how many registered nurses there were at the jail between 2004 and 2005, or if there was any increase in the number of nurses from the

previous year. Ex. 5, Romero Dep. 182:10-16. He did not know whether any of the nurses, other than the psychiatric nurses, had psychiatric training. *Id*. at 183:24 – 184:3.

222. Romero did not know the qualifications of the nurse practitioners that worked at DCJ, and not know if there was any increase in 2005 in the number of nurse practitioners from the previous year. Ex. 5, Romero Dep. 182:19 – 183:9.

223. Romero did not know how many doctors worked at the DCJ or if there was any increase in the number of doctors in 2005 to deal with the increased population. Ex. 5, Romero Dep. 183:15-18. Romero could not testify how many hours per week any of the doctors or medical personnel worked. *Id*. at 183:19-23.

224. During 2005, there was also a 44 percent increase in medical nursing and a 96 percent increase in nurse practitioner visits, and that kind of workload increase on medical staff can also increase the risk that medical staff is fatigued and thus more likely to make mistakes. Ex. 5, Romero Dep. 197:14 – 198:4.

225. Romero could provide no evidence regarding how or whether the increased demand on medical staff was dealt with by the Denver Sheriff's Department in 2005. Ex. 5, Romero Dep. 198:5-8.

O. Defendants' Expert, Michael Haley, Concerning Acceptable Practices in the Management and Care of Inmates is Unreliable

226. Although Haley testified that based on the training material he reviewed there was sufficient training to DSD deputies regarding suicide prevention, he could not verify the dates that any of the training reflected in the documents was given. Ex. 26, Haley Dep. 169:7 – 170:6.

227. And, Haley could not verify whether any of the deputies charged with Mr. Vigil's case had received any of the Academy training that he reviewed. *Id*. at 171:1-5.

P. Diabetes at PADF

228. Deeds, the Rule 30(b)(6) designee on the provision of medical services at the PADF testified that although there was a policy in effect that detainees should be seen within one half hour of their arrival, on a busy day it could take more than one half hour before an inmate was seen. Ex. 7, Deeds Dep. 48:15 – 49:15.

229. Detainees at the PADF were provided food by the deputies at about 5:00 a.m., between 10:00 and 11:00 a.m. and then again in the early afternoon, around 2:30 or 3:00 p.m.. Ex. 7, Deeds Dep. 68:14-22.

230. The only policy at the PADF regarding how the deputies monitor an individual with Type I diabetes would be to complete their rounds. Ex. 7, Deeds Dep. 72:23 – 73:9.

231. Than could not identify any training as of September 2007 that was provided to the DSD officers at the PADF regarding what procedures to follow if a person being booked states that he or she has diabetes. Ex. 11, Than Dep. 61:19-25.

232. Than could not identify any training provided at the Training Academy regarding diabetes prior to September 2007, Ex. 11, Than Dep. 63:17-20, and could not say whether the deputies had any training regarding providing food to detainees with diabetes. *Id*. at 64:13-17.

233. Than was unaware of any training provided prior to September 2007 to the DSD officers regarding what procedures they should follow if a deaf person with diabetes was booked into one of the facilities operated by the DSD. Ex. 11, Than Dep. 64:23 – 65:4.

234. Than did not know whether the deputies were trained regarding how they would know whether an inmate/detainee had diabetes, whether they were trained to know the difference between type 1 and type 2 diabetes, did not know if they had any training regarding the symptoms of hypoglycemia, and did not know if the deputies had ever received training about

what they should do if an inmate informed them that he had taken insulin but had not received food. Ex. 11, Than Dep. 66:19 – 67:25.

235. Than did not know whether a detainee with diabetes had to see medical personnel prior to his or her release from custody, and did not know if the deputies received any training regarding ensuring that medical orders related to a detainee had been complied with prior to the person's release. Ex. 11, Than Dep. 68:7-16.

236. Than could not identify any specific training that the Denver Sheriff Department officers had on diabetes prior to October 2008. Ex. 11, Than Dep. 69:4-7.

Q. Sarah Burke

237. Ms. Burke has Type 1 diabetes, which was diagnosed January 6, 2004. Ex. 16, Burke Dep. 10:8-14

238. Ms. Burke is also profoundly deaf. *Id*. at 10:3-4.

239. Ms. Burke's diabetes treatment includes three (3) to four (4) insulin injections per day, monitoring her blood glucose four (4) to five (5) times per day, and careful management of carbohydrate intake in her meal plan. She takes Humalog, a fast-acting insulin at meals, and Lantus, a long acting insulin at bedtime. She must eat within 15-30 minutes of the time she takes her Humalog or she risks dangerously low blood sugar. Ms. Burke treats hypoglycemia, low blood sugar, by eating foods or drinking liquids with simple sugars to quickly raise her blood sugar. *Id*. at 11:11 – 12:13; Ex. 50, Sarah Burke Decl. ¶¶ 7-10.

240. Ms. Burke communicates primarily by American Sign Language. Ex. 16, Sarah Burke Dep. 9:15-18. While she can write notes in some situations, in complex situations such as those involving medical treatment or when under stress, she cannot communicate effectively in

writing, and she requires a sign language interpreter to effectively communicate in situations involving medical or legal advice or decision making. Ex. 50, Sarah Burke Declaration ¶¶ 4-5.

241. On the evening of August 29, 2007, Ms Burke took six units of Humalog insulin at 4:30. Her blood glucose at that time was 126. She was preparing the evening meal for herself and her family. Ex. 50, Sarah Burke Decl. ¶ 11, Ex.51, Medical Services Admission Assessment Record for Sarah Burke, Deposition Ex. A to Lowell Pippenger (Bates No. P000900).

242. Both of Ms. Burke's children can hear. Ex. 16, Sarah Burke Dep. 9:12-14.

243. Three Denver police officers, Merino and Epp and another officer, arrived at the family home at 4:45 pm, before she had a chance to eat. Ex. 19, Joseph Merino Dep. 12:16-18. Ex.50, Sarah Burke Decl. ¶ 19. They departed at approximately 7:30 p.m. Ex. 16, Burke Dep. 27:13-18.

244. Ms. Burke tried to communicate to the officers that she is deaf and requested a sign language interpreter. Ex. 16, Sarah Burke Dep. 25:11-20, 28:24 – 30:6.

245. The arresting officer knew Ms. Burke had diabetes. Ex. 19, Merino Dep. 25:3-5. There was no notation on the officers' log that Ms. Burke is deaf, has diabetes, or that she requested an interpreter. Ex. 52, SRO/HSRO Daily Activity Log, Deposition Ex. A to Joseph Merino (Bates No. U000887).

246. Ms. Burke's request for a sign language interpreter was refused, and the officers forced her eight-year-old son to interpret. Ex. 16, Sarah Burke Dep. 25:19-20, 27:19 – 29:23; Ex. 50 Sarah Burke Decl. at ¶¶ 14-15; Ex. 53, James Burke Decl. at ¶¶ 8-9.

247. The officers placed Ms. Burke under arrest. Her husband, Mr. Burke, who is also deaf, tried to give the police Ms. Burke's insulin, emergency medications, and diabetes supplies

but the police refused to allow her to take her medications with her. Ex. 16, Sarah Burke Dep. 31:16-25, 32:4-14.; Ex. 53, James Burke Decl. at ¶ 11.

248. The officers drove Ms. Burke to the District 3 Denver police station. Ex. 19, Merino Dep. 22:7-9.

249. Ms. Burke began to experience symptoms of hypoglycemia about an hour after the police arrived, because she had taken her insulin and was not allowed to eat or to take her emergency medications with her. *Id*. at 50:1-4.

250. An officer at District 3 who said he could communicate in sign language could not even understand when Ms. Burke asked to use the restroom. *Id*. at 33:25 – 35:4; Ex. 50, Sarah Burke Decl. ¶ 20.

251. Ms. Burke requested an interpreter at the District 3 station. Id. at 33:23 – 34: 6. No qualified sign language interpreter was provided while Ms. Burke waited at District 3. *Id*. at 35:5-7; . Ex. 50, Sarah Burke Decl. ¶ 21.

252. Ms. Burke reports that she was experiencing signs and symptoms of hypoglycemia, having taken her insulin and allowed no food for over 3 hours. (shaking, sweating, difficulty concentrating). *Id*. at 49:15 – 50:4; Ex. 50, Sarah Burke Decl. ¶ 24.

253. Contrary to the arresting officer's training, no medical services were provided at the District 3 facility. *Id*. at 50:5-11. The arresting officer testified that the only training he had on diabetes was that people with diabetes may appear intoxicated, that people with diabetes may be dependent on glucose levels, and to call an ambulance when someone complains of a diabetic reaction. Ex. 19, Merino Dep. 60:2-24

254. Ms. Burke was subsequently transferred from District 3 to the PADF, where she was then in the legal and physical custody of the Denver Sheriff's Department. Ex. 16, Sarah

Burke Dep. 35:12-22. She asked to write something so that she could request an interpreter, but she was ignored. *Id.* at 35:23 – 36:17.

255. Later, when Ms. Burke was provided a piece of paper, she wrote, "I want an interpreter and I need to see a doctor and I need to eat." The officer ignored the message and spoke verbally to her, and she could not understand what he was saying. Ex. 16, Burke Dep. 37:20 – 38:4.

256. About three and a half hours after arriving at PADF, Ms. Burke was taken to a person she believed to be a medical officer. Ex. 16, Burke Dep. 38:11-24.

257. The intake was conducted at 2200, by Lowell Pippenger, seven-and-one-half hours after she had taken her insulin. *Id*. at 38:11-15, and Ex. 51, Medical Services Admission Assessment Record for Sarah Burke, Deposition Ex. A to Lowell Pippenger.

258. Ms. Burke once again requested an interpreter but was given a paper to write on. Ms. Burke tried to explain on the paper that she had diabetes and needed to eat, and that she needed an interpreter. Ex. 16, Burke Dep. 38:16-21; 39:9-11; 54:23-25.

259. Ms. Burke stated that she continued to have symptoms of hypoglycemia during this assessment, and stated that it was difficult to communicate with the officer. He continued to communicate verbally which she could not understand. *Id*. at 39:7-11; Ex. 50, Sarah Burke Decl. ¶ 29.

260. There is a note on the Medical Assessment Form that Ms. Burke communicated with the officer in writing, but the actual writings were not produced by Denver. The officer correctly noted her complaints. Ex. 51.

261. Ms. Burke asked for a blood glucose monitor. After leaving the room and returning several times, the medical officer produced a blood glucose meter. Ex. 50, Sarah Burke Decl. ¶ 30.

262. Ms Burke testified that the monitor appeared to be an old meter, large and unlike meters commonly used today. Ex. 50, Sarah Burke Decl. ¶ 31.

263. Ms. Burke testified that the officer struggled with the procedure, attempting to put the wrong end of the strip into the meter. Ex.50, Sarah Burke Decl. ¶ 32.

264. The Medical Services Admission Record documented a blood glucose level of 377, which is very high. Ex. 16, Burke Dep. 39:16-17.

265. Ms. Burke recalled looking at the monitor screen and seeing 28, which is dangerously low. Ex. 50, Sarah Burke Decl. ¶ 33.

266. The Medical Services Record documents a communication with Dr. Crum, who ordered an injection of Regular insulin 5 units and a sack lunch now. Ex. 51.

267. The officer did not contact a sign language interpreter to address the discrepancy between the reported observation and the blood glucose documented on the record nor was a second test performed. Ex. 54, Linda Edwards Expert Report.

268. The record documents that at some unidentified time the insulin was given. Ex. 51.

269. Ms. Burke relates that she protested the insulin because she already was experiencing hypoglycemia. Ex. 16, Burke Dep. 39:19-23; Ex.50, Sarah Burke Decl. ¶ 34.

270. There is no record that the sack lunch was provided. In fact, Ms. Burke firmly denies that any food was given to her at any time during the time she was in custody, despite the fact that she asked for food and continued to ask for an interpreter. *Id*. at 40:9-21; 41:19; 43:12-

13; 52:4-7; *see also* Sarah Burke Declaration ¶ 35 The nurse told Ms. Burke that she would have to wait until 4:30 in the morning to get any food. S. Burke Dep. 40:17-21.

271. She was unable to communicate with her husband because the TTY device was broken. *Id*. at 44:10 – 45:10.

272. Ms. Burke states that her husband had communicated with an officer that he would pick her up at 3:00 a.m., but Ms. Burke was not given the message. *Id*. at 48:20-23; Ex. 50, Sarah Burke Decl. ¶ 38.

273. Ms. Burke was released from the PADF between 2:00 a.m. and 2:30 a.m. and given bus tokens to get home. *Id*. at 45:11-16, and 46:2-12; Ex. 50, Sarah Burke Decl. ¶ 37.

274. Because of the late hour, no public transportation was available. *Id*. at 46:14-16.

275. Ms. Burke was released to the street, on the corner of 13th and Cherokee streets in downtown Denver. *Id*. at 46:2-12; Ex. 50, Sarah Burke Decl. ¶ 39.

276. Ms. Burke felt ill and disoriented. Id. at 49:18 – 50:4; Ex. 50, Sarah Burke Decl. ¶ 40.

277. After walking to a light rail station, and learning from a sign there would be no train for hours, she began to walk back to the PADF to find someone to help her. Ex. 16, Sarah Burke Dep. 46:14-19; Ex. 50, Sarah Burke Decl. ¶ 41.

278. A man driving by in a van offered to give Ms. Burke a ride. Exhausted and confused, Ms. Burke accepted the ride. *Id*. 46:19-23; Ex. 50, Sarah Burke Decl. ¶ 42.

279. Instead of taking her home, the man tried to sexually assault her. *Id*. 46:25 – 47:4; Ex. 50, Sarah Burke Decl. ¶ 43.

280. Ms. Burke managed to escape and somehow made her way back to the light rail station on foot. *Id*. 47:4-16; Ex.50, Sarah Burke Decl. ¶ 44.

281. By the time Ms. Burke returned to her home, she was severely hypoglycemic. Ex. 50, Sarah Burke Decl. ¶ 45.

282. Ms. Linda Edwards, RN, MHS, and Certified Diabetes Educator, provided an expert report in this case regarding Ms. Burke's case. Ex. 54, Linda Edwards Expert Report.

283. Ms. Edwards opined that the refusal of the police officers to allow Ms. Burke to take her glucose tablets from home contributed to the hypoglycemia she began to experience within an hour after her arrest. *Id*. at 5, ¶ 4.

284. Ms. Edwards opined that the failure of the police department to provide her with medical care when she was held at the District 3 station demonstrated deliberate indifference and willful disregard for Ms. Burke's serious medical needs. *Id*. at 6, ¶ 8.

285. Ms. Edwards opined that the failure of the deputies at the PADF to provide her a sign language interpreter and food demonstrated deliberate indifference to her serious medical needs. *Id*. at 6-7, ¶ 9. She further opined that the medical staff at the PADF failed to identify serious discrepancies between the history provided by Ms. Burke and the blood glucose readings and failed to recheck those readings or obtain the assistance of a sign language interpreter, but rather proceeded with an insulin injection despite the protest of Ms. Burke placing her in a high risk of seizure, loss of consciousness, brain damage and death. The failure to provide Ms. Burke with an interpreter during her communications with medical personnel resulted in the documentation of erroneous medical information and could have resulted in serious and potentially fatal decisions. *Id*. at 7-8, ¶¶ 10, 12 and 13. She also opined that the failure of DSD deputies at the PADF to communicate to Ms. Burke that her husband was planning on picking her up on her release from the PADF, and then discharging her without this knowledge at a time

when her symptoms were consistent with a hypoglycemia state placed her at serious risk of physical harm. *Id*. at 8, ¶14.

286. Ms. Edwards concluded that: "At every encounter during Ms. Burke's detention, the officers demonstrated reckless and willful deliberate indifference to her needs for a sign language interpreter and serious medical needs. The officers also repeated refused to provide measures that she requested and that were necessary to manager her diabetes and avoid serious consequences including death. By this omission and by the additional actions of giving her an insulin injection of Regular insulin without food and by releasing her to the street in the middle of night in an impaired state, the department placed her at risk for personal physical harm as well as serious risk from hypoglycemia." *Id*. at p. 9, ¶6.

R. Roger Krebs

287. As the result of a childhood illness and medical treatment, Roger Krebs has been deaf since he was 18-months-old. Ex. 18, Roger Krebs Dep. 12:16 – 13:8.

288. Mr. Krebs cannot hear voices and cannot communicate verbally. *Id*. at 10:24 – 11:7.

289. Mr. Krebs's deafness has resulted in his feeling that there is a wall when he tries to communicate with a hearing person and that he is sometimes treated like a child because he communicates differently than a hearing person. *Id*. at 11:7-13.

290. His primary mode of communication, including his family, is through sign language. *Id*. at 10:10-23.

291. As with many individuals who have been deaf since childhood, Mr. Krebs does not read or write with fluency. *Id*. at 11:8-10.

292. Mr. Krebs cannot read lips and is frustrated when asked to do so. *Id*. at 13:9-14, 14:5-7, 25:8 – 26:1.

293. His primary mode of communication is ASL, not English. *Id*. at 28:24 – 29:4.

294. Sometimes Mr. Krebs is able to communicate exchanging short notes. *Id*. at 14:22 – 15:4.

295. In order to effectively communicate in situations involving medical or legal advice, decision making, or more than very simple language, Mr. Krebs requires the services of a qualified sign language interpreter. *Id*. at 90:3-16, and Ex. 17, Roger Krebs Decl. at ¶ 3.

296. On March 29, 2007, Mr. Krebs was traveling by bus from Colorado Springs, where he lives, to Salt Lake City, Utah. Ex. 17, Krebs Decl. at ¶ 4.

297. During a layover in Denver, a security guard at the Greyhound Bus Station did not understand that Mr. Krebs was deaf and could not respond to verbal instructions. A scuffle ensued, and Mr. Krebs was taken into custody by the Denver Police Department. Ex. 18, Roger Krebs Dep. 59:9 – 60:20, 61:2 - 62:11, 63:9-21; Ex. 17, Krebs Decl. at ¶ 5.

298. Mr. Krebs repeatedly asked the police officer for an interpreter, but they refused to do so. *Id*. at 67:14-16.

299. Because his foot had been injured at the bus station, he was taken by ambulance to the Denver Health Medical Center. Ex. 18, Roger Krebs Dep. 68:16-22, 70:20-22; Ex. 17, Krebs Decl. at ¶ 6.

300. The hospital provided him with a sign language interpreter throughout his treatment. *Id*. at 73:24 – 74:1; Ex. 17, Krebs Decl. at ¶ 6.

301. Because of the injuries to his ankle, Mr. Krebs was given two crutches. Ex. 18, Roger Krebs Dep. 74:2-9.

302. Mr. Krebs asked that the hospital interpreter accompany him from the hospital to the PADF. Ex. 17, Krebs Decl. at ¶ 7.

303. Mr. Krebs was told that no interpreters were allowed at the PADF. Ex. 17, Krebs Decl. at ¶ 8.

304. Mr. Krebs was told that he would have an interpreter when he appeared in court. Ex. 17, Krebs Decl. at ¶ 9.

305. At the PADF, Mr. Krebs asked for an interpreter during the booking process. Ex. 18, Roger Krebs Dep. 75:7-9, 75:18, 79:25 – 80:16.

306. Mr. Krebs continued to ask the deputies at the PADF for an interpreter. He was never provided with an interpreter. *Id*. at 80:19-25.

307. Mr. Krebs also asked for a pencil and paper and that request was also denied. *Id*. at 81:10-14.

308. Mr. Krebs asked for and was denied access to any technology that would allow him to make a telephone call. Ex. 17, Krebs Decl. at ¶ 10.

309. Mr. Krebs was offered medical treatment at the PADF but without an interpreter, could not effectively communicate with the treatment providers. Ex. 18, Roger Krebs Dep. 76:1-4, 77:6-21, 78:2-3.

310. Mr. Krebs was placed in a cell by himself and had no contact with other detainees. Ex. 17, Krebs Decl. at ¶ 11.

311. Mr. Krebs was given no method for contacting the PADF staff. Ex. 17, Krebs Decl. at ¶ 12.

312. The next morning, March 30, 2007, PADF staff awakened Mr. Krebs by hitting him in the chest with a bag containing his breakfast. Ex. 17, Krebs Decl. at ¶ 13.

313. According to the deposition testimony of Major Deeds, tossing a sack lunch at a deaf inmate to awaken him is improper. Ex. 7, Deeds Dep. 70:23 - 71:4.

314. Mr. Krebs tried to communicate with PADF staff about his situation but needed an interpreter to do so. Ex. 18, Roger Krebs Dep. 90:3-16. Because there was no communication, and Mr. Krebs did not understand what was happening, he felt like a dummy. *Id*. at 91:3 – 93:4.

315. Without communication, Mr. Krebs did not feel safe at the PADF. *Id*. at 93:5-11.

316. Mr. Krebs was not provided with an interpreter for his arraignment before the Denver County Court but did ask to be accommodated. Ex. 18, Roger Krebs Dep. 88:24 – 89:8, 89:21 – 90:2.; Ex. 55.

317. In response, an employee of the Defendants told him that if he persisted in asking for an interpreter, he would have to remain at the PADF for three (3) more days until an interpreter could be provided. Ex. 17, Krebs Decl. at ¶ 15.

318. Mr. Krebs was then told, that if he pleaded guilty to all charges, he could be released and not have to remain incarcerated at the PADF. Ex. 17, Krebs Decl. at ¶ 16h.

S. Training Provided to Denver Police Department Regarding Providing Sign Language Interpreters:

319. Captain Michael Than and Ms. Kosinski were the Rule 30(b)(6) designees regarding the training provided to Department of Safety employees regarding sign language training and the training provided to police officers regarding inmates who are deaf or have diabetes. Ex. 33.

320. Than did not know anything about the training that Denver Police Department employees had received regarding sign language interpreters. Ex. 11, Than Dep. 61:5-8. Defendant failed to designate any other person regarding the training that the DPD officers had

regarding sign language training or training of its police officers regarding inmates who are deaf or have diabetes. Ex. 33.

321. In the material Kosinski cited in her affidavit, [Doc 197-7, Exhibit A-4 (part 2), p. 32, police officers should have been aware that "According to Title III of the ADA, police officers are responsible for calling out the interpreter," and that the billing for interpreters will be handled through headquarters. . Kosinski testified that she does not advise that pen and paper is the most effective way to communicate with deaf individuals. Ex. 2, Kosinski Depo 24:19-23. Kosinski testified that providing an interpreter is optimum for effective communication. *Id.* at 50:22-25. Kosinski also testified that using a child to interpret for a parent being arrested is not effective communication. *Id.* at 49:5-18.

322. Instead, Police officers believe that pen and paper is an effective way to communicate with deaf individuals. Ex. 19, Joseph Merino Dep. 61:4-13; Ex. 56, Nicholas Rocco-McKeel Dep. 24:14-25. Officer Merino believed that using a child to interpret provided effective communication. Ex. 19, Merino Dep. 27:14-22.

323. Kosinski conducts a 1 hour training for the Denver Police Department academy. Ex 2, Kosinski Depo at 36:4-6 and would like to have more time to conduct the training. *Id.* at 36:10-14. As a result of the time constraints, recruits no longer conduct role plays, an effective form of adult education. *Id.* at 37:24-38:10

324. Kosinski has never reviewed effective communication policies for the Denver Police Department. Ex. 2, Kosinski Dep. 8:15-21.

325. Officer Merino was still in training when he arrested Sarah Burke. Ex. 19, Merino Dep. 12:11-15, and could not remember the specifics of his training on how to deal with deaf and hard of hearing individuals. Ex. 19, Joseph Merino Dep. 56:15-24.

Provision of Sign Language Interpreters

326. Kosinski testified that an interpreter could be called and dispatched in as few as five to twenty minutes, depending on traffic. Ex. 2, Kosinski Dep. 42:2-21.

327. Kosinski testified that for an arraignment, an interpreter can be provided in court the same day a request is made. *Id*. at 78:7-14.

328. Kosinski testified that a sheriff deputy should contact the court and request an interpreter on behalf of a deaf detainee for an arraignment. *Id*. at 47:21-23.

329. Kosinski testified that it is inadvisable to use a child to interpret for his parents. *Id.* at 48:24 – 49:2.

T. Organizational Standing of Colorado Cross-Disability Coalition ("CCDC")

330. CCDC's mission is to promote independence, self-reliance and full participation for people with disabilities. CCDC's mission is advanced by organizing, educating and advocating to promote systemic change. Ex. 57, Reiskin Decl. ¶ 4

331. Part of CCDC's mission involves ensuring that individuals with disabilities receive reasonable accommodations in their interactions with the City and County of Denver and other entities, including effective communication for individuals who are Deaf, and accommodations for disabilities such as diabetes. *Id*. at ¶ 5.

332. CCDC is Colorado's largest state-wide organization of and for individuals with disabilities. With a small staff and very restricted budget, CCDC works with the legislature on issues affecting individuals with disabilities; counsel individuals who encounter discrimination based on disability or who are having trouble securing the benefits to which they are entitled; through their Center for the Rights of Parents with Disabilities, counsel disabled parents encountering discrimination, for example, in guardianship and dependency and neglect matters;

engage in outreach and education through speaking and teaching engagements. These activities keep their staff busy more than full time. Any time CCDC has to devote to addressing discriminatory conduct such as the City's refusal to provide sign language interpreters to, or accommodate the medical conditions of, pretrial detainees takes their staff away from these other important duties. *Id*. at ¶ 6

333. CCDC has received complaints from people with disabilities, including individuals who are deaf, hard of hearing, and who have diabetes, about the failure of the City and County of Denver, including its police and sheriff departments to provide accommodations, policy modifications, and auxiliary aids and services. *Id*. at ¶ 7.

334. Defendant City and County of Denver's failure to provide interpreters sends the message to other municipalities and businesses that they do not need to provide sign language interpreters and other auxiliary aids and services in the legal context. This makes CCDC's mission that much harder. *Id*. at. ¶ 8.

335. Defendant City and County of Denver's failure to provide adequate medical care to prisoners with diabetes sends the message to other municipalities that they too do not need to provide adequate medical care to prisoners with disabilities. *Id*. at ¶ 9.

336. CCDC's mission was frustrated by Defendants' failure to provide interpreters and other auxiliary aids and services to Deaf and hard of hearing individuals. *Id*. at¶ 10.

337. CCDC's mission was frustrated by Defendants' failure to provide adequate medical care to individuals, including individuals with diabetes, who are in Defendants' custody. *Id*. at ¶ 11.

338. Defendants' failure to provide auxiliary aids and services, and adequate medical care has forced CCDC to devote its very scarce resources to advocating on behalf of aggrieved individuals, including the individual plaintiffs in this matter. *Id*. at ¶ 12

339. In the Fall of 2006, CCDC staff member Jaime Lewis represented CCDC and its members -- including people who are Deaf and hard of hearing and people with diabetes -- at meetings with community relations ombudsman for Defendant's Office of the Independent Monitor. Mr. Lewis discussed access issues for incarcerated individuals with disabilities and medical conditions. He also discussed access issues for individuals involved with the Denver Police Department. *Id*. at ¶ 13.

340. These meetings were not part of Mr. Lewis's regular duties, and diverted him from doing other work for the organization. *Id*. at ¶ 14.

341. In 2007, CCDC attorneys Carrie Ann Lucas and Kevin Williams attended meetings concerning accessibility of the City's new justice center and access for attorneys, litigants, staff members, and detainees. They did this at least in part because of the City's history of discrimination, including but not limited to its discrimination against disabled pretrial detainees. Because of this history of discrimination, CCDC predicted that the planned justice center would not adequately address the needs of individuals with disabilities. For that reason, the organization asked Ms. Lucas and Mr. Williams to take time away from their other tasks to meet with the City on this matter. *Id*. at ¶ 15.

342. These meetings were not part of Ms. Lucas' or Mr. Williams' regular duties, and diverted them from doing other work for the organization. *Id*. at ¶ 16.

343. In 2008, Ms. Lucas and paralegal Briana McCarten spent time corresponding with the Department of Safety to get records from Plaintiff Sarah Burke's arrest and detention. This

diverted them from other work for the organization, such as representing parents with disabilities in child protection cases. *Id*. at ¶ 17.

344. Naturally, the time that Mr. Williams, Ms. Lucas and Ms. McCarten have devoted to litigating this case has taken significant time away from other important tasks. *Id*. at ¶ 18.

345. In light of the City's history of discrimination against individuals with disabilities, and in particular against pretrial detainees who are Deaf or have diabetes, CCDC will have to devote resources in the future to monitoring the City's actions and taking steps to remedy any discrimination encountered or observed. *Id*. at ¶ 19.

346. CCDC continues to hear from individuals who have faced discrimination by the Denver Police Department and Sheriff's Department, and will continue to meet with and advocate for such individuals in ways that divert their staff from other important work. *Id*. at ¶ 20.

347. Because the City has not changed its policies and practices with respect to pretrial detainees with disabilities, it is highly likely both that the City will continue to discriminate against such individuals, as it has in the past, and that such individuals will contact CCDC to seek assistance, as they have in the past. When this happens, CCDC will continue to divert their scarce resources to counseling and advocating for those against whom the City has discriminated. *Id*. at ¶ 21.

U. Colorado Association of the Deaf ("CAD") Organization Standing

348. CAD's mission is to promote the awareness and welfare of deaf and hard of hearing persons in Colorado, to combat discrimination against the deaf and hard of hearing individuals and their families and actively to promote and advance educational, vocation, economic and social standards for the deaf and hard of hearing citizens. The CAD envisions this

world to be a place where all people recognize the value of the deaf individuals, the world to be fully accessible to the deaf community and consistently demonstrate compassion and respect. Ex. 58, Pfau Decl. ¶ 4.

349. Part of this mission involves ensuring that individuals who are Deaf or hard of hearing receive reasonable accommodations, including effective communication, in their interactions with the City and County of Denver and other entities. *Id*. at ¶ 5.

350. CAD is Colorado's largest state-wide organization of and for individuals who are Deaf or hard of hearing. With a very restricted budget, CAD works with the legislature on issues affecting individuals who are Deaf and hard of hearing; counsel individuals who encounter discrimination based on Deafness, and engage in outreach and education through speaking and teaching engagements. Any time CAD has to devote to addressing discriminatory conduct such as the City's refusal to provide sign language interpreters takes them away from these other important duties. *Id*. at ¶ 6.

351. CAD has received complaints from Deaf individuals about the failure of the City and County of Denver, including its police and sheriff departments to provide sign language interpreters and other auxiliary aids and services. *Id*. at ¶ 7.

352. Defendant City and County of Denver's failure to provide interpreters sends the message to other municipalities and business that they do not need to provide sign language interpreters and other auxiliary aids and services in the legal context. This makes CAD's mission that much harder. *Id. at* ¶ 8.

353. CAD's mission was frustrated by Defendants' failure to provide interpreters and other auxiliary aids and services to Deaf and hard of hearing individuals. *Id*. at ¶ 9.

354. Defendants' failure to provide auxiliary aids and services has forced CAD to devote its very scarce resources to advocating on behalf of aggrieved individuals, including the individual plaintiffs in this matter. *Id*. at ¶ 10.

355. CADs former president, Michelle Muth Rodriguez, worked to combat discrimination by teaching sign language classes to Department of Safety employees. *Id*. at ¶ 11.

356. CAD board members have been forced to spend time educating members on grievance procedures, and their rights to interpreters as a result of the City's discrimination. *Id.* at. ¶ 12.

357. In light of the City's history of discrimination against individuals with disabilities, and in particular against pretrial detainees who are Deaf, CAD will have to devote resources in the future to monitoring the City's actions and taking steps to remedy any discrimination encountered or observed. *Id*. at ¶ 13.

358. CAD continues to hear from individuals who have faced discrimination by the Denver Police Department and Sheriff's Department, and will continue to meet with and advocate for such individuals in ways that divert CAD staff from other important work. *Id*. at ¶ 14.

359. Because the City has not changed its policies and practices with respect to pretrial detainees who are Deaf or hard of hearing, it is highly likely both that the City will continue to discriminate against such individuals, as it has in the past, and that such individuals will contact CAD to seek assistance, as they have in the past. When this happens, CAD will continue to divert their scarce resources to counseling and advocating for those against whom the City has discriminated. *Id*. at ¶ 15.

360. Pursuant to Division III, Section 4 of the Denver Police Department Operations Manual, Chief Whitman "is the executive head of the police department" and shall formulate and enforce departmental policies, and promulgate orders to the employees of the police department as may be deemed proper. Ex. 59, Denver Police Department Operations Manual, Sections 4.01, 4.02 and 4.03.

361. According to Denver's Career Service Authority, the Undersheriff is responsible for "developing objectives while implementing strategies and managing plans, programs, and projects for the Sheriff Department directing operations and support services at DCJ, the Pre-Arraignment Detention Facility/Court Services and Administration/Training." Ex. 60, Career Service Authority, Undersheriff, at 2-3.

362. According to Denver's Career Service Authority, the Division Chief is responsible for "developing objectives, implementing strategies, managing plans, programs, and projects and directing operations and support services" at the PADF "and/or Administration/Training." The essential duties of the Division Chief are described as "creates, discovers, and/or incorporates best practices," "[m]akes decisions that directly impact subordinate staff in designated functional and/or operational areas and delegates decision-making responsibility and authority to subordinate staff as appropriate," and "[p]lans, designs, and develops programs, projects, procedures, and standards utilizing functional/technical expertise and directs and manages their implementation." Ex 60, Career Service Authority Deputy Sheriff Division Chief.

ARGUMENT

I. Standard of Review: Defendants' Motions Do Not Satisfy Rule 56.

In considering a motion for summary judgment, the Tenth Circuit "repeatedly has emphasized that [courts] must draw all inferences in favor of the party opposing summary judgment." *O'Shea v. Yellow Tech. Servs., Inc.*, 185 F.3d 1093, 1096 (10th Cir. 1999). Indeed, "[t]he non-movant is given 'wide berth to prove a factual controversy exists.'" *Smith v. Diffee Ford-Lincoln-Mercury, Inc.*, 298 F.3d 955, 966 (10th Cir. 2002).

> Where different ultimate inferences may properly be drawn, the case is not one for summary judgment. The court must examine the summary judgment papers in the light most favorable to the party opposing the motion. All the ambiguities and disagreements must be resolved in favor of the party against whom summary judgment is sought.

Webb v. Allstate Life Ins. Co., 536 F.2d 336, 339-40 (10th Cir. 1976) (citations omitted).

In reviewing antidiscrimination laws such as the Americans with Disabilities Act, 42 U.S.C. § 12101 *et seq.*, ("ADA") and section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794 ("section 504"), the Tenth Circuit has held that a court "'must be mindful of their remedial purposes, and liberally interpret their provisions to that end.'" *Trainor v. Apollo Metal Specialties, Inc.*, 318 F.3d 976, 983 (10th Cir. 2002) (quoting *Wheeler v. Hurdman*, 825 F.2d 257, 262 (10th Cir. 1987)).

Affidavits supporting a motion for summary judgment "must be made on personal knowledge [and] set out facts that would be admissible in evidence . . .." Fed. R. Civ. P. 56(e)(1). A decision to grant summary judgment can be made only "if the pleadings, the discovery and disclosure materials on file, and any affidavits show that there is no genuine issue as to any material fact and that the movant is entitled to judgment as a matter of law." *Id.* Rule 56(c)(2). The "moving party carries the burden of showing beyond a reasonable doubt that it is

entitled to summary judgment." *Trainor*, 318 F.3d at 979 (internal quotation omitted). "Even when . . . the moving party does not have the ultimate burden of persuasion at trial, it has both the initial burden of production on a motion for summary judgment and the burden of establishing that summary judgment is appropriate as a matter of law." *Id.* "'If a moving party fails to carry its initial burden of production, the nonmoving party has no obligation to produce anything, even if the nonmoving party would have the ultimate burden of persuasion at trial. In such a case, the nonmoving party may defeat the motion for summary judgment without producing anything.'" *Id.* (quoting *Nissan Fire & Marine Ins. Co. v. Fritz Cos.*, 210 F.3d 1099, 1102-03 (9th Cir. 2000).

As detailed above and in the accompanying Plaintiffs' Motion to Strike, Defendants' Motions completely fail to satisfy either Rule 56 or the Defendants' burden, as the moving party, to show -- through admissible evidence based on personal knowledge -- that there is no genuine issue of material fact. Plaintiffs demonstrate below that there are disputed issues of fact and law preventing summary judgment on all arguments raised by Defendants. However, before even reaching those arguments, Plaintiffs respectfully request that this Court deny Defendants' Motions for the simple reason that they did not comply with Rule 56.

II. Genuine Issues of Material Fact Preclude Summary Judgment On Plaintiffs' ADA and Section 504 Claims.

A. Elements of Claims under the ADA and Section 504.

Under Section 504, a qualified individual with a disability may not, solely by reason of his or her disability, be "excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance . . .." 29 U.S.C. § 794(a). To establish a claim under this provision, a plaintiff is required to show that (1) he has a disability; (2) he is otherwise qualified to participate in the program; (3) the

program receives federal financial assistance; and (4) the program discriminated against him. *Powers v. MJB Acquisition Corp.*, 184 F.3d 1147, 1151 (10th Cir. 1999). To establish a claim under Title II of the Americans with Disabilities Act, 42 U.S.C. § 12131 *et seq.*, a plaintiff is required to show that (1) he is a qualified individual with a disability; (2) he was excluded from participation in or denied the benefits of a public entity's services, programs, or activities; and (3) such exclusion, denial of benefits, or discrimination was by reason of a disability. *Robertson v. Las Animas County Sheriff's Dep't*, 500 F.3d 1185, 1193 (10th Cir. 2007). Title II "essentially simply extends the anti-discrimination prohibition embodied in section 504 . . . to all actions of state and local governments." *Chaffin v. Kan. St. Fair Bd.*, 348 F.3d 850, 859 (10th Cir. 2003) (citing H.R. Rep. No. 101-485, pt. 2, at 84 (1990), reprinted in 1990 U.S.C.C.A.N. 303, 367).

Defendants do not contest that Plaintiffs are/were qualified individuals with disabilities or that the City is a public entity under Title II and receives federal financial assistance. Dkt. #197 at 42. Thus, the only dispute is whether the City discriminated against Plaintiffs on the basis of disability. The Department of Justice regulations implementing Title II prohibits Defendants from discriminating on the basis of disability "directly or through contractual . . . arrangements . . .." 28 C.F.R. § 35.130(b)(1). They require Defendants to "make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability . . .." *Id.* § 35.130(b)(7). Specifically, these regulations require that Defendants:

- take appropriate steps to ensure that communications with disabled detainees "are as effective as communications with others;" and
- "furnish appropriate auxiliary aids and services where necessary" to afford

disabled detainees equal opportunity to participate in their programs and activities. *Id.* § 35.160(a) & (b)(1). The term "auxiliary aids and services" includes "qualified interpreters" and "other effective methods of making aurally delivered materials available to individuals with hearing impairments." *Id.* § 35.104. "In determining what type of auxiliary aid and service is necessary," Defendants must "give primary consideration to the requests of the individual with disabilities." *Id.* § 35.160(b)(2). These regulations are entitled to substantial deference. *Robertson*, 500 F.3d at 1195 & n.7. "The only limitation on these duties is that a public entity is not required 'to take any action that it can demonstrate would result in a fundamental alteration in the nature of a service, program, or activity or in undue financial and administrative burdens.'" *Id.* at 1196 (quoting 28 C.F.R. § 35.164); *see also* 28 C.F.R. § 35.130(b)(7)(fundamental alteration defense to reasonable accommodation requirement). Defendants here have not argued that measures required to ensure effective communications with Plaintiffs, avoid disability-based isolation, or accommodate Ms. Burke's diabetes would result in either a fundamental alteration or an undue burden.

B. Ms. Burke's and Mr. Krebs's Arrests were Covered by Title II and Section 504.[9]

The Tenth Circuit has held that "a broad rule categorically excluding arrests from the scope of Title II . . . is not the law." *Gohier v. Enright*, 186 F.3d 1216, 1221 (10th Cir. 1999). Thus, Defendants' argument -- relying on a Fourth Circuit case decided two years before *Gohier* -- that Title II does not apply to arrests, Dkt. #197 at 42 (citing *Rosen v. Montgomery County, Md.*, 121 F.3d 154, 157 (4th Cir. 1997)), is contrary to clear circuit precedent, and Defendants do not cite much less attempt to distinguish *Gohier*. Indeed, the Department of Justice instructs that, "[d]uring interrogations and arrests, a sign language interpreter will often be necessary to

[9] Plaintiffs do not argue that Defendants had a duty to provide accommodations at the scene of Mr. Vigil's arrest.

effectively communicate with an individual who uses sign language." Commonly Asked Questions about the Americans with Disabilities Act and Law Enforcement, **http://www.ada.gov/q&a_law.htm** (last visited Jan. 16, 2010); *see also* Preamble to Regulation on Nondiscrimination on the Basis of Disability in State and Local Government Services ("Preamble"), 28 C.F.R. pt. 35, app. A[10] ("The general regulatory obligation to modify policies, practices, or procedures requires law enforcement to make changes in policies that result in discriminatory arrests or abuse of individuals with disabilities.") One court has explained:

> Although to the lay reader [the language of Title II] may suggest only commonly available and publicly shared accommodations such as parks, playgrounds, and transportation, the Act in no way limits the terms 'services, programs, or activities' and appears to include all core functions of government. Among the most basic of these functions is the lawful exercise of police powers, including the appropriate use of force by government officials acting under the color of law.

Schorr v. Borough of Lemoyne, 243 F. Supp. 2d 232, 235 (M.D. Pa. 2003); *see also, e.g.*, *Calloway v. Glassboro Dep't of Police*, 89 F. Supp.2d 543, 555 (D.N.J. 2000) (finding ADA applicable to a situation where a deaf person was subjected to police investigative questioning without the assistance of a qualified interpreter); *Jackson v. Inhabitants of Sanford*, 1994 WL 589617, at*6 (D. Me. Sept. 23, 1994) (calling the municipal defendant's contention that the ADA is inapplicable to arrests "plainly wrong" and holding that Title II of the ADA applied to the plaintiff's discriminatory arrest and failure to train claims).

While the Tenth Circuit has not had the opportunity to address the precise contours of Title II's requirements in the context of an arrest, a number of courts have followed the Fifth Circuit's reasonable balance that "Title II does not apply to an officer's on-the street responses to reported disturbances or other similar incidents . . . prior to the officer's securing the scene and

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[10] http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=4918901c38195bfa7aaedca8f5158e26&rgn=div9&view=text&node=28:1.0.1.1.36.7.32.3.11&idno=28)http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=4 (last visited Jan. 18, 2010).

ensuring that there is no threat to human life," but that "[o]nce the area [is] secure and there [is] no threat to human safety, [police are] under a duty to reasonably accommodate [an arrestee's] disability." *Hainze v. Richards*, 207 F.3d 795, 801, 802 (5th Cir. 2000); *see also, e.g., Sudac v. Hoang*, 378 F. Supp. 2d 1298, 1306 (D. Kan. 2005) (following *Hainze* and holding that arrests should not be categorically excluded from the scope of Title II or Section 504); *Sallenger v. City of Springfield*, 2005 WL 2001502, at *31 (C.D. Ill. Aug. 4, 2005) (holding *Hainze* analysis "compelling"); *Schorr*, 243 F. Supp. 2d at 237 (applying *Hainze*).

Under this standard, Title II applied during the arrests of Ms. Burke and Mr. Krebs, and Defendants were under an obligation to accommodate their disabilities. Denver police went to Ms. Burke's house to do a welfare check on her children. Defs.' Fact No. 139. She was arrested peacefully on a bench warrant relating to having missed required parenting classes. *Id.* Nos. 133, 137 and 148. There was no disturbance, incident, or hot pursuit, and no threat to human life or safety. *See id.* No. 148. Denver Police were at Ms. Burke's home for almost three hours, Pls.' Add'l Fact No. 243, more than enough time to secure the services of a sign language interpreter. *See id.* No. 326. Mr. Krebs had been handcuffed by security guards at the bus station when the police arrived, so again the area was secure and there was no threat to human safety. Defs.' Facts Nos. 106-07.

These situations are similar to -- though even less dangerous than -- the situation in *McCray v. City of Dothan*, 169 F. Supp. 2d 1260 (M.D. Ala. 2001), *aff'd in part, rev'd in part on other grounds*, 2003 WL 23518420 (11th Cir. 2003). In that case, the police responded to a dispute concerning private property damage at a restaurant, attempted to communicate in writing with the plaintiff -- who was deaf -- while the plaintiff requested an interpreter, and ultimately arrested the plaintiff without providing an interpreter. 169 F. Supp. 2d at 1275. There was no

evidence suggesting that the plaintiff "posed any 'threat to human safety' which created a necessity for questioning him or arresting him prior to complying with his request for an interpreter." *Id.* The court concluded that "under these circumstances, the police defendants were under an obligation under the ADA to accommodate in effecting arrest activities." *Id.*

Because the circumstances of Ms. Burke's and Mr. Krebs's arrests were entirely peaceful and never represented a threat to human safety, Title II applied and required that Defendants accommodate their disabilities.

C. Defendants Failed to Effectively Communicate with Plaintiffs in Violation of Title II and Section 504.

The Tenth Circuit case of *Robertson v. Las Animas County Sheriff's Department*, 500 F.3d 1185 (10th Cir. 2007) requires that Defendants' Motion be denied to the extent it addresses Defendants' failure to effective communicate with Plaintiffs. *Robertson* held that a request for an accommodation -- specifically accommodations for a deaf detainee -- need not be explicit if the "disabled individual's need for an accommodation is 'obvious.'" *Id.* at 1197 (internal quotations omitted). The case also reaffirmed the Department of Justice regulation requiring that, "'[i]n determining what type of auxiliary aid and service is necessary, a public entity shall give primary consideration to the requests of the individual with disabilities.'" *Id.* at 1196 (quoting 28 C.F.R. § 35.160). Ultimately, the Tenth Circuit held that disputed issues of fact precluded summary judgment on the deaf detainee's claim under Title II of the ADA. *Id.* at 1199.

Robertson discusses in great detail the application of the ADA to deaf pretrial detainees, that is, it is directly on point with respect to the lion's share of Plaintiffs' ADA (and thus Section 504) claims. Defendants, however, only cite it for its recitation of the basic three-part standard for liability under the ADA, Dkt. #197 at 40; nowhere do Defendants acknowledge the holdings

above or attempt to address them in the context of the present litigation.

Robertson is in harmony with a number of other cases holding that the question of what constitutes effective communication is generally a question of fact precluding summary judgment. *See, e.g.*, *Chisholm v McManimon*, 275 F.3d 315, 327-28 (3d Cir 2001); *Duffy v. Riveland*, 98 F.3d 447, 456 (9th Cir. 1996); *Salinas v. City of New Braunfels*, 557 F. Supp. 2d 777, 783 (W.D. Tex. 2008); *Center v. City of West Carrollton*, 227 F. Supp. 2d 863, 870 (S.D. Ohio 2002).

1. The *Robertson* Case Controls and Demonstrates that Summary Judgment As To Plaintiffs' ADA and Section 504 Claims Should Be Denied.

The plaintiff in the *Robertson* case had been arrested and detained by the defendant sheriff's department. He was completely deaf but had a cochlear implant that permitted him to hear human voices when the person speaking faced him from a short distance. He could not, however, use the telephone. Because he lost his hearing late in life, he had no trouble speaking. *Id.*, 500 F.3d at 1188-89. During the intake process following his arrest, he stated that he had no health problems. *Id.* at 1189. While in his cell, despite the fact that it had a telephone, he sent a note stating that he wanted to talk to his attorney; the note did not indicate that he could not use the phone or required a TTY. Mr. Robertson was eventually taken to a room in the detention facility in which he was to observe and participate in his probable cause hearing by closed-circuit television, though because he could not hear, he did not know what was going on. He told the detention officer he could not hear, but nothing was done. *Id.*

Mr. Robertson sued for violation of, among other things, Title II of the ADA. Like Defendants here, the defendants in *Robertson* argued that Mr. Robertson did not request accommodations and that -- during the probable cause hearing -- no communication was

necessary because Mr. Robertson's lawyer was present to speak for him.

The Tenth Circuit held that the second argument "misses the point." Mr. Robertson was eligible to participate in the probable cause hearing so the defendant had an obligation to ensure it was conducted "on nondiscriminatory terms." *Id.* at 1199.

In response to the first argument, the Tenth Circuit -- as noted above -- held that "[w]hen a disabled individual's need for an accommodation is obvious, the individual's failure to expressly 'request' one is not fatal to the ADA claim." *Id.* at 1197. Besides the fact that there was a genuine issue as to whether the plaintiff requested an accommodation, the Tenth Circuit held that there was a genuine issue concerning whether the defendants were on notice of his need for an accommodation even without such a request. *Id.* at 1198. For example, even though Mr. Robertson never stated that he could not use a telephone, deputies had seen him use a relay service and he had written a note to contact his attorney rather than using the phone near his cell. "[T]he totality of the circumstances present at least a fact question as to whether it was obvious that Mr. Robertson needed an auxiliary aid to be afforded an equal opportunity to use the phone." *Id.*

"Practically speaking, if they knew Mr. Robertson [was] deaf, there is a question of fact regarding whether his need for an accommodation was obvious when he attempted to use prison services necessarily involving aural communication." *Id*. That is, once the defendants were on notice that Mr. Robertson was deaf, there was at least a question of fact concerning whether accommodations were required for aural communication. This controlling Tenth Circuit holding precludes summary judgment as to all Plaintiffs' effective communication claims.

2. Defendants Failed to Effectively Communicate with Mr. Vigil in Violation of Title II and Section 504.

Defendants' principal arguments against the ADA claims relating to Mr. Vigil -- that

there is no evidence that Mr. Vigil asked for an interpreter; and that, in any event, there is no evidence that, for example, the medical screening or intake forms contain inaccurate information, Dkt. #197 at 43 -- were explicitly rejected by the Tenth Circuit in *Robertson*. Summary judgment is thus inappropriate as to Mr. Vigil's ADA and Section 504 claims.

Mr. Vigil is now deceased, having committed suicide in Defendants' custody. It is thus not possible to ask Mr. Vigil whether he requested an interpreter. It is, however, uncontested that Defendants knew that Mr. Vigil was deaf and did not read lips. Pls.' Add'l Fact No. 25. Plaintiffs have introduced evidence that Mr. Vigil was pre-lingually deaf, used sign language as his primary form of communication, and could not read lips or use spoken English. *Id.* Nos. 1-7, 25. Mr. Vigil's communications barriers were far greater than those of the plaintiff in *Robertson*, who was able to speak fluent English and hear people who faced him and were speaking from a short distance. *Robertson*, 500 F.3d at 1188-89. Based on the latter case, the simple fact that Defendants knew that Mr. Vigil could not hear or read lips is sufficient to create "a question of fact regarding whether his need for an accommodation was obvious when he attempted to use prison services necessarily involving aural communication." *Id.* at 1198.

It is also a question of fact whether Defendants were on notice that written communication with Mr. Vigil was not sufficient. For example, on the DCJ's Classification Intake Form, Mr. Vigil checked "no" for the question whether he was a United States citizen when in fact Defendants knew that he was a citizen. Pls.' Add'l Facts Nos. 159, 163. It is at least a disputed issue of fact whether Defendants knew that writing was not effective communication with Mr. Vigil. Commentary to the Department of Justice's ("DOJ's") Title II regulations notes that written materials may not be sufficient, and that "a qualified interpreter may be necessary when the information being communicated is complex, or is exchanged for a

lengthy period of time." *See* Preamble, 28 C.F.R. pt. 35, app. A;[11] *see also McCray*, 169 F. Supp. 2d at 1275 (holding that it was a question of fact whether written communications were effective where arrestee was pre-lingually deaf and used sign language as his primary form of communication).

Finally, in commentary to section 35.160, the DOJ makes clear that Defendants were required to "provide an opportunity for individuals with disabilities to request the auxiliary aids and services of their choice." *See* Preamble, 28 C.F.R. pt. 35, app. A. There is no evidence that Defendant took any steps whatsoever to provide Mr. Vigil the opportunity to request auxiliary aids or services.

Defendants argue that there is no evidence that information in the medical or classification forms was inaccurate. As the Tenth Circuit held in *Robertson*, this "misses the point." *Id.* at 1199. Medical screening, classification, and Defendants' other interactions with Mr. Vigil are programs and activities that must be provided "on nondiscriminatory terms." *Id.* Mr. Vigil had the right to effective communication with Defendants concerning his medical and psychological history and other matters.

Defendants assert that deaf inmates had access to TDD's to the same extent as all inmates. Dkt. #197 at 4. There is no evidence that Defendants offered Mr. Vigil the opportunity to use a TDD or request access to one. In addition, when Plaintiffs inspected both facilities pursuant to Rule 34, the neither TDD permitted the user to reach a relay operator. Pls.' Resp. Fact No. 169.

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[11]The Title III commentary makes a similar point: "It is not difficult to imagine a wide range of communications involving areas such as health, legal matters, and finances that would be sufficiently lengthy or complex to require an interpreter for effective communication." Preamble to Regulation on Nondiscrimination on the Basis of Disability by Public Accommodations and in Commercial Facilities, 28 C.F.R pt 36, App. B, http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=644ac3d350d54a389f01d50678397081&rgn=div5&view=text&node=28:1.0.1.1.37&idno=28#28:1.0.1.1.37.6.32.9.13 (last visited Jan. 18, 2010).

Defendants assert that the televisions in the building where Mr. Vigil was housed "have" closed-captioning. It is not clear whether this use of the present tense is intentional; what is clear is that during Plaintiffs' Rule 34 inspection, no such closed captioning was available. Pls.' Resp. Fact. No. 171.

3. Defendants Failed to Effectively Communicate with Ms. Burke and Mr. Krebs During Their Arrest and Detention in Violation of Title II and Section 504.

Ms. Burke and Mr. Krebs both testified that they repeatedly asked for a sign language interpreter during their respective arrests, bookings, and detentions at the PADF. Pls.' Add'l Facts Nos. 244, 251, 254, 255, 258, 270, 298, 302-03, 305-06, 316-17; Pls.' Resp. Facts Nos. 144. Defendants were required to give primary consideration to those requests -- even if they believed written communication to be sufficient, *see* Dkt. #197 at 44, 48 -- with the only limitation being those of the fundamental alteration or undue burden defenses, *see Robertson*, 500 F.3d at 1196 (citing 28 C.F.R. § 35.164), neither of which Defendants have asserted. It is at the very least a disputed issue of fact whether Defendants were required to provide a sign language interpreter to Ms. Burke and Mr. Krebs to ensure effective communication during their arrest and detention.

Defendants' argument that written communications would have been effective for Ms. Burke based on her letter-writing skills, *see* Dkt. #197 at 48, ignores two key points. First, the question is entirely hypothetical: Defendants refused to communicate with her even in writing. Pls.' Add'l Fact No. 255. In any event, Ms. Burke has testified that her primary language is American Sign Language, that while she can write notes in some situations, in complex situations such as those involving medical treatment or when under stress, she cannot communicate effectively in writing, and that she requires a sign language interpreter to

effectively communicate in situations involving medical or legal advice or decision making. Pls.' Add'l Fact No. 240. Thus while written communication may be effective where more time is available to communicate -- such as the time she is able to take to compose a letter -- a sign language interpreter is necessary for her to engage in a conversation or to receive complex information concerning her legal or health status. *Id.* The DOJ has made clear that giving primary consideration to Ms. Burke's request, as required by section 35.160(b)(2), "means that the public entity must honor the choice, unless it can demonstrate that another *equally effective* means of communication is available." Preamble, 28 C.F.R. pt. 35, app. A (emphasis added). Defendant presents no evidence that written communication is equally effective; again, Ms. Burke has raised at least a disputed issue of fact concerning the hypothetical effectiveness of written communication.

Defendants argue that Ms. Burke was not entitled to an interpreter during her arrest because she does not challenge the arrest for lack of probable cause. They argue that she was not entitled to an interpreter during her booking at the PADF and for her communications with the PADF nurse, and that Mr. Krebs was not entitled to one during his arrest, booking, and medical screen because "there was no communication that needed to occur, but did not." Dkt. #197 at 44-45, 47-48. This, again, misses the point. Just as the plaintiff in *Robertson* was entitled to effective communication during his probable cause hearing despite the fact that his lawyer participated and charges were dropped, *see id.*, 500 F.3d at 1199, Ms. Burke and Mr. Krebs were entitled to effective communication during their arrest and booking. Indeed, Defendants' argument that no communication was necessary during the booking process is almost identical to the argument -- rejected by the Tenth Circuit -- that no communication was necessary during Mr. Robertson's probable cause hearing. *Id.* Furthermore, the DOJ has made clear that for medical

communications, "an interpreter is likely to be necessary . . .." Title II Technical Assistance Manual § II-7.1000, Illustration 1.[12]

Finally, Defendants argue that the fact that Ms. Burke understood a single word -- "contempt" -- during the almost three hours the Denver Police were at her house means that effective communication was achieved. Dkt. #197 at 47-48. This does not constitute effective communication. Among other things, Ms. Burke testified that she did not know what this meant, Pls.' Resp. Fact No. 146, and without an interpreter, she did not have the opportunity to ask follow-up questions so that she could understand why she was being arrested. In addition, far more than one word was exchanged during the lengthy period the officers were at her house; under *Robertson* she was entitled to effective communication concerning the activities of the police officers in her home, not just a one-word account of the grounds for her arrest.

Ultimately, as established in the cases cited above, the question whether effective communication occurred is one of fact for the jury, precluding summary judgment.

4. Mr. Krebs Is Entitled to Effective Communication Without Having to Spend the Weekend in Jail to Secure Auxiliary Aids and Services.

Mr. Krebs's arraignment on municipal ordinance violations took place on March 30, 2007, the day after his arrest. Defs.' Fact No. 118. He requested an interpreter for this hearing, but was told that if he would have to remain at the PADF for an additional three days until an interpreter could be provided, but that if he pled guilty, he would be immediately released. As a result, Mr. Krebs pled guilty to all charges without waiting for an interpreter so that he could be released. Pls.' Add'l Facts Nos. 316-18. Mr. Krebs was in Defendants' custody throughout this interaction.

As an initial matter, Defendants had an obligation under section 35.160 to provide an

[12] http://www.ada.gov/taman2.html#II-7.1000 (last visited Jan. 18, 2010).

interpreter or ensure that Mr. Krebs could communicate his request to the court. As noted above, that regulation requires effective communication, and the commentary to that regulation requries that public entities "provide an opportunity for individuals with disabilities to request the auxiliary aids and services of their choice." Preamble, 28 C.F.R. pt. 35, App. A. In addition, Defendants are not permitted to "place a surcharge on a particular individual with a disability . . . to cover the costs of measures, such as the provision of auxiliary aids." 28 C.F.R. § 35.130(f). If Defendants cannot condition the receipt of auxiliary aids such as interpreters on the payment of money, even more can they not condition such measures on the agreement to forego one's liberty for three days.

Defendants' argument that Mr. Krebs is somehow seeking to invalidate his plea, again, misses the point: Mr. Krebs seeks no such thing, but rather had the right to effective communication regardless of the result of his arraignment hearing. *See Robertson*, 500 F.3d at 1199. As such, Defendants' reference to *Heck v. Humphrey*, 512 U.S. 477 (1994), is entirely misplaced. *See* Dkt. #197 at 47. Under *Heck* and its progeny, Mr. Krebs could not bring an ADA claim that had the effect of invalidating his plea. Where, however, "'plaintiff's action, even if successful, will *not* demonstrate the invalidity of any outstanding criminal judgment against the plaintiff, the action should be allowed to proceed.'" *Heck*, 512 U.S. at 487 (emphasis in original), *quoted in Martinez v. City of Albuquerque*, 184 F.3d 1123, 1126 (10th Cir. 1999). An award of damages for Defendants' failure to provide effective communication in no way impugns Mr. Krebs's plea or conviction.

D. Defendants Failed to Reasonably Accommodate Ms. Burke's Diabetes in Violation of Title II and Section 504.

Defendants had an obligation make reasonable modifications of their policies and procedures to ensure Ms. Burke did not suffer discrimination on the basis of her diabetes. *See* 28

C.F.R. § 35.130(b)(7) (Title II regulations); *Chaffin v. Kan. State Fair Bd.*, 348 F.3d 850, 857 (10th Cir. 2003) (section 504 requires reasonable accommodations; quoting *Alexander v. Choate*, 469 U.S. 287, 301 (1985)).[13]

When Ms. Burke was arrested, she had just administered insulin and was preparing dinner for herself and her family. Pls.' Add'l Fact No. 241. This meant that, to avoid dangerously low blood sugar levels, she would have to have access to food and medicine -- insulin and/or glucose pills -- while in Defendants' custody. *Id.* No. 239. Ms. Burke requested two modifications to Defendants' policies: (1) that she be permitted to have necessary medications accompany her when she was arrested, *id.* No. 247;[14] and (2) that Defendants provide her something to eat, *id.* No. 255. Defendants refused both, including their almost unfathomable refusal -- over the course of over four hours at the PADF -- to simply provide her a small snack. Defs.' Facts Nos. 152, 162; Pls.' Add'l Fact No. 270. (Defendants claim that Ms. Burke received a sack lunch, *see* Defs.' Fact No. 156; Ms. Burke denies this, and states that she was told she would have to wait until 4:30 in the morning before food would be made available. Pls.' Add'l Fact No. 270.)

Defendants' only available defense to the obligation to accommodate Ms. Burke's diabetes is that such a modification would "fundamentally alter the nature of the service, program, or activity." 28 C.F.R. § 35.130(b)(7); *see also Choate*, 469 U.S. at 300 (holding that, under section 504, a recipient of federal funds "need not be required to make 'fundamental' or 'substantial' modifications to accommodate the handicapped, [but] may be required to make 'reasonable' ones."). Defendants do not argue that permitting Ms. Burke to have her medication

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[13] "Although Title II of the ADA uses the term 'reasonable modification,' rather than 'reasonable accommodation,' these terms create identical standards." *McGary v. City of Portland*, 386 F.3d 1259, 1266 n.3 (9th Cir. 2004) (citation omitted).

[14] To be clear, Ms. Burke was not asking that *she herself* hold onto her medication while in police custody. Rather, her husband tried to give it to a police officer, but they refused to take it. Pls.' Add'l Fact No. 247.

accompany her to the police station or the PADF or providing her with a snack at sometime between 7:30 pm and 2:00 am would have fundamentally altered any part of their program.

Defendants' refusal to accommodate Ms. Burke's diabetes and deafness combined to produce a very dangerous result. When Defendants tested Ms. Burke's blood sugar level at approximately 10:00 p.m. -- at which time she had been suffering the symptoms of low blood sugar for some time -- Ms. Burke recalls that it was measured at 28, confirming that her blood sugar level was dangerously low. Pls.' Add'l Fact No. 265. Defendants, however, recorded a measurement 377, a very high level. *Id.* No. 264. As a result, Defendants gave her a shot of insulin, *id.* No. 268, precisely the wrong thing to have done under the circumstances, and one that exacerbated the effects of their discriminatory refusal to provide food in the previous three and a half hours. *Id.* No. 286. This interaction demonstrates the importance of "giv[ing] primary consideration to the requests of the individual with disabilities." *See* 28 C.F.R. § 35.160(b)(2). Had Defendants heeded Ms. Burke's requests -- as they were required by law to do -- she would have been able to receive the food she needed long before 10:00, and to clear up any misunderstanding concerning her blood sugar level.

E. Defendants' Decision to Isolate Mr. Vigil Based on His Disability Was a Violation of the ADA and Section 504.

In passing the ADA, Congress found that

> historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem.

42 U.S.C. § 12101(a)(2). Accordingly, the Supreme Court has recognized that "that unjustified institutional isolation of persons with disabilities is a form of discrimination . . .." *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 600 (1999). The Title II regulations require that, "[a] public

entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. § 35.130(d).

Defendants isolated Mr. Vigil based on the fact that he was deaf. Their "Admissions Assessment" for the PADF states, "Is deaf. Does not read lips. Does communicate by writing. Claims negative for all medical problems, in writing. *Housed alone for this reason*." Defs.' Fact No. 5 (emphasis added). The overwhelming evidence is that Mr. Vigil was housed by himself in the Special Management Unit at the DCJ because he was deaf. Deputy Sheriff Coleman did not even complete the paperwork on Mr. Vigil but was operating under a classification system that automatically called for placing inmates with "physical handicaps" in Administrative Segregation. *See* Pls.' Resp. Fact No. 31.

The record is thus in dispute whether Mr. Vigil was isolated based on his disability. At this juncture, the Court must presume that the sole reason for Mr. Vigil's segregation was his deafness. Defendants offer no justification for this measure. As such, this unjustified segregation constitutes a violation of the ADA and Rehabilitation Act.

F. Defendants' Failure to Train Its Employees Concerning the Requirements of the ADA and Section 504 Is Actionable Under Those Statutes.

It is undisputed that Defendants provided inadequate training concerning interaction with detainees with disabilities. *See generally* Pls.' Add'l Facts Nos. 44-69. For example, while the City provides a two-hour session regarding inmates who are deaf or hard of hearing as part of deputies' initial training at the Academy, Pls.' Add'l Fact No. 44, there is some evidence that this training did not begin until 2004. *Id.* No. 45. Lorrie Kosinski, the individual who provides this training, testified that she is not surprised that deputies do not remember information from her trainings, that she does not specifically train on ADA requirements, and that she would like to have more time for training. *Id.* Nos. 47-48. The City's Rule 30(b)(6) designee on training

testified that none of the deputies are trained in sign language, that he does not know training deputies received concerning accommodations for effective communication and was not aware of such training at the Academy. *Id.* Nos. 53, 55, 59. Deputies did not receive training concerning when it was appropriate to use written communications and when that might not be appropriate, for example, in medical communications or expecting inmates to read and comprehend legal forms. *Id.* No. 57.

This failure to train is actionable under the ADA and, accordingly, the Rehabilitation Act. In *Schorr v. Borough of Lemoyne*, 243 F. Supp. 2d 232 (M.D. Pa. 2003), for example, the plaintiffs' decedent -- who was mentally ill -- was shot and killed in a confrontation with police. The plaintiffs did not argue that the degree of force used by the individual officers was inappropriate in exigent circumstances, but rather that the police commission was liable under the ADA for failing to properly train those officers. *Id.* at 238. The court held that this stated a claim under the ADA. *Id.*; *see also Hogan v. City of Easton*, 2004 WL 1836992, at *7 (E.D. Pa. Aug. 17, 2004) (holding that "the Complaint states a valid claim under the ADA based on the failure of the City and County to properly train its police officers for encounters with disabled persons."); *cf. Camarillo v. Carrols Corp.*, 518 F.3d 153, 157 (2d Cir. 2008) (holding that a public accommodation's failure to train its employees in the requirements of Title III of the ADA can constitute a violation of that statute).

G. Defendants Provide No Evidence To Support Their Arguments that Plaintiffs Are Not Entitled to Compensatory Damages or Injunctive Relief.

Almost as an afterthought at the end of their brief section addressing the ADA and Section 504, Defendants make two arguments in two sentences, neither supported by sufficient evidence to satisfy Rule 56. Defendants assert that Plaintiffs did not prove intentional discrimination sufficient to claim compensatory damages. *See* Dkt. #197 at 49. They also argue

that because Mr. Vigil is deceased and Mr. Krebs and Ms. Burke have been released, Plaintiffs are not entitled to an injunction; they do not address Plaintiffs Colorado Cross-Disability Coalition and the Colorado Association of the Deaf (collectively "Organizational Plaintiffs"). *Id.* Because Defendants provide no evidence or case citations for the propositions (1) that Plaintiffs did not prove intentional conduct or (2) that the Organizational Plaintiffs' claims for injunctive relief are moot, Defendants have failed to carry their burden of production under Rule 56, and summary judgment as to all Plaintiffs' claims for compensatory damages and the Organizational Plaintiffs' claims for declaratory and injunctive relief must be denied. *See Trainor*, 318 F.3d at 979 ("If a moving party fails to carry its initial burden of production, the nonmoving party has no obligation to produce anything, even if the nonmoving party would have the ultimate burden of persuasion at trial. In such a case, the nonmoving party may defeat the motion for summary judgment without producing anything." (Internal quotation omitted.))

Plaintiffs have, in any event, alleged and proven facts sufficient to support compensatory damages and the Organizational Plaintiffs' claims for injunctive relief.

1. Plaintiffs Have Provided Sufficient Evidence of Intentional Conduct to Support Their Claims for Compensatory Damages.

To recover compensatory damages under the ADA and section 504, Plaintiffs must prove that Defendants' conduct was intentional. *See Barber v. Colo. Dep't of Revenue*, 562 F.3d 1222, 1228 (10th Cir. 2009). Intentional conduct does not require a showing of animosity or ill will, but rather "'can be inferred from a defendant's deliberate indifference to the strong likelihood that pursuit of its questioned policies will likely result in a violation of federally protected rights.'" *Id.* at 1228-29 (quoting *Powers v. MJB Acquisition Corp.*, 184 F.3d 1147, 1153 (10th Cir. 1999) and citing *Duvall v. County of Kitsap*, 260 F.3d 1124, 1139 (9th Cir. 2001)). Intent requires "(1) 'knowledge that a harm to a federally protected right is substantially likely,' and (2)

'a failure to act upon that . . . likelihood.'" *Barber*, 562 F.3d at 1229 (quoting *Duvall*, 260 F.3d at 1139). In this case, it is undisputed that Defendants were aware of Plaintiffs' disabilities and explicitly refused to accommodate them. Both Mr. Krebs and Ms. Burke requested interpreters and Ms. Burke requested accommodations for her diabetes; *see* Pls.' Add'l Facts Nos. 244, 247, 251, 254, 255, 258, 270, 298, 302-03, 305-06, 316-17; Pls.' Resp. Facts Nos. 144; with respect to all three Plaintiffs the need for sign language interpreters was obvious.[15] "When the plaintiff has alerted the public entity to his need for accommodation (or where the need for accommodation is obvious, or required by statute or regulation), the public entity is on notice that an accommodation is required, and the plaintiff has satisfied the first element of the deliberate indifference test." *Duvall*, 260 F.3d at 1139.

Plaintiffs also satisfy the second element: it is undisputed that Defendants never provided interpreters to Mr. Vigil, Mr. Krebs or Ms. Burke, nor did they permit Ms. Burke to be accompanied by her diabetes medication or provide her with a snack as was necessary to address her low blood sugar. The Tenth Circuit in *Barber* provided as "illustrative" of intentional conduct a case in which

> a police officer, despite having knowledge of the [hearing-impaired] arrestee's disability, administered sobriety tests with verbal instructions, interrogated him at length, and administered Miranda warnings without any accommodations to ensure the arrestee understood those proceedings. . . . Such a blatant disregard of the arrestee's disability was held to support a finding of deliberate indifference.

Id., 562 F.3d at 1230 (citing *Delano-Pyle v. Victoria County, Tex.*, 302 F.3d 567, 570-71, 575-76 (5th Cir. 2002)). Undertaking important police and correctional interactions -- arrest; booking; medical or psychological screening; and the like -- with an obviously deaf detainee but without

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[15] *See Robertson*, 500 F.3d at 1197 ("When a disabled individual's need for an accommodation is obvious, the individual's failure to expressly 'request' one is not fatal to the ADA claim.").

an interpreter is sufficient to find deliberate indifference.

2. The Organizational Plaintiffs' Claims for Injunctive Relief are not Moot.

Defendants assert that they are entitled to summary judgment on declaratory and injunctive relief because Mr. Vigil is deceased and Mr. Krebs and Ms. Burke have been released. Dkt. #197 at 49. Defendants do not, however, address the right of the remaining Plaintiffs -- the Colorado Cross-Disability Coalition and the Colorado Association of the Deaf (collectively "Organizational Plaintiffs") -- to such relief and the single case on which they rely -- *Green v. Branson*, 108 F.3d 1296, 1300 (10th Cir. 1997) -- concerns the effect of the release of individual plaintiffs on injunctive relief; it does not involve organizational plaintiffs.

As noted above, since Defendants did not present evidence or argument relating to the Organizational Plaintiffs' claims for injunctive relief, their motion for summary judgment on those claims must be denied. *See Trainor*, 318 F.3d at 979.

If this Court elects to review the evidence in support of these claims, it is undisputed that the missions of both Organizational Plaintiffs have been frustrated and both have had to divert scarce resources to identify and counteracting Defendants' discrimination. *See* Pls.' Add'l Facts Nos. 330-59. This is sufficient to establish the Organizational Plaintiffs' standing for injunctive relief.

To establish standing for injunctive relief, a plaintiff must show that:

> (1) she has suffered an "injury in fact" that is (a) concrete and particularized and (b) actual or imminent, not conjectural or hypothetical; (2) the injury is fairly traceable to the challenged action of the defendant; and (3) it is likely, as opposed to merely speculative, that the injury will be redressed by the relief requested.

Tandy v. City of Wichita, 380 F.3d 1277, 1283 (10th Cir. 2004) (citing *Friends of the Earth, Inc. v. Laidlaw Envtl. Servs., Inc.*, 528 U.S. 167, 180-81 (2000)). Standing under Title II of the ADA

and the section 504 extends to the "full limits of Article III," that is, there are no prudential limitations on standing. *Tandy*, 380 F.3d at 1287 & n.14.

Organizations such as CCDC and CAD can show injury-in-fact if they can show that Defendants' allegedly discriminatory conduct frustrated their anti-discrimination efforts or caused them to devote resources to identifying and counteracting the discriminatory practices. *See, e.g., Havens Realty Corp. v. Coleman*, 455 U.S. 363, 379 (1982); *see also, e.g., Equal Rights Ctr. v. Equity Residential*, 483 F. Supp. 2d 482, 486 (D. Md. 2007) ("Thus, to allege a redressable injury-in-fact caused by defendants under the FHA, plaintiff need only allege facts that demonstrate that the defendants' actions either have caused the organization to divert resources to identify and counteract the defendants' unlawful practices, or that the challenged actions have frustrated plaintiff's mission.") In *Smith v. Pacific Properties and Development Corp.*, 358 F.3d 1097 (9th Cir. 2004), for example, a disability rights organization alleged that it was organized with the purpose of eliminating discrimination against people with disabilities. As such, "[a]ny violation of the [Fair Housing Amendments Act] would therefore constitute a frustration of [its] mission." *Id.* at 1105 (quoting *Fair Hous. of Marin v. Combs*, 285 F.3d 899, 905 (9th Cir. 2002)).

Similarly, in *Equal Rights Center*, the organization showed diversion of resources by alleging that it undertook an investigation of the defendants' alleged discrimination. *Id.*, 483 F. Supp. 2d at 487. In *Smith*, actionable diversion of resources occurred when the plaintiff organization "monitor[ed] the violations and educate[d] the public regarding the discrimination at issue." *Id.*, 358 F.3d at 1105.

Based on the facts set forth above, the Organizational Plaintiffs have established injury-in-fact. There is also no question that this injury was caused by Defendants' discrimination.

See, e.g., Equal Rights Ctr. v. AvalonBay Cmtys. Inc., 2009 WL 1153397, at *6 (D. Md. Mar. 23, 2009) (holding that organization's diversion of resources to investigate discrimination was caused by that alleged discrimination).

Finally, because Defendants provide no evidence that they have ceased their practice of refusing to provide interpreters to detainees, it is predictable that the Organizational Plaintiffs will have to continue to devote scarce resources to investigating such conduct, counseling the victims of such conduct, and working to remediate such conduct. Pls.' Add'l Facts Nos. 345-47; 357-59. In any event, as noted above, Defendants do not argue that the Organizational Plaintiffs' claim for injunctive relief were moot. Had they made such an argument, they would have had to have met the standard set forth by the Supreme Court in *Friends of the Earth, Inc. v. Laidlaw Envtl. Servs. (TOC), Inc.*, 528 U.S. 167, 189 (2000): Defendants bear a "heavy burden" to show that "'subsequent events [make] it absolutely clear that the allegedly wrongful behavior could not reasonably be expected to recur.'" *Id.* at 189 (citations omitted). In the absence of any evidence whatsoever that the Organizational Plaintiffs' claims are moot, Defendants have not met this heavy burden.

III. THE CIVIL RIGHTS CLAIMS

A. Constitutional Right to Intimate Association.

Because Ms. Ulibarri did not bring this claim, there is no need to consider Defendants' argument found at Dkt. #198 at 43, § III.

B. Statutes of Limitation.

Defendants next argue that the claims against Lovingier, Foos, Wislon and Whitman in their individual capacity brought by Ulibarri and the Estate are barred by the two-year statute of limitation. Defendants are correct and these claims should be dismissed.

Defendants next argue that any civil rights claims by CCDC and CAD, the institutional Plaintiffs, that are "based upon the arrest and incarceration of Shawn Vigil" are also barred by the two year statute of limitations. Dkt. # 198 at 4. Defendants, however, misapprehend the nature of organizational claims.

As noted above, in *Havens Realty Corp. v. Coleman*, 455 U.S. 363 (1982), the United States Supreme Court held that an organization has standing to sue in its own right if alleges a personal stake in the outcome of the controversy so as to warrant invocation of federal court jurisdiction. *Id*. at 378-379. In *Havens*, the Court reviewed a claim of organizational standing by Housing Opportunities Made Equal (HOME), a nonprofit organization whose purpose was to make equal opportunity in housing available to residents in a metropolitan area. HOME claimed that it had been "frustrated by defendants' racial steering practices in its efforts to assist equal access to housing through counseling and other referral services." *Id*. at 379. Given these allegations, the *Havens* Court ruled that there can be no question but that the organization had suffered injury in fact because HOME had alleged "concrete and demonstrable injury to the organization's activities – with the consequent drain on the organization's resources. . .." *Id*.

In this case, CCDC and CAD have standing to sue in their own right. Both CCDC and CAD have provided facts to show that each has suffered injury in fact. Pls.' Add'l Fact Nos. 330 – 359. Thus, the claims of CCDC and CAD are not "based on" the claims of any of the individual Plaintiffs in this case – but rather injury to the organization itself. Thus, as the injury to both CCDC and CAD is on-going, Pls.' Add'l Fact Nos. 338-347 and 351-359, those claims are not barred by any statute of limitations.

Finally, even assuming *arguendo* that some portions of the claims of CCDC or CAD were based upon the arrest and incarceration of Shawn Vigil, the addition of these plaintiffs in

the Amended Complaint would not be barred by the statute of limitations. To the contrary, courts have routinely held that the additional of new plaintiffs to a case after the statute of limitations has expired is allowed and relates back to the date of the original complaint as long as the new plaintiffs do not allege new claims for relief. *See Am. Banker's Ins. Co. of Fla., et.al v. Colo. Flying Acad., Inc, et al.*, 93 F.R.D. 135, 136-137 (D. Colo. 1982)(Court allowed new plaintiff party after statute of limitations because no material difference in claims and defendants were not prejudiced by the addition.); *Ottawa County Lumber & Supply, Inc. et al v. Sharp Elecs. Corp*, 2004 WL 813768 at 42(D. Kan. Feb. 17, 1004) (Court allowed addition of plaintiffs after statute of limitation and found that it related back to original date of complaint as there was no prejudice to defendant.); *Stoppelman v. Owens*, 580 F. Supp. 944, 945-946 (D.D.C. 1983)(Court allowed the addition of several plaintiffs three months after the statute of limitations expired because addition did not alter the facts and issues on which the action was based.)

In the present case, the addition of the organizational plaintiffs in no way alters the facts and issues upon which the case is based, Defendants have had a full opportunity to defend the action with the additional Plaintiffs, and there is no prejudice to the Defendants by the lack of earlier notice of the addition of these Plaintiffs. Accordingly, even if the claims of the institutional Plaintiffs are somehow "based on" the claims of Mr. Vigil, they should be allowed to proceed and their claims should relate back to the filing of the original complaint.

C. The Law Governing Municipal Liability.

Defendants err in their recitation of the law as to what is required to establish municipal liability. After noting that civil rights claims against Defendants LaCabe, Lovingier, Foos, Wilson and Whitman in their official capacities are treated as claims against the City & County of Denver, a correct statement of the law, they conclude that because of their arguments about

each named Defendants' lack of liability in their individual capacities, there can be no municipal liability. Dkt. #197 at 49-50. Defendants appear to be arguing that because Plaintiffs sued these Defendants in their individual capacities, municipal liability can be premised only on misconduct by those Defendants. They are wrong.

Establishing municipal liability requires a showing of "(1) the existence of a municipal custom or policy and (2) a direct causal link between the custom or policy and the violation alleged." *Hollingsworth v. Hill*, 110 F.3d 733, 742 (10th Cir. 1997) (quotation omitted). Thus, municipal liability under § 1983 attaches where "a deliberate choice to follow a course of action is made from among various alternatives by the official or officials responsible for establishing final policy with respect to the subject matter in question." *Pembaur v. City of Cincinnati*, 475 U.S. 469, 483 (1986). For liability purposes, decisions made by officials with final policymaking authority have created policies for § 1983 purposes. *Id.* at 481. That decision is an act of the governmental entity which was "officially sanctioned or ordered." *Id.* at 480. Further, the failure to follow a policy that is lawful on its face may also result in municipal liability. "For all intents and purposes, ignoring a policy is the same as having no policy in place in the first place." *Woodward v. CMS*, 368 F.3d 917, 929 (7th Cir. 2004) (affirming jail's liability for condoning its employees' violating suicide prevention policies). "[A] municipality is responsible for *both* actions taken by subordinate employees in conformance with preexisting official policies or customs and actions taken by final policymakers, whose conduct can be no less described as the 'official policy' of a municipality." *Simmons v. Uintah Health Care Special Serv. Dist.*, 506 F.3d 1281, 1285 (10th Cir. 2007) (emphasis in original). A policy of inaction may also rise to the level of a municipal policy. Where there is a "widespread practice that, although not authorized by written law or express municipal policy, is 'so permanent and well

settled as to constitute a "custom or usage" with the force of law.'" *Kettering v. Larimer County Det. Ctr*., 2008 WL 4426268at *26 (D. Colo. 2008) (citing *City of St. Louis v. Praprotnik*, 485 U.S. 112, 127 (1988)); *see also Oviatt v. Pearce*, 954 F.2d 1470, 1477 (9th Cir. 1992) (holding that a custom of inaction sufficient to establish municipal liability). Additionally, "a plaintiff need not show that the policy promulgated by the municipality is unconstitutional in every application; proof that the policy is unconstitutional as applied in the plaintiff's case will suffice." *Brown v. Whitman*, 651 F. Supp. 2d 1216, 1227-28 (D. Colo. 2009) (citing *Christensen v. Park City Municipal Corp*., 554 F.3d 1271, 1279 (10th Cir. 2009)). Municipal liability can also rest upon a demonstration of a custom that is "so permanent and well settled as to constitute a custom or usage with the force of law." *City of St. Louis v. Praprotnik*, 485 U.S. 112, 127 (1988) (quotation omitted); *see also Moss v. Kopp*, 559 F.3d 1155, 1168-69 (10th Cir. 2009).

Thus, municipal liability arises out of a municipality's established policies, customs and practices—which may be unrelated to the misconduct elsewhere attributed to a government employee sued in his individual capacity. Indeed, a grant of qualified immunity for a defendant sued in his individual capacity does not necessarily result in a municipality's exculpation. For example, in *Dill v. City of Edmond*, the municipality was liable for a due process violation despite upholding a grant of qualified immunity to the City's Chief of Police. The court made this ruling because the qualified immunity determination was based on the court's conclusion that the law was not clearly established at the time of the constitutional violation. 155 F.3d 1193, 1212 (10th Cir. 1998) (abrogated on other grounds by *Crawford-El v. Britton*, 523 U.S. 574 (1998)).

Another principle of municipal liability at work here is that decision makers cannot protect a governmental entity from liability simply by delegating their decision making authority.

Randle v. City of Aurora, 69 F.3d 441, 448 (10th Cir. 1995). Three facts must be considered in determining who is a final decision maker: (1) whether the governmental official is constrained by policies not of his making, (2) whether the decision is final or is subject to review by another, and (3) whether the decision touches on issues with the grant of authority given to the official. *See also Praprotnik*, 485 U.S. 112, 127 (1988) (plurality op.); *Randle,* 69 F.3d at 448.

Because Defendant LaCabe is a final decision maker, his unlawful policies, as well as the practices he tolerated created municipal liability. It should be beyond dispute that Defendant LaCabe is a final policymaker. McCabe was appointed as Denver's Manager of Safety in 2003. Dkt. #197 at 33, ¶ 184. Under Denver's Municipal Code, the Manager of Safety "exercises the powers and performs the duties of sheriff under the laws of the state." Denver Muni. Code at § 14-122, By Colorado statute, sheriffs have the authority and responsibility to oversee county jails. C.R.S. § 30-10-511. Thus, Defendant LaCabe, as Manager of Safety, is the final policymaker for matters concerning the operation of the PADF and the DCJ. *See Cortese v. Black*, 838 F.Supp. 485, 496 (D. Colo. 1993). Because LaCabe is a final policy maker and decision maker for the City & County of Denver, his acts are the acts of the City including all constitutional and federal law violations. *Tunget v. Board of County Comm'rs of Delta County*, 992 P.2d 650, 651-52 (Colo. App. 1999).

D. The Law Governing Individual Capacity Claims.

Flowing from their contention that Plaintiffs have no evidence that any constitutional or federal statutory rights were violated, Defendants contend that all of Plaintiffs' claims against Defendants LaCabe, Lovingier, Foos, Wilson and Whitman in their individual capacities are barred by the doctrine of qualified immunity. Dkt. #198 at 44-48.

Qualified immunity balances two competing and fundamentally important interests: "the need to hold public officials accountable when they exercise power irresponsibly and the need to shield officials from harassment, distraction, and liability when they perform their duties reasonably." *Pearson v. Callahan*, 129 S. Ct. 808, 815 (2009). Officials who act reasonably are shielded from "civil damages liability as long as their actions could reasonably have been thought consistent with the rights they are alleged to have violated." *Anderson v. Creighton*, 483 U.S. 635, 638 (1987) (citations omitted); *see also Richardson v. McKnight*, 521 U.S. 399, 407-08 (1997). In practice this means these officials are entitled to immunity only "'if their conduct does not violate clearly established rights of which a reasonable government official would have known.'" *Graves v. Thomas*, 450 F.3d 1215, 1218 (10th Cir. 2006). As demonstrated below, these individual Defendants failed to act reasonably in refusing to accommodate the needs of deaf and diabetic inmates at the PADF and at the DCJ.

Thus, when a defendant sued in his individual capacity seeks qualified immunity, a plaintiff "must show that (1) the official violated a constitutional or statutory right; and (2) the constitutional or statutory right was clearly established when the alleged violation occurred." *Mimics, Inc. v. Village of Angel Fire,* 394 F.3d 836, 841 (10th Cir. 2005) (internal quotation marks omitted). For a constitutional right to be clearly established, its contours must be sufficiently clear that a reasonable official would understand that what he is doing violates that right. This is not to say that an official action is protected by qualified immunity unless the very action in question has previously been held unlawful, *Mitchell v. Forsyth*, 472 U.S. 511, 535 (1985), but it is to say that in the light of pre-existing law, the unlawfulness must be apparent. *Anderson v. Creighton*, 483 U.S. 635, 640 (1987). In *Pearson v. Callahan*, the Supreme Court held that federal courts have the discretion to determine "which of the two prongs of the qualified

immunity analysis should be addressed first in light of the circumstances in the particular case at hand." *Id.* at 818.

E. Eighth and Fourteenth Amendment Claims

Defendants make two arguments in an effort to absolve themselves from liability under the Eighth and Fourteenth Amendments: (1) the municipality of the City & County of Denver is not liable because no one at DCJ had reason to know that Mr. Vigil was suicidal and (2) none of the Defendants named in their individual capacities were aware of his detention and could not have acted to his detriment. Each argument lacks merit.

1. The Municipality is Liable to Plaintiffs for Its Violations of the Eighth and Fourteenth Amendments.

Because of multiple conflicting issues of fact regarding even the existence of Defendants' policies and customs, dismissing Plaintiffs' municipal liability claims would be improper. Defendants identify two policies they claim were in place during the relevant time periods. They then proceed to argue that the policies are lawful on their face and as a result, neither policy could have resulted in harm to the Plaintiffs. (Plaintiffs specifically incorporate Pls.' Add'l Fact Nos. 32-34, 35-37, 43, 71-82, 89-93, 98-99; see also discussion of constitutionally inadequate training and supervision.) Because there are multiple factual disputes about the existence and content of Denver's policies, practices and customs regarding the treatment of deaf or hard of hearing inmates and disabled inmates, Plaintiffs' municipal liability claims should not be summarily dismissed.

The two policies identified by Defendants are:

- The official policy of the City & County of Denver was to make sign language interpreters available to the Denver Sheriff and Police Departments twenty-four (24) hours a day, seven (7) days a week. Dkt. #197 at 51.

- The official policy of the City & County of Denver was that deaf or hard of hearing inmates had the same access to a TDD as hearing inmates did with telephones. *Id.*

As to the first policy, the interpreter policy, the only evidence of this policy is Lorrie Kosinski's affidavit; Defendants have yet to provide any other documentation that sign language interpreters were available "24/7." There is also conflicting evidence as to whether the deputy sheriffs, or their superiors, knew of such a policy. For example, Deputy Sheriff Coleman, a classification officer at the DCJ could not recall whether there was policy in 2005 about providing a sign language interpreter for deaf or hard of hearing inmates. Pls.' Add'l Fact No. 69. Deputy Sheriff Pablo did not know the procedure for bringing a sign language interpreter to the jail. Pls.' Add'l Fact No.79. In December 2008, Deputy Sheriff Pacheco still did not know the procedure for bringing a sign language interpreter to the DCJ and was unaware of any procedure for doing so. Pls.' Add'l Fact No. 90. Sergeant Romero, a 30(b)(6) designee, described Lorrie Kosinski as being the on-call sign language interpreter. Pls.' Add'l Fact No. 77. Romero also testified that there was no written policy in 2005 advising deputies about the services offered by Ms. Kosinski's office. *Id.* Not until May 5, 2009, was a policy issued requiring classification deputies to contact Kristen Spakes, a case manager in Building 22A at the DCJ, when conducting a classification or a primary security assessment of a deaf inmate. Ex. 5, Romero Dep. 64:21 – 65:19. Ms. Spakes is not a certified American Sign Language interpreter. Ex. 5, Romero Dep. 73:24 – 74:1. To this day, Defendants have provided no documentation or testimony that interpreter services were ever provided to the PADF or to the DCJ.

Equally troubling is Denver's assertion that hearing impaired inmates were afforded the same access to a telephone as hearing inmates. This is simply not true. Although Ms. Burke did

not use a TDD telephone, the one provided to her at the PADF would not allow her to make a relay call. Pls.' Add'l Fact No. 271. At the DCJ, the TDY telephone was locked in the sergeant's office well away from the Special Administration tiers. Pls.' Resp. Fact No. 35. The Inmate Handbook contained no information about the phone or how to access it. Pls.' Resp. Fact No. 33. Moreover, during depositions, including depositions of fact witnesses and 30(b)(6) witnesses, no one was able to explain how a deaf inmate would know about the existence of the TDY telephone. In fact, when Ms. Ulibarri called the jail to find out why her son was not calling home, she was told that the TDY telephone was broken. Pls.' Resp. Fact No. 54. Thus, although Denver argues that it had two lawful policies governing effective communication for deaf inmates, the facts establish the contrary: if the policies governing the use of a TDD telephones existed, the Defendants' practice was to ignore them. *Woodward*, 368 F.3d at 929.

Significantly, a policy unacknowledged in Denver's briefing is unlawful on its face, its classification policy. Classification officers at the DCJ relied upon a Post Order in deciding where to house inmates. *See* Denver Department of Safety, COJL Posts Order, Building 6 at 1, §§ I.A(1-7). Ex. 27., All inmates in Building 6 where Mr. Vigil was housed received classification codes depending upon their sexual identity, medical issues, addiction issues or even a physical disability. *Id.* at 16, § F. Mr. Vigil was classified as "X 07A." Ex. 28, List of Housing Assignments for Shawn Vigil . This classification is reserved for inmates with drug or alcohol addictions, emotionally or mentally disturbed inmates or "physically handicapped" inmates.

Defendants applied this policy to Mr. Vigil. During his deposition, Classification Officer Coleman unequivocally stated that Mr. Vigil received the X07A classification and placement

into Building 6 because of his deafness. Pls.' Resp. Fact No. 28. ("If he was deaf, it would be X07A.").

2. The Municipal Defendants' Policies, Practices and Customs Violated Mr. Vigil's, Mr. Krebs's and Ms. Burke's Constitutional Rights to Adequate Medical Care.

The municipal Defendants are liable under § 1983 for the acts of Defendant LaCabe, who was the Manager of Safety and the final policymaker in matters regarding the PADF and the DCJ. Defendant LaCabe with actual knowledge acquiesced in, *inter alia*, the following conduct, which caused or contributed to the claimed constitutional violations. Municipal liability is established where the municipality, through its decision makers, made a deliberate choice to follow a particular course of action that results in a violation of a plaintiff's constitutional and/or federal rights.[16] *Pembauer v. City of Cincinnati*, 475 U.S.469, 478-79(1986).

Here, the multiple failures by LaCabe and the Division Chiefs who also set policy for the PADF and DCJ precluded Mr. Vigil, Mr. Krebs and Ms. Burke from receiving constitutionally minimal medical care. There is plentiful evidence, certainly enough to defeat summary judgment, that it was the Defendants' written practice and custom to refuse to accommodate deaf inmates in any manner. Pls.'Add'l Fact Nos. 36, 37. It is undisputed that no interpreters were provided for Mr. Vigil, Mr. Krebs or Ms. Burke, or for any other deaf person at either the PADF or the DCJ. Pls.' Add'l Fact Nos. 72, 88-95. Moreover, the custom and practice at the PADF and the DCJ was to house deaf inmates alone and to preclude them from participating in the activities available to inmates in the general population. Pls.' Add'l Fact Nos. 27, 34, 36. There were no written policies in place at the DCJ concerning how to communicate with deaf inmates, and the . Pls.' Add'l Fact Nos. 76, 78.

[16] Municipalities are not entitled to a qualified immunity defense. *Owen v. City of Independence*, 445 U.S. 622, (1980)

These same final decision makers also failed to provide minimally adequate medical care to Ms. Burke when she was in the midst of a serious diabetic episode. These deficiencies are not surprising in light of the lack of policies concerning the welfare of inmates with diabetes. Pls.' Add'l Fact Nos. 228-236. According to Deeds, the Division Chief for the PADF, meals at that facility were provided on a strict schedule. Pls.' Add'l Fact No. 229. There were no policies in place for monitoring diabetics. Pls.' Add'l Fact No. 230. Than, Defendants' 30(b)(6) designee regarding the training of deputies on diabetic issues, did not know of *any* training regarding diabetics prior to October 2008. Pls.' Add'l Fact No. 231-236 When Ms. Burke asked to have her blood sugar level checked, because she had given herself her insulin shot seven-and-one-half hours earlier, Pls.' Add'l Fact No. 257, the nurse did not know where the monitor was, and when he finally located it, did not know how to use it. Pls.' Add'l Fact Nos. 261-265.

Deaf inmates and inmates with diabetes are a substantial part of the American population. This means that on any given day, deaf inmates and inmates with diabetes can be arrested and then placed in the custody of the Denver Sheriff's Department. Yet, the City has no adequate policies or procedures in place. Given the City and County of Dennver's shocking lack of adequate policies, training and supervision at the PADF and DCJ regarding deaf inmates and diabetic inmates, summary judgment should not be granted on Plaintiffs' municipal liability Eighth Amendment claims.

3. The Failures of the Individual Defendants to Institute Compliance With the Section 504 and the ADA Resulted in Violations of Mr. Vigil's Rights Under the Eighth Amendment.

Mr. Vigil was incarcerated at DCJ as a pre-trial detainee. The protections afforded to pretrial detainees accrue through the Fourteenth Amendment's Due Process Clause while convicted prisoners are protected by the Eighth Amendment's Cruel and Unusual Punishments

Clause. Nonetheless, both groups of prisoners are "entitled to the same protection . . . 'against deliberate indifference to their serious medical needs.'" *Meade v. Grubbs*, 841 F.2d 1512, 1530 (10th Cir. 1988) (quoting *Garcia v. Salt Lake County*, 768 F.2d 303, 307 (10th Cir. 1985)). As a practical matter then, the protections afforded to both categories of prisoners are identical. *Ginest v. Bd. of County Comm'rs*, 333 F. Supp. 2d 1190, 1195 (D. Wyo. 2004).[17] Prison officials are obligated to provide "adequate medical care." *Id. at* 1196 (citing to *Estelle v. Gamble,* 429 U.S. 97, 103 (1976)). This affirmative obligation extends to both physical and mental health conditions. *Olsen v. Layton Hills Mall*, 312 F.3d 1304 (10th Cir. 2002); *Sutton v. Utah State Sch. for the Deaf & Blind*, 173 F.3d 1226, 1240 (10th Cir. 1999). The Eighth Amendment "also protects against future harm to an inmate." *Hunt v. Uphof*, 199 F.3d 1220, 1224 (10th Cir. 1999). A "serious medical need" includes preemptive care to "protect an inmate against a future risk." *See Helling v. McKinney*, 509 U.S. 25, 32-33 (1993); *Hunt* at 1224, *Ginest* at 1197; *Doty v. County of Lassen*, 37 F.3d 540, 546 (9th Cir 1994) (holding that a prisoner has a serious medical need if the failure to treat the condition could result in further significant injury). Additionally, the inadequate keeping of medical records creates a "grave risk of unnecessary pain and suffering," the Eighth Amendment is violated. *Cody v. Hillard*, 599 F.Supp. 1025, 1057 (D. S.D. 1984).

These constitutional duties are in place because of an inmate's necessary and nearly total reliance on his jailers to provide for his most basic needs, including his medical needs:

> [E]lementary principles establish the government's obligation to provide medical care for those whom it is punishing by incarceration. An inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met. In the worst cases, such a failure may actually produce

[17] For reading ease, Plaintiffs will simply refer to the Eighth Amendment rather than the Fourteenth Amendment.

> physical "torture or a lingering death," . . . , the evils of most immediate concern to the drafters of the Amendment. In less serious cases, denial of medical care may result in pain and suffering which no one suggests would serve any penological purpose. The infliction of such unnecessary suffering is inconsistent with contemporary standards of decency as manifested in modern legislation codifying the commonlaw view that "it is but just that the public be required to care for the prisoner, who cannot by reason of the deprivation of his liberty, care for himself."
>
> *Estelle v. Gamble*, 429 U.S. at 103-104

To prove that jail officials violated the Eighth Amendment requires proof that: (1) a prisoner faced "a substantial risk of serious harm," which is an objective inquiry; and (2) the prison official was deliberately indifferent to the prisoner's health or safety, a subjective inquiry. *Farmer v. Brennan*, 511 U.S. 825, 834 (1994). A "substantial risk of harm" includes the risk of death. Under *Garrett v. Stratman*, a "substantial risk of harm" "may be satisfied by lifelong handicap, permanent loss, or considerable pain." 254 F.3d 946, 950 (10th Cir. 2001). This necessarily encompasses death.

"Deliberate indifference" lies "somewhere between the poles of negligence at one end and purpose or knowledge at the other." *Farmer*, 511 U.S. at 836; *Mata v. Saiz*, 427 F.3d 745, 752 (10th Cir. Colo. 2005). Therefore, a plaintiff seeking to recover under the Eighth Amendment need only show recklessness, not an "express intent to harm." *Mitchell v. Maynard*, 80 F.3d 1433, 1442 (10th Cir. 1996). The *Farmer* decision equated "deliberate indifference" with criminal recklessness, which in turn can be established through circumstantial evidence. *Farmer* at 837-38, 843. Prison officials may not ignore or turn a blind eye to the obvious. *Id.* at 842 & n.8.

"*Prison officials show deliberate indifference to serious medical needs if prisoners are unable to make their medical problems known to the medical staff*." *Hoptowit v. Ray*, 682 F.2d

1237, 1253 (9th Cir. 1982) (emphasis added). For deaf prisoners, failing to provide qualified interpreters or other needed assistive devices for medical and mental health treatment where "communication between patient and medical personnel is essential to the efficacy of treatment, violated the Eighth Amendment's proscription against cruel and unusual punishment." *Clarkson v. Coughlin*, 898 F. Supp. 1019, 1033 (S.D.N.Y. 1995).

Individual supervisory liability may found under § 1983 when a reasonable person in the supervisor's position would have known that his conduct infringed a plaintiff's constitutional rights, and his conduct bore a causal relationship to the subordinate's constitutional violation. *Greason v. Kemp*, 891 F.2d 829, 836 (11th Cir. 1990) (finding deliberate indifference by supervisors to an inmate's psychiatric needs).

Plaintiffs incorporate herein by reference Pls.' Add'l Fact Nos. 55, 59-61, 64-65, 67-69, 77-131, 170-179, 183-184, 228-236, 243, 282-286, 293-294, 298, 303-318, 316, 331. As established by Plaintiffs' responses to Defendants' "undisputed" facts and Plaintiffs' additional facts, there is overwhelming evidence that deputies at the PADF and DCJ either receive no training or constitutionally defective training and that the employees who work directly with inmates are proceeding as they always have. The record also establishes that there is no substantive training at the PADF or DCJ regarding the Rehabilitation Act or the ADA. These are institutionalized failures and as such, are the responsibility of the Defendants sued in their individual capacities. It is, therefore, the failure by each of the supervisory Defendants, LaCabe, Lovingier and Foos, in their individual capacities, to accommodate Mr. Vigil's deafness that resulted in his being denied access to all medical treatment, including psychiatric treatment or mental health counseling, which violated his Eighth Amendment right to be free from cruel and unusual punishment. There is a direct causal relationship between these Defendants' depriving

Mr. Vigil of the ability to communicate his need for healthcare and his resulting death. These Defendants cannot argue that they acted reasonably in violating the Rehabilitation Act and the ADA, which were enacted in 1973 and 1990 respectively, and which were intended in part, to ensure that disabled persons were no longer denied access to medical treatment.

"Once a public entity has knowledge of an individual's disability, the entity must also have knowledge that an individual requires an accommodation of some kind to participate in or receive the benefits of its services." *Robertson v. Las Animas County Sheriff's Dep't.*, 500 F.3d 1185, 1197 (10th Cir. 2007). The *Robertson* case also involved a deaf inmate who was held in the county jail and denied any accommodation despite needing to speak with his attorney and attend a court hearing. Although the case raises no direct Eighth Amendment concerns, it illustrates how violations of the Rehabilitation Act and the ADA by county jails who refuse to accommodate deaf inmates can result in constitutional violations. *See also Brown v. King County Dept of Adult Corrections*, 1998 U.S. Dist. LEXIS 20152 at **30-33 (S.D. Ohio 2002) (denying summary judgment on § 1983 claim based on violations of a deaf inmate's Rehabilitation and ADA rights); *Center v. City of West Carrollton*, 227 F.Supp.2d 863, 872 (S.D. Ohio 2002) (same); *Hanson v. Sangamon County Sheriff's Department*, 991 F.Supp. 1059, 1063-64 (C.D. Ill. 1998) (denying motion to dismiss § 1983 claim and defense of qualified immunity arising out of the arrest and detention of a deaf man).

One of the constitutionally necessary services of a jail is to provide adequate medical care and treatment for prisoners. *Estelle v. Gamble*, 429 U.S. 97. The policy and practice at the DCJ was to provide *no* accommodation for deaf inmates, including any assessment of the most effective way to communicate with these inmates, to assure that their most basic needs, such as medical care, could be met. If the need for accommodation is obvious, or statutorily required, the

public entity is on notice that an accommodation is required. *Robertson*, 500 F.3d at 1197. Prisons also have a duty to identify and treat prisoners with mental health issues, which includes identifying potentially suicidal inmates.

Defendants also argue that because Mr. Vigil's jail records contain no indication that he was suicidal, they cannot be liable under the Eighth Amendment. Dkt. #198 at 46-47. There are multiple problems with this proposition. First, the accuracy, and therefore the reliability, of the records is doubtful because they were created without any effective communication with Mr. Vigil. The records are also disastrously incomplete. For example, the Mental Health Screening contains little information beyond Mr. Vigil's name and DPD#. The weekly nursing segregation round records are no more valid –they too contain no real information beyond Mr. Vigil's identification. And, although all but one of the segregation forms indicates that Mr. Vigil had no complaints,[18] there is no way to know how the nursing staff communicated with Mr. Vigil—or even if they did. *Id. See, e.g*, Ex.43 which contains only Mr. Vigil's temperature and blood pressure, information that can be obtained without any communication whatsoever. Additionally, although Defendants attempt to rely on the nursing medication rounds as an additional basis for proving they had no way of knowing about Mr. Vigil's suicidal thoughts, the deposition testimony is that if an inmate was not receiving medication, the nurses only checked to make sure everyone else was "breathing." Pls.' Resp. Fact No. 37.

Second, while Denver relies upon an affidavit from Dr. Crum who apparently "analyzed" Mr. Vigil's jail records and concluded that Mr. Vigil had "ample opportunity to seek medical attention if needed," and his suicide could not have been prevented, [19] Dr. Crum's conclusions are as flawed as the jail records and amount to nothing more than speculation. Certainly, Dr.

[18] No boxes are checked on 000128. See Ex. A-6 from Dkt. #198 and attachments thereto.
[19] Defendants failed to identify Dr. Crum or provide a report as required by Fed.R.Civ.P. 26(a)(2). For this reason, Plaintiffs have moved to strike portions of Dr. Crum's affidavit.

Crum never examined or met with Mr. Vigil. The report from Dr. Haley, Defendants' expert witness, and upon which Denver also attempt to rely, should be disregarded for his total reliance on the same inadequate records. Moreover, his credibility is severely tarnished by the ongoing DOJ investigation of his management of the Mobile County City Jail and his contempt of court citations when he was Commissioner of the Alabama Department of Corrections.

The cases the Denver Defendants rely upon for their lack of knowledge about Mr. Vigil's suicidal thoughts are readily distinguishable from the instant case—because the prisoners in those cases had the ability to communicate with their jailers-- something Mr. Vigil was unable to do. For example, in *Barrie v. Grand County*, the detainee had no difficulties in communicating with jail officials and affirmatively denied being suicidal. He also asked for a lawyer and refused to be interviewed by the police. The detainee was also routinely observed during regular rounds. Under the facts of that case, the test devised by the Tenth Circuit: that a government official "acts with deliberate indifference, if its conduct (or adopted policy) disregards a known or obvious risk that is very likely to result in a violation of the prisoners constitutional rights," is appropriate. 119 F.3d 862, 869 (10th Cir. 1997). Here, however, Mr. Vigil was never offered the opportunity to communicate his distress as did the detainee in the *Barrie* case; and, the reason he was unable to do so, must be laid directly at the feet of the Defendants—not Mr. Vigil. He could not communicate with anyone at the jail, including health care workers; he did not know how to ask for help and was never told how to in a way that he could understand; he could not write beyond the first or second grade level, he could not sign, he could not call his family. He could not even watch close captioned television. Completely isolating a deaf man, who was facing substantial time in prison—which to him must have looked like an eternity of utter loneliness based on his incarceration at DCJ—is deliberate indifference. Defendant's conduct and policy

was to isolate the deaf, solely because of their deafness. Because Defendants muzzled Mr. Vigil, they should not be allowed to prevail on the argument that they knew of no specific risk that Mr. Vigil would commit suicide.

Estate of Hocker v. Walsh, 22 F.3d 995, another jail suicide hanging case also relied upon by the Defendants, is distinguishable for similar reasons. There, Ms. Hocker had multiple opportunities to communicate, and she used them. She spoke with the police officers who arrested her, spoke with jail staff, and appeared in court twice. She also met with her attorney, who noticed nothing out of the ordinary. Despite the multiple opportunities to seek help, Ms. Hocker remained silent with no outward signs of distress. Mr. Vigil, however, had none of these opportunities, and the reason he could not was because he was denied effective communication and had no means of seeking medical help.

Another deliberate indifference case, albeit not a jail suicide case, is instructive here, *Oxendine v. Kaplan*, 241 F.3d 1272 (10th Cir. 2001). In *Oxendine*, a prison physician performed surgery reattaching one of the prisoner's fingertips when it had been accidentally caught in a cell door. Recovery went poorly (the reattached fingertip was turning black), a fact of which the prisoner repeatedly informed the prison healthcare staff, who nonetheless failed to send the prisoner to a specialist. *Id.* at 1278. There, the court held that the delay in seeking appropriate medical treatment satisfied the subjective component of the deliberate indifference standard. In reaching that decision, the court relied on the principle that deliberate indifference may be shown "when prison officials prevent an inmate from receiving treatment or *deny him access to medical personnel capable of evaluating the need for treatment*." *Id.* at 1277-79 (citing *Sealock v. Colorado*, 218 F.3d 1205, 1211 (10th Cir. 2001) (emphasis added in *Oxendine*). Here, because of the denial of a sign language interpreter, and an inability to read and understand the provisions of

the Inmate Handbook, Mr. Vigil was denied access to appropriate medical personnel, or even to meet with the ARB. Substantively, precluding an inmate from effectively communicating his serious medical needs is no different from those cases where a prison official ignores an inmate's need for medical treatment.

Long before 2005, the law was well established that the Rehabilitation Act and the ADA applied to municipal jails. *Penn. Dep't of Corrs. v. Yeskey*, 524 U.S. 206 (1998). These Defendants in their individual capacities acted beyond unreasonably in choosing to ignore federal laws mandating the protection of disabled inmates, including Shawn Vigil. The shame of it is that two years after his death, they still refused to provide sign language interpreters for Roger Krebs and Sarah Burke.

F. Defendants Substantially Enhanced the Danger To Mr. Vigil, Which Culminated in His Suicide.

The Estate of Vigil[20] and Sarah Burke each brought state created substantive due process claims (Fourth Claim for Relief in Plaintiffs' Second Amended Complaint, Dkt. # 48 at 28-31). Defendants argue that state created danger claims must be dismissed because neither the Estate of Vigil nor Plaintiff Burke can show misconduct that shocks the conscience under a theory of municipal or individual liability. Dkt. #198 at 48-54.[21] A state created danger claim is founded on state actors' creating or enhancing "the danger that harmed that individual." *Uhlrig v. Harder*, 64 F.3d 567, 572 (10th Cir. 1995); *see also DeShaney v. Winnebago County Dep't of Soc. Servs.*, 489 U.S. 189, 189-90 (1989).

[20] Plaintiffs inadvertently identified Debbie Ulibarri as bringing a substantive due process on behalf of herself. Additionally, given the information provided by Defendants in their summary judgment motions, Plaintiffs agree that there is no individual capacity claim against Defendant Lovingier arising out of the events culminating in Mr. Vigil's death. Additionally, the Vigil Plaintiffs brought no claims against the Denver Police Department and will not, therefore, respond to Defendants' argument as to Mr. Vigil.

[21] Despite asking that all of Plaintiffs' claims for relief in the Second Amended Complaint be dismissed on summary judgment, Defendants made no argument regarding municipal liability and their Fourth Claim for Relief.

The controlling legal principles for establishing a state created danger claim are as follows:

> (1) state actors created the danger or increased the plaintiff's vulnerability to the danger in some way,
>
> (2) the plaintiff was a member of a limited and specifically definable group,
>
> (3) the defendants' conduct put the plaintiff at substantial risk of serious, immediate, and proximate harm,
>
> (4) the risk was obvious or known,
>
> (5) the defendants acted recklessly in conscious disregard of that risk, and
>
> (6) the conduct, when viewed in total, shocks the conscience of federal judges.
>
> *Robbins v. Okla.*, 519 F.3d 1242, 1251 (10th Cir. 2008).

The Tenth Circuit explained the meaning of the first element of this test, namely that state actors create or enhance the danger or otherwise increase a plaintiff's vulnerability to harm, in *Armijo v. Wagon Mound Pub. Schs.*, 159 F.3d 1253 (10th Cir. 1998). There, parents sued a school and several school officials in their individual capacities when their son committed suicide after being suspended from school. A school official delivered the student to his empty family home without notifying his parents. The school also knew that the son had repeatedly expressed thoughts of suicide and that, and he had access to firearms in his home. After arriving home, the boy killed himself with one of those guns. *Id.* at 1256-57. Finding these facts adequate to establish a state created danger claim, the Tenth Circuit affirmed the district court's refusal to grant summary judgment to two of the individual defendants. *Id.* at 1264.

With regard to the first element and Mr. Vigil, there is no evidence that he was suicidal before he was incarcerated, but, he had routinely met with a therapist for counseling, sometimes

daily, when he was a student at Colorado School for the Deaf and the Blind to help him control his frustration at not being understood and depression. Pls.' Add'l Fact Nos. 4-14. Mr. Vigil had also asked for additional counseling after leaving school. *Id.* at 15. Without an adequate mental health assessment—and there was none—Mr. Vigil's emotional distress had no outlet. Furthermore, the Denver Defendants acted affirmatively in classifying Mr. Vigil as needing to be housed alone and away from the general population, simply because he was deaf. Given his extant stresses—being deaf in a world geared for hearing persons—these Defendants increased the danger and Mr. Vigil's vulnerability to emotional collapse. He was left alone in a cell with a sheet to hang himself from an exposed vent.

Defendants also enhanced Ms. Burke's vulnerability to danger. *Ulrig v. Harder*, a case heavily relied upon by Defendants, referred to a case from the Ninth Circuit as "the classic case of state actors creating a danger" so as to give rise to 1983 liability, *Wood v. Ostrander,* 879 F.2d 583 (9th Cir. 1989). In *Ostrander*, police officers placed plaintiff in danger by impounding her car and abandoning her in a high crime area at 2:30 a.m., thereby "distinguishing Wood from the general public and triggering a duty of the police to afford her some measure of peace and safety.'" 879 F.2d 583, 589-90 (9th Cir. 1989), *cert. denied*, 498 U.S. 938 (1990). *Ulrig v. Harder*, 64 F.3d 567, 572 (10th Cir. 1995).

What happened to Wood is nearly identical to the Denver Sheriff's Department treatment of Sarah Burke. They did not tell her that her husband was coming to take her home and expected to arrive at the PADF at approximately 3 a.m. Pls.' Add'l Fact No. 272. She asked for assistance in contacting her husband and was shown the TTY telephone, but it was broken. *Id.* at 271. Having full knowledge of her deafness, the police escorted Ms. Burke outside the PADF and left her alone in downtown Denver in the middle of the night with some bus tokens. No

public transportation was available, and Ms. Burke did not know how to use RTD. *Id.* at 273-275. She was disoriented and confused because she was now hypoglycemic. She found her way to the light rail station but no trains were running. *Id.* at 277.

A stranger offered her a ride home, which she accepted with frightening consequences:

> Well, it's hard for me to talk about it. I'm sorry. And he drove to an alley, and he knew I was deaf, and wrote a note, said, "You and me will have fun. I'll give you money for a taxi. Don't worry." Well, that freaked me out, and so I got out of there and ran at full speed, and I didn't know where I was.
>
> *Id.* at 278-280; Ex. 16, Sarah Burke Dep. 46:25 – 47:6.

Ms. Burke was afraid to return to the jail because she could no longer trust their employees: both the police and the sheriffs had denied her interpreter services and refused to provide her with food even though she needed to balance her insulin—and had given her still more insulin. Pls.' Add'l Fact at 269. She eventually found her way back to the Light Rail Station, and by then, the trains were running, so she was able to finally go home. Ms. Burke was more fortunate than Ms. Wood—but not by much. And, in *Wood*, the appellate court found that the plaintiff had presented a fact question to be decided by the jury as to whether the police officials affirmatively placed her in a position of danger. *Id.*, 879 F.2d at 589-90.The same principle should be operative here.

When Defendants denied Mr. Krebs the use of a sign language interpreter despite his oft-repeated requests for one, as is required by the Rehabilitation Act and the ADA. He too went through intake without a sign language interpreter and was left with no understanding of the legal process. The deputy sheriffs also sent him to court without an interpreter and told him that if he insisted upon an interpreter, he would have to spend another 72 hours in jail. It is not

surprising that Mr. Vigil signed anything he could to avoid returning to jail where he had been frightened, isolated and ignored.

By virtue of their deafness, Mr. Vigil, Mr. Krebs and Ms. Burke are all "members of a limited and specifically definable group," and readily satisfy the second element of the test.

As to the third prong, Plaintiffs must demonstrate that Defendants affirmatively placed each of them at substantial risk of serious, immediate, and proximate harm. *Briggs v. Johnson*, 274 Fed.Appx. 730, 739 (10th Cir. 2008) (denying a motion to dismiss where plaintiff alleged he was discouraged from reporting his daughter's physical abuse by her mother that resulted in the child's death) (relying on *Currier v. Doran*, 242 F.3d 905, 921 (10th Cir. 2001); *see also Sutton v. Utah State School for the Deaf & Blind*, 173 F.3d 1226, 1239 (10th Cir. 1999) (holding that a teacher's aide affirmatively placed a special needs child at risk of further molestation by leaving her post as bathroom monitor to answer the telephone).

Here, Defendants placed all three Plaintiffs at substantial risk of serious immediate and proximate harm in the following ways. In denying Mr. Vigil access to a sign language interpreter, Defendants barred his access to all physical and mental health treatment during his incarceration as well as all meaningful human contact. He had just turned age 23 and learned that he was facing a substantial amount of jail time; yet, no deputy or health care provider approached him. Defendants also barred his access to his family who would have been a source of comfort to him. Defendants also sent Mr. Krebs to court without an interpreter leaving him entirely vulnerable. Despite promising Ms. Burke's husband that they would tell her that her husband would be at the jail take her home, they did not. Instead, Defendants forced Ms. Burke to leave the jail in the middle of the night with a few bus tokens—when the busses were not running.

Plaintiffs can also readily satisfy the fourth prong of the test: the risk was obvious or known. Mr. Vigil, Mr. Krebs and Ms. Burke were known to be deaf (and Ms. Burke was in the middle of a diabetic crisis). No one could effectively communicate with Mr. Vigil which placed him at great risk of feeling overwhelmed and helpless; when he tried to meet with ARB, he was not allowed to, and he was never reclassified—it was simply a matter of when he could no longer cope, and it took only days after he appeared in court with an interpreter and learned what kind of jail time he was confronting. Defendants sent Mr. Krebs to court without an interpreter and threatened him with additional jail time if he continued to request an interpreter. Defendants ignored Ms. Burke's requests for food, denied her access to her emergency medication and concluded by sending her into downtown Denver in the middle of the night even though they knew that her husband was coming to take her home.

Defendants' conduct was also reckless as demonstrated by their adamant refusal to abide by the Rehabilitation Act and Title II of the ADA—both of which were enacted to prohibit discrimination. Their refusal to comply with federal law was almost certain to result in harm to deaf and diabetic arrestees and detainees.

The last element of the state created danger test is that the conduct by the government officials "shock the conscience of federal judges." *Moore v. Guthrie*, 438 F.3d 1036, 1043 (10th Cir. 2006). Establishing this element depends upon the factual context. In an emergency situation, such as a high speed police pursuit, instantaneous action is required. *Sacramento v. Lewis*, 523 U.S. 833, 840 (1998). In that setting, there must be an intent to harm independent of any legitimate law enforcement objective. *Id.* Negligence falls at the opposite end of the spectrum and will not shock the conscience of the court. *Id.* at 848-49.

There is, however, a middle ground of government misconduct that shocks the conscience and it turns on whether government officials had time to deliberate before acting. *Id.* at 851 (citing *Whitley v. Albers*, 475 U.S. 312, 320 (1986)). A prison custodial claim, such as Plaintiffs in this case, is the most likely setting for these kinds of claims because deliberation is not only possible, it is required: a prisoner is under "a regime that incapacitates [him from exercising] ordinary responsibility for his own welfare." *Id.* "Nor does any substantial countervailing interest excuse the State from making provision for the decent care and protection of those it locks up; 'the State's responsibility to attend to the medical needs of prisoners [or detainees] does not ordinarily clash with other equally important governmental responsibilities.'" *Id.* at 851-52 (alteration in original; internal citation omitted). The Court turned to an Eighth Amendment deliberate indifference analysis in determining the proper standard to be applied in the police chase in *Lewis*:

> [T]here is the luxury enjoyed by prison officials of having time to make unhurried judgments, upon the chance for repeated reflection, largely uncomplicated by the pulls of competing obligations. When such extended opportunities to do better are teamed with protracted failure even to care, indifference is truly shocking.
>
> *Lewis* at 853.

Judge Babcock applied these principles in a case arising out of the Columbine Massacre, *Sanders v. Board of County Comm'rs of Jefferson County*, 192 F. Supp. 2d 1094 (D. Colo. 2001). The crux of plaintiffs' claims was that the state created the danger in refusing to rescue Mr. Sanders long, who was slowly bleeding to death, after the Kleebold and Harris suicides. In denying a motion to dismiss on a state created danger claim, Judge Babcock considered *Lewis* in regarding the time available for deliberation and concluded that the Jefferson County defendants had time to bring Mr. Sanders to safety and chose not to. *Id.* at 1115. "I do conclude that at some

point during the afternoon, the Command Defendants gained the time to reflect and deliberate on their decisions. At that point, the Command Defendants demonstrated a deliberate indifference towards Dave Sanders' plight shocking to the conscience of this federal court." *Id.*

As a direct result of Defendants' misconduct, Mr. Vigil is dead. Ms. Vigil narrowly escaped being sexually assaulted or possibly worse, and Mr. Krebs was forced to appear in court without much understanding of the proceedings.

Finally, the individual Defendants argue that they had no personal participation in any of the harm that befell Plaintiffs, and therefore, cannot be liable. Dkt. #198 at 50-55. The law does not require such a showing. Where a supervisor fails to train or to implement needed policies, they are deliberately indifferent to the rights of persons that their subordinates have contact with, and those failures can enhance the danger to such persons. *Sutton*, 173 F.3d at 1240-41 (citing with approval *Greason v. Kemp*, 892 F.2d 829, 837 (11th Cir. 1990)); *see also Currier v. Doran*, 242 F.3d 905, 925 (10th Cir. 2001) ("This court has long held that a supervisor may be individually liable when there is 'essentially a complete failure to train, or training that is so reckless or grossly negligent that future misconduct is almost inevitable.'").

Plaintiffs have placed before this court abundant evidence that Defendants, both institutionally and individually, utterly failed to accommodate deaf prisoners in express violation of two firmly established federal laws, the Rehabilitation Act and the ADA. This misconduct is the quintessential example of "deliberate indifference" under the substantive due process danger creation theory of liability. As a result of the complete failures of the Defendants in their individual capacities: any deaf prisoner could suffer the same or similar fate as Mr. Vigil, Mr. Krebs and Ms. Burke. They could be: completely isolated as Mr. Vigil was; incorrectly classified; damned by the lack of accurate physical or mental health assessments; have their Type

I diabetes or other serious medical needs disregarded because of a lack of communication; thrown out in to the street in the middle of the night with no means of asking for help; or sent to court without an interpreter. The individual Defendants literally had years, not minutes and not hours, to comply with the Rehabilitation Act and the ADA. Their failure to do so was deliberately indifferent and quite rightly shocks the conscience.

With these facts in place, and with an appreciation of the "touchstone" of the Due Process Clause, "protection of the individual against arbitrary action of government," *Wolff v. McDonnell*, 418 U.S. 539, 558 (1974) (*abrogated on other grounds by Sandin v. Conner*, 414 U.S. 472, 485 (1995)). Plaintiffs' state created danger claims should withstand summary judgment.

G. Substantive Due Process – Special Relationship

Plaintiffs Estate of Vigil, Burke and Krebs brought individual special relationship substantive due process claims in the Sixth Claim for Relief in Plaintiffs' Second Amended Complaint. Dkt. #48 at 33-34. Defendants argue, in a single paragraph, that none of these individual special relationship claims can survive summary judgment because: (1) neither Burke nor Krebs was subjected to a violent act by a third party, and (2) none of the Plaintiffs "was ever in the personal presence, much less the custody of LaCabe, Lovingier, Foos, Wilson or Whitman." Dkt. #198 at 54.

Where the state affirmatively restrains an individual's freedom to protect himself, such as by incarceration, the state has then entered into a "special relationship" during the period of restraint to protect that individual from violent acts. *Armijo v. Wagon Mound Pub. Schs.*, 159 F.3d 1253, 1261 (10th Cir. 1998). "'The affirmative duty to protect arises not from the State's knowledge of the individual's predicament . . . but from the limitation which it has imposed on

his freedom to act on his own behalf.'" *Armijo*, 159 F.3d at 1261 (quoting *Deshaney v. Winnebago County Dep't of Soc. Servs.*, 489 U.S. 189, 200 (1989)). Thus, a "special relationship" exists when the plaintiff is an inmate or prisoner. *See Uhlrig v. Harder*, 64 F.3d at 572.

1. Mr. Vigil.

Under *Youngberg v. Romeo*, that "special relationship" imposes a duty on government actors to prevent the restrained individual from harming himself. 457 U.S. 307, 324 (1982) ("The State . . . has the unquestioned duty to provide reasonable safety for all residents . . . within the institution."). Because of this special relationship, jails and prisons are not entitled to ignore an inmate's serious medical needs. *See Olsen v. Layton Hills Mall*, 312 F.3d 1304, 1315-18 (10th Cir. 2002); *Oxendine v. Kaplan*, 241 F.3d 1272, 1276-79 (10th Cir. 2001); *Sealock v. Colorado*, 218 F.3d 1205, 1209-12 (10th Cir. 2000); *Ginest v. Bd. of County Comm'rs*, 333 F. Supp. 2d 1190, 1196-1203 (D. Wyo. 2004) (collecting cases). The test for determining whether an involuntarily committed person had been provided reasonable safety is whether the governmental actors exercised professional judgment. *Collignon v. Milwaukee County*, 163 F.3d 982, 987 (7th Cir. 1998) (citing *Youngberg*, 457 U.S. at 321).

Here, there is no dispute that Mr. Vigil was incarcerated at the time of his suicide. In fact, he was being held in the Special Administration unit—a jail within a jail—because of his deafness. But what sets this case apart from so many special relationship cases is that his jailers not only took away his mobility—they also eviscerated his ability to communicate by not providing him with a sign language interpreter so that he could effectively communicate his mental state to his jailers, including the ARB, his family or even to another prisoner.

Mr. Vigil was prelingually deaf, which meant that he could neither hear nor speak. He was also unable to read lips. Nor, could he readily express himself in writing and lacked the ability to read beyond the second-grade level and was unable to understand the Inmate Handbook. Pls.' Add'l Fact. No. 8. His primary source of communication was ASL and by extension a TDY telephone. Because of the written and unwritten policies, practices and customs at DCJ, he was deprived of access to both. No sign language interpreter was ever available to him throughout his incarceration other than when he appeared in court or met with his criminal defense attorney. At some point during Mr. Vigil's imprisonment, he drew a picture of himself where he was walled in, with tears running down his face. Ex. 37. Most reading was beyond him, and there was no closed captioned television. He had no one to communicate with, and was aware that he was facing a potentially long period of incarceration. If a deputy or nurse came to his door, he had no effective way to communicate with that person. Mr. Vigil had nothing but time sitting there day after day and night after night. His attempts to communicate with the ARB came to naught—and no one ever provided him with an explanation about why he was deprived of the opportunity to do so. In light of Defendants utter failure to accommodate Mr. Vigil's disabilities, they undeniably "imposed on his freedom to act on his own behalf." *Armijo v. Wagon Mound Pub. Schs.*, 159 F.3d 1253, 1261 (10th Cir. 1998).

As has also been established, Mr. Vigil never received a mental health assessment at DCJ. Pls.' Add'l Fact No. 205. He was also never provided with a sign language interpreter which made it impossible for anyone to assess his risk of suicide. Thus, there is no evidence that any government actor exercised professional judgment regarding Mr. Vigil's mental health status. Doing nothing more than feeding and clothing an inmate—and otherwise, simply "warehousing" him is constitutionally inadequate.

2. Sarah Burke.

There is no dispute that Ms. Burke was an arrestee and then a pretrial detainee, which gave rise to a substantive due process special relationship claim. *Armijo*, 159 F.3d at 1261. In light of that relationship, the Defendants, as government actors, owed Ms. Burke a duty to exercise their professional judgment. Unfortunately, those professionals failed Ms. Burke in three very serious ways: first, neither the police nor the sheriff's departments provided her with her preferred means of communication—a sign language interpreter. Pls.' Add'l Fact No. 240. This meant that she had no understanding of why she had been arrested. This deprivation also made it impossible for her to communicate accurately about her imminent and serious medical need for help with her Type 1 diabetes. Second, the police officers refused to let Ms. Burke take her emergency medications with her and also refused to let her eat despite her trying to explain that she had just taken an insulin shot and needed food to balance her blood sugar. Third, the longer she went without medical treatment, the more dangerous her diabetic condition became. And, the Sheriff's Department delayed Ms. Burke an opportunity to meet with a health care professional. The police arrived at her home at dinner time. *Id*. at241. The records provided by the Defendants show that she was not seen by a health care professional until approximately 10 p.m., and who gave her additional insulin which she did not need. *Id*. at 256-257. Ms. Burke required food, which she never received. *Id*. at 270. A delay in providing necessary medical care violates the Eighth Amendment. *Oxendine v. Kaplan*, 241 F.3d 1272.

3. Roger Krebs.

As with Ms. Burke, Mr. Krebs was an arrestee and then a pretrial detainee, who by virtue of that status had a special relationship with the Denver Police and Sheriff's Departments. *Armijo* at 1261. Those actors owed him a duty to exercise their professional judgment. They did

not. Defendants failed to exercise their professional judgment, thereby depriving him of effective communication in their refusal to bring in a sign language interpreter during his arrest, his incarceration and his appearance in court.

H. Unconstitutional Failure to Train and Supervise

1. Official Liability for the Failure to Train and Supervise in violation of 42 U.S.C. § 1983

Defendants next claim that Plaintiffs cannot show genuine issues of disputed fact with respect to their Fifth Claim for Relief, that the Defendants have official liability for the failure to properly train and/or supervise the officers resulting in a violation of the Plaintiffs due process rights. [Dkt. # 197, p. 51-52]. The record, however, shows a wealth of facts which support Plaintiffs' claim.

The inadequacy of officer training gives rise to liability under 42 U.S.C. § 1983 where the failure to train amounts to deliberate indifference to the rights of persons with whom the officers come into contact. *Olsen v. Layton Hills Mall,* 312 F.3d 1304, 1318 (10th. Cir. 2002) *citing City of Canton v. Harris*, 489 U.S. 378, 385 (1989). Deliberate indifference on behalf of a municipality may be found with a single violation of federal rights if the violation was highly predictable and a plainly obvious consequence of a municipality's actions. *Olsen*, 312 F.3d at 1318. In other words, "the need for more or different training is so obvious, and the inadequacy so likely to result in the violation of constitutional rights, that the policymakers of the city can reasonably be said to have been deliberately indifferent to the need" for additional training. *Jenkins v. Woods*, 81 F.3d 988, 994 (10th Cir. 1996), quoting *City of Canton v. Harris*, 489 U.S. at 390. When officers are placed in recurring situations in which the violation of federal rights is likely to occur, it can be then said that the need to provide proper training to the officers is "obvious." *City of Canton*, 489 U.S. at 390. Finally, in order to establish municipal liability,

there must be a causal link between the inadequate training and the violation of federal rights. *Brown v. Gray*, 227 F.3d 1278, 1290-1291 (10th Cir. 2000)(A sufficient causal link existed between the off-duty officer's use of excessive force because the officer's actions were directly attributable to his position as an officer and to "the dearth of instruction he received on implementing the always armed/always on duty policy while off-shift.")

In *Olsen*, the Tenth Circuit held that there were sufficient facts to establish that a county manifested deliberate indifference by its failure to train its officers to deal with a certain disability, Obsessive Compulsive Disorder ("OCD"). In that case, the Plaintiff alleged that the officers were aware that he suffered from OCD, yet took no steps to accommodate his disability, resulting in the Plaintiff experiencing panic attacks during the booking process at the county jail. The Court noted that the County did not provide any training for handling individuals with that disability and essentially allowed the deputies discretion in dealing with the disorder. *Id.* at 1310-1311. Noting that the disorder occurs in more than two percent of the population, and thus "one could hardly deem it an obscure disorder," the fact that the county had "scant procedures" on dealing with the disability, and the officers' apparent ignorance to the plaintiff's request for medication, the *Olsen* Court held that a violation of federal rights was quite possibly a "'plainly obvious' consequence" of the County's failure to train its officers to accommodate the disability. *Id.* at 1319-1320, *citing Barney v. Pulsipher,* 143 F.3d 1299, 1307 (10th Cir. 1998). The Court then denied the county's motion for summary judgment.

As argued above, Plaintiffs have shown a violation of the federal rights of Shawn Vigil, Sarah Burke, and Roger Krebs secured by the Fourteenth Amendment, the American with Disabilities Act, and the Rehabilitation Act. Similar to the facts in *Olsen*, the evidence in this case shows that there are genuine issues of disputed facts regarding the inadequacy of training

and supervision and whether the municipality acted with deliberate indifference to the rights of deaf inmates and those with diabetes.

a. Deaf Individuals

(1) *Shawn Vigil and the City and County of Denver and Denver Sheriff Department*:

Here, there is a wealth of evidence that the Defendants consciously disregarded a known risk in failing to train its officers on how to accommodate inmates who are deaf, provided insufficient training and supervision of DSD officers regarding suicide prevention, and no training whatsoever with regard to preventing suicides of deaf inmates. Plaintiffs specifically incorporate all of the facts in Plaintiffs' Statement of Additional Facts, ¶¶ 1-227. For purpose of this argument, Plaintiffs highlight some of the relevant facts below:

Approximately three percent of the population is deaf or hard of hearing, according to the National Center for Health Statistics. Pls.' Add'l Fact No. 70. It is beyond dispute that deafness qualifies as a disability under the American with Disabilities Act (the "ADA") which became law in 1990. Despite the clear mandate of the ADA that requires public entities to provide "meaningful access to their programs and services," *Robertson,* 500 F.3d at 1195, the only training provided to DSD deputies at the jail regarding how to accommodate inmates who are deaf was that provided at the Training Academy. Pls.' Add'l Fact Nos. 52, 64, 67, 69.

It is clear that regardless what the DSD deputies were taught at the training academy, the fact that there was no refresher or supplemental training after they graduated from the academy shows that the academy training alone was grossly inadequate. *Id.* at 52, 60, 62-64, 66, 67, 69. The officers charged with Mr. Vigil's care had graduated from the training academy from between four to ten years prior to Mr. Vigil's incarceration and had little to no memory of any

training provided at the academy regarding how to deal or communicate with deaf inmates. *Id.* at 64, 67, 69, 55-58, 60.

It is not surprising that there was no in-service training at DCJ regarding dealing with deaf inmates because there were no policies at the jail that required accommodating the needs of deaf inmates. *Id.* at 76 – 80, 89, 90, 93. None of the deputies who came into contact with Mr. Vigil or their supervisors at the DCJ could identify any policy regarding accommodations for deaf inmates and no accommodations were ever offered to him to allow him to effectively communicate. *Id.* and Nos., 93, 94. Even the Inmate Handbook that was in effect in 2005, Exhibit 35, does not contain any information about accommodations for individuals with disabilities. Importantly, the Defendants have not produced one document in this case that was in effect in 2005 evidencing any policy at either facility mandating when a sign language interpreter should be provided.

Despite the fact that the jail and PADF regularly housed deaf inmates, *Id.* at 88, 154 there was no evidence that a sign language interpreter *has ever* been brought to the jail or the PADF to assist with communication with a deaf inmate. *Id.* at 72, 80, 88, 95, 154. In fact, no one ever offered any accommodations of any kind to Mr. Vigil during his entire stay at the DCJ. *Id.* at 94, 95, 118, 119, 126, 128, 129. The only accommodation he was provided at the PADF was a one-time access to a TTY. *Id.* at 29.

Although the testimony provided by Ms. Koskinski specified that a sign language interpreter should be brought in when obtaining medical information or assessing a person's risk of suicide, *Id.* at 51, no such precautions were taken with Mr. Vigil. *Id.* at 26, 95, 155, 117 - 119. Even when obtaining critical information, such as during the medical assessment at the PAF, the intake classification at the DCJ, and a medical and mental health assessment at the DCJ, there

was no effort on the part of DSD to bring in a sign language interpreter to assist Mr. Vigil. *Id.* 26, 95, 155

Despite the fact that the medical personnel were required to follow the policies and procedures of the DSD, *Id.* at 17, 170, the DSD provided no training to these personnel at the PADF or DCJ regarding how to accommodate a deaf inmate. *Id.* at 17, 170 – 172.
The nurse who performed the medical assessment at the PADF testified it generally took him 12 to 15 seconds to perform the assessment because he was under pressure from the deputies to complete the assessment quickly. *Id.* at 23. Even Defendants' own expert, Michael Haley, testified that 15 seconds would not have been an adequate amount of time to conduct the medical assessment intake screening at the PADF, and that he would be concerned that any medical professional who felt rushed to complete such an assessment may not be as thorough as needed. *Id.* Chief Foos testified that Costin was not the type of person to be trusted with carrying out the duties of the Denver Sheriff Department. *Id.* at 22.

At the DCJ, the intake officer charged with classifying Mr. Vigil also just gave him the classification intake form and expected him to be able to understand the form. *Id.* at 155. The classification form was not completely properly and contained demonstrably wrong answers that should have put the classification officer on notice that Mr. Vigil could not comprehend the form. *Id.* at 156 - 163. Despite the fact that proper classification of an inmate was vital to properly assessing the suicide risk of an inmate, *Id.* at 178, the classification officer never took any steps to ensure that effective communication occurred during the intake procedure, and instead sent Mr. Vigil on to the medical personnel without taking any steps to secure a sign language interpreter.

Importantly, a critical step in assessing Mr. Vigil's risk of suicide was the completion of a medical and mental health assessment. *Id.* at 176. Despite the importance of these screenings, no meaningful medical exam was performed on Mr. Vigil and absolutely no mental health screening was performed. *Id.* at 178. The only medical information that was ever taken on Mr. Vigil was his blood pressure and his temperature – the two items that did not require communication with Mr. Vigil. *Id.* at 177. It was the responsibility of the DSD deputies to ensure that this screening had been performed – and they failed. *Id.*, at 179.

In addition to the need to assess his risk of suicide by completing a proper classification intake and medical and mental health screening, the next line of defense to preventing inmate suicide was to ensure that the inmate had the ability to effectively communicate with the deputies charged with his care. *Id.* at 116. The overwhelming evidence shows that Mr. Vigil had no meaningful communication with anyone at the jail because he was deaf. None of the deputies charged with supervising Mr. Vigil ever attempt to communicate with him. *Id.* at 118, 119. To the contrary, Deputy Pablo stated he did not know how anyone could communicate with Shawn Vigil because he was deaf. *Id.* at 118. Deputy Pacheco admitted that he never communicated with Mr. Vigil because he was deaf. *Id.* Although Defendants argue that regular nursing rounds were conducted on the tier, Pablo admitted that this consisted of the nurses just checking to see if the inmate was breathing. *Id.* at 130. No sign language interpreter was ever brought in to allow Mr. Vigil to effectively communicate with any of the nursing staff. *Id.* at 130.

Although Mr. Vigil tried on three occasions to reach out to the ARB regarding his problems, he was never seen by the Board. *Id.* at 183-186. The Chairperson of the ARB could not explain why the ARB failed to meet with Mr. Vigil despite his request. *Id.* at 184-186. Whatever the reason, there can be little doubt but that the failure of the ARB to meet with him

would have felt like a rejection to Mr. Vigil. In any event, there would not have been a sign language interpreter provided at any of the scheduled meetings with the Board. *Id.* at 190.

Moreover, the DSD officers were not provided adequate training on suicide prevention and had no training on suicide prevention relating to deaf inmates. *Id.* at 101. Although the defense expert opined that the officers had been properly trained on suicide prevention, he admitted that all of the training material provided to him was undated and he could not verify that the training reflected in the material had been performed prior to October 2005, *Id.* at 226, or that the deputies charged with Mr. Vigil's care had received any of the training that he reviews. *Id.* at 227. Thus, the defense expert's ability to opine on the adequacy of the training is incredible.

Assuming *arguendo* that the Post Order attached to Romero's affidavit in Defendants' Motion for Summary Judgment, [Dkt. # 197-8, , Exhibit A-5, Exhibit 6, p. 31] is evidence of a "suicide policy" at the DSD, there is no evidence that the deputies were trained on that policy. The Post Order states, in pertinent part:

> "Suicide is the number one cause of deaths in jails; therefore making rounds and logging rounds are essential. Inmates may become suicidal at any point during their stay. High-risk periods include the time immediately after booking, after receiving bad news, court, or after suffering some type of humiliation or rejection."

However, Deputy Pacheco stated that he had not been provided suicide prevention training since he attended the academy, *Id.* at 108, and did not know that suicide was the number one cause of death in jail, did not know the high risk periods for suicide, and did not believe that suffering humiliation or rejection would increase the risk of suicide. *Id.* at 111. He also did not know what factors in the jail environment posed a risk of inmate suicide, *Id.* at 108, and he did not know the warning signs of suicide. *Id.* at 114.

The evidence also shows that the deputies routinely did not follow the mandate of the post order which required them to take the critical step of making and documenting rounds in order to prevent inmate suicides. For the one month period during which Mr. Vigil was housed in the ABC tier of Building 6, the undisputed evidence is that rounds were routinely not documented as having been made in the morning hours, and there is no evidence that they were made during the time in which Mr. Vigil committed suicide. *Id.* at 141, 142, 143. Importantly, there is not one shred of evidence that any deputy conducted a round when Mr. Vigil committed suicide, between 8:25 and 9:00 a.m. on the morning of September 27, 2005. *Id.* at 199. Chief Foos testified that a pattern of failing to conduct rounds would be a pattern of decreased staff observation which would increase the risk of inmate suicide, *Id.* at 137, and that he had no basis to believe that rounds had been conducted in Mr. Vigil's housing unit as required. *Id.* at 143.

Moreover, not only does the evidence show the lack of any coherent suicide prevention policy, the lack of suicide prevention training, the utter lack of policies or training regarding how to accommodate deaf inmates, Mr. Vigil had almost every single warning sign of a potential suicide risk – all of which were ignored. Specifically, the testimony in this case was that inmates had an increased risk of suicide if there were housed in a single-cell unit in special housing, *Id.* at 100, 104, were isolate, *Id.* at 100, 104, 105, 107, were facing charges with a significant sentence, *Id.*, 121, were thinking about their sentence, *Id.*, had recently been to court or gotten bad news, *Id.*, at 110, had no visitors, *Id.* at 121, had a birthday while incarcerated, *Id.*, were feeling rejected by jail staff, *Id.* at 107, 110, or were withdrawn or had a change in eating habits. *Id.* 113.

Mr. Vigil was housed in the special management unit for the sole fact that he was deaf and isolated in a single-cell, *Id.* at 151, had no ability to communicate with the jail deputies or

medical staff because of the lack of an interpreter, *Id.* at 94, 95, 118, 119, 126, 128, 129, was facing charges that carried a lengthy sentence, *Id.* at 125, and there is evidence that he was contemplating that sentence while sitting in his cell. *Id.* at 122. He had been to court only nine days prior to his suicide where he would have learned of the potential length of his sentence. [Dkt. 197-2, Exhibit A-1, p. 2]. He had no visitors while in the jail, Defendants' Motion for Summary Judgment, Dkt. # 197, ¶47, and he had a birthday while incarcerated at the DCJ. [Dkt. # 197-8, Exhibit A-5, Exhibit 3, p. 15, and Dkt., # 197-10, Exhibit A-7, Exhibit 1, p. 8]. Mr. Vigil's cell assignment was changed frequently while at DCJ, thereby making it harder for him to form friendships with other inmate, ultimately being placed in the next to last cell in the tier, far removed from the officer's cage. *Id.* at 105. None of the deputies or jail staff ever tried to communicate with him, *Id.* at 188, 119, thereby isolating him even more. When he tried to reach out to communicate his problems to the ARB, he was rejected. *Id.* at 183-186. There is evidence that he was not eating, and did not come out of his cell. *Id.* at 121, 124. While he was at DCJ, Mr. Vigil drew a picture of himself surrounded by a brick wall crying, *Id.* at 122, – clearly evincing that he was depressed. The suicide occurred during a time when there was a pattern of decreased staff supervision which increases the risk of suicide. *Id.* at 141. Lastly, despite Chief Foos' testimony that he knew that most suicides in jails occur by hangings and that the jail would take "every possible step to remove known and obvious places where an inmate might hang themselves," *Id.* at 106, Mr. Vigil was placed not only alone in an isolated cell which had a vertical bar recessed into the wall a few feet above the toilet - with no discernable purpose other than being a convenient place to commit suicide. *Id.* at 41, 196.

In essence, Mr. Vigil exhibited every warning sign for suicide risk – but had no means to communicate his despondency and none of the DSD staff bothered to make any effort to assess

his risk of suicide – or ensure that such assessment had been done by medical. Deputy Pacheco even admitted that he could not assess Mr. Vigil's risk of suicide because he could not communicate with him. *Id.* at 117.

What is also undisputed is that during the period of Mr. Vigil's incarceration, the jail was experiencing significant overcrowding, resulting in an increase in officer overtime and officer fatigue. *Id.* at 213-220. Similarly, the demands on the medical staff significantly increased during this time without any increase in staffing, thereby increasing the risk of mistakes by medical personnel. *Id.* at 221-225. The DSD supervisors failed to add additional deputies or medical personnel and took no steps to alleviate the problem. *Id.* at 220, 225.

After reviewing the evidence in this case, Dr. Progrebin opined that there was inadequate training and policies at the DCJ with respect to suicide prevention, suicide risks and those risks specifically associated with deaf inmates, and that, as a result, the DSD was deliberately indifferent to the serious mental health needs of Shawn Vigil during his incarceration at the DCJ, and that this deliberate indifference caused the death of Shawn Vigil. *Id.*, at 148.
Even after the suicide, there was no investigation at the jail regarding the circumstances around the suicide, *Id.* at 202-204, there was no investigation into the OIM inquiry about the suicide risk posed by Mr. Vigil prior to the suicide, *Id.* at 202, 207 and no objective review by Chief Foos of the evidence in this case. Had any objective review been conducted, it would have been clear that DSD procedures, where they existed, were routinely violated, and that there was a lack of necessary policies and procedures in place to prevent the tragic death of Shawn Vigil. The fact that no such assessment occurred is part of the pattern of the on-going failure of the DSD to train and supervise it deputies and enact appropriate policies regarding suicide prevention, especially with respect to deaf inmates.

Just as in *Olsen*, here, where at least three percent of the population is deaf and there were no policies or procedures on how to accommodate deaf inmates and to ensure effective communication, proper assessment, and observation of these inmates in order to assess their risk of suicide, there can be no doubt but that a violation of federal rights is a "plainly obvious consequence" of the County's failure to train and supervise its officers to accommodate the disability. *See Olsen*, *supra*. at 1319-1320. The overwhelming evidence shows that there was no policy to provide accommodations to deaf inmates, that the deputies were not trained on how to observe or accommodate deaf inmates to ensure proper assessment of a suicide risk, and there was a pattern of the deputies failing to perform their duties. If there had been proper training, policies and supervision, the deputies would have been aware that Mr. Vigil posed an extreme risk of suicide and appropriate precautions would have been taken to prevent the tragic consequence that occurred in this case. There can be no doubt but that there is a casual link between the failure to implement appropriate training, policies, and supervision and Mr. Vigil's suicide. Accordingly, summary judgment should be denied with respect to this claim.

There can be no doubt but that the failure to provide proper policies regarding the need to accommodate deaf inmates, the failure to train the DSD deputies on the need to accommodate these individuals, as well as the failure to properly train the deputies regarding suicide prevention, especially the inherent risks associated with isolating a deaf inmate and failing to provide him the means of communicating his depression, directly resulted in the suicide of Shawn Vigil. But for these deficiencies, the deputies would have been aware that Mr. Vigil posed a high risk for suicide and would have taken appropriate precautions.

(2) *Sarah Burke and Roger Krebs:*

The inadequacy of training is demonstrated by officer and deputy responses to deaf inmates and arrestees. Neither of these individuals received interpreter services, or other accommodations, despite their obvious need for them. Pls.' Add'l Fact Nos. 74, 94, 246, 251, 255, 258, 267, 271, 298,305, 306, 307, 308, and 316,

Both police officers who interacted with Plaintiff Burke and Krebs testified that pen and paper was the most effective way to interact with deaf individuals. *Id.* at 322. This is contrary, however, to the training both received from Lorrie Kosinski, the city's trainer. *Id.* at 321. It is notable that one officer, Joseph Merino, who was involved in the arrest of Sarah Burke, was a recent graduate of the academy, still in training, and could not remember what he was taught regarding interactions with deaf individuals. *Id.* at 325. Even more remarkable is that he arrested Ms. Burke with a training officer present, and the training officer did not ensure that Ms. Burke had effective communication. *Id.*

In the past, Defendants provided a full day of training for recruits at the pre-service academy. *Id.*, 46. Defendant City, however, could provide no explanation as to why the training was shortened. *Id.* Defendant's trainer, Lorrie Kosinski testified that she needs more time to train officers. *Id.* at 49 Officers and deputies are not provided with refresher training regarding communication with deaf and hard of hearing individuals. *Id.* at 52. Ms. Kosinski, who drafts the curriculum for the trainings, does not have input into what recruits are tested upon, at the end of the academy. *Id.* at 50. Kosinski herself testified that she could use more time to train academy recruits, and that she has dropped an effective teaching method, role play, from her trainings due to the limited time she has to train. *Id.* at 49 and 52.

As stated above, over three percent of the population is deaf. *Id.* at 70. Thus, it is likely that these officers and deputies will encounter deaf individuals in the future, and given that each officer believed that they had established effective communication, or did not believe effective communication was necessary, it is likely they will disregard the federally protected rights of deaf individuals in the future.

(b) *Diabetes and Sarah Burke*:

Plaintiff Sarah Burke has type I diabetes. *Id.* at 237. On the day she was arrested, the police arrived as she was cooking dinner and a few minutes after she had taken her fast acting insulin. *Id.* at 239, 241, 243. She must eat within 15-30 minutes after her fast acting insulin, or she risks dangerously low blood sugar. *Id.* at 239. She did not have time to eat before the police officers arrived. *Id.* at 243. During the course of her arrest and subsequent detention, Ms. Burke experienced symptoms of severe hypoglycemia. *Id.* at 249, 252, 259, 269, 276, and 281. Ms. Burke's untreated hypoglycemia was a direct result of Defendant's failure to properly train its officers regarding the care of individuals with diabetes. While Ms. Burke told the arresting officers she had diabetes, they neither allowed her to eat, nor take her emergency diabetes supplies with her when she was arrested. *Id.* at 247. Despite knowing that Ms. Burke had diabetes, the officers did nothing to get her medical care, nor allow her to treat her diabetes herself. *Id.* at 247, 249, and 253. The arresting officer testified that his training was that if an individual is experiencing diabetes related problems, he is to call an ambulance. *Id.* at 253. The arresting officer, who was still in training, and with a training officer, was not trained on recognizing symptoms of hypoglycemia. *Id.* at 253. Despite his training, the arresting officer, nor his superior that was training him, did not contact an ambulance to treat Ms. Burke. Instead, Ms. Burke's condition worsened while she was in the custody of the Denver Police Department.

Ms. Burke was later transferred to the PADF where she was in the custody of the Denver Sheriff Department. *Id.* at 254. The policy is that all individuals have a medical assessment within thirty minutes. *Id.* at 228. Ms. Burke requested medical attention upon her arrival at PADF, but was not provided with medical care. *Id.* at 255. Ms. Burke did not see a medical officer until she had been at PADF for three and a half hours. *Id.* at 256.

The only policy at the PADF regarding how the deputies monitor an individual with Type I diabetes would be to complete their rounds. *Id.* at 230. The City testified that the DSD has no policies to identify individuals with diabetes at booking or intake. *Id.* at 231. In addition the City could not identify any training provided to DSD deputies during the pre-service academy regarding diabetes, nor any training regarding the provision of food to diabetics. *Id.* at 232, 233, 234, 235, 236. The City simply does not train DSD deputies regarding the care of inmates with diabetes. *Id.*

The failure to provide medical care to Ms. Burke demonstrates deliberate indifference to her federally protected rights. *Id.* at 284, 285, and 286. Diabetes is a common condition, and officers and deputies are likely to encounter other indivduals with diabetes. The failure to provide any training to deputies and the inadequate training provided to police officers gives rise to a claim for failing to properly train and/or supervise the officers resulting in a violation of the Plaintiffs due process rights.

2. Individual Liability of Governmental Actors LaCabe, Lovingier, Wilson, and Whitman for the Failure to Train and Supervise in violation of 42 U.S.C. § 1983.

In the motion for summary judgment with respect to the individual Defendants in their individual capacity, Defendants' argue that summary judgment must be granted with respect to all individual Defendants with respect to Plaintiffs' failure to train or supervise claim, relying

primarily on the argument that Plaintiffs cannot show that these individuals had any "personal interaction or involvement" with the Plaintiffs. [Dkt. # 198, p. 51] However, under the applicable law, there are sufficient issues of disputed facts on this issue with respect to the claims against Defendants LaCabe, Lovingier, Wilson and Whitman.[22]

It is well-settled that the inadequacy of officer training may serve as the basis for §1983 liability where the failure to train or supervise amounts to deliberate indifference to the rights of the persons with whom the police or deputies come into contact. *City of Canton*, 489 U.S. at 389. The Tenth Circuit has clearly established that a supervisor may be individually liable for failing to adopt or implement policies or training of subordinates to prevent the deprivation of federal rights. *Sutton v. Utah State Sch. for the Deaf & Blind*, 173 F.3d 1226, 1241 (10th Cir. 1999, *citing Meade v. Grubbs*, 841 F.2d 1512, 1527-1528 (10th Cir. 1988); *McClelland v. Facteau*, 610 F.2d 693, 696-98 (10th Cir. 1979).

In *McClelland, supra,* the Tenth Circuit made it clear that the mere fact that a police chief or sheriff had "no personal knowledge of or did not participate or acquiesce" in any of the alleged deprivation of rights, did not absolve him from individual liability. *Id.* 610 F.2d at 695. To the contrary, the Court held that a supervisor can be held individually liable if he fails to perform a duty which results in the deprivation of federal rights. *Id.* at 695-696. Also s*ee Snell v. Tunnell*, 920 F.2d 673, 700 (10th Cir. 1990); *Meade,* 841 F.2d at 1528 (A supervisor, such as a chief of police, may be liable as a supervisor under § 1983 when he failed to train or supervise, or where the training is so grossly negligent that future misconduct is nearly inevitable). In other words, a supervisor can be subject to liability under §1983 if there is an "affirmative link" between the supervisor's actions or inactions and the violation of the federal right. An

[22] Plaintiffs agree that the claims in the Second Amended Complaint do no relate back with respect to those claims regarding Shawn Vigil and thus the individual claims against Chief Foos are properly dismissed.

affirmative link can be established by showing that the supervisor's failure to establish policies or procedures, or to train and supervise his subordinates, led to the violation. *McClelland*, 610 F.2d at 696. Evidence that the training or procedures were defective raises an issue of fact as to whether the supervisor's duty was breached. *Id.* at 697.

Moreover, it is also beyond dispute that a supervisor may be held liable where there is essentially a complete failure to train, or training that is so reckless or grossly negligent that the violation of federal rights is almost inevitable. *Zawacki v. Colo. Springs*, 759 F. Supp. 655, 662 (D. Colo. 1991), citing *Meade*, 841 F.2d at 1527-1528. Although he may delegate his duty to supervise to subordinates, when the supervisor, such as a police chief or sheriff, retains the ultimate responsibility for what occurs in his department, the perimeters of his duty are uncertain and must be determined at trial. *McClelland*, 610 F.2d at 697.

(a) Individual Liability of LaCabe:

Defendant LaCabe is a final policymaker with respect to all of the operations of the Denver Sheriff Department and the Denver Police Department. McCabe was appointed as Denver's Manager of Safety in 2003. Dkt. #197 at 33, ¶ 184. Under Denver's Municipal Code 14-122, the Manager of Safety "exercises the powers and performs the duties of sheriff under the laws of the state." By Colorado statute, sheriffs are responsible for the acts of their deputies, C.R.S. § 30-10-506, and have the authority and responsibility to oversee county jails pursuant to C.R.S. § 30-10-511 which provides, in pertinent part, that "the sheriff shall have charge and custody of the jails of the county, and of the prisoners in the jails, and shall supervise them himself or herself or through a deputy or jailer." *See McMillan v. Hammond*, 404 P.2d 549, 552 (Colo. 1965) (A sheriff has a duty to exercise due care for the safety of prisoners). Thus, as the sheriff, Defendant LaCabe is the final policymaker for all matters concerning the operations of

the jail, including its policies. *See Cortese v. Black*, 838 F.Supp. 485, 496 (D. Colo. 1993). In addition, the manager of safety has "full charge and control of the departments of fire and police." Charter §§ 2.6.1, 2.6.2 (formerly §§ A9.1, A9.2); *City & County of Denver v. Powell*, 969 P.2d 776 (Colo. App. 1998).

As detailed in Plaintiffs' Statement of Additional Facts, and as highlighted above, in this case there is an abundance of evidence that as the final policymaker for the Denver County Jail, Defendant LaCabe failed to establish or implement an adequate suicide prevention policy, particularly related to deaf inmates, and completely failed to establish or implement any policies regarding the provision of necessary accommodations to deaf inmates as required by the ADA. In addition to his failure to establish policies or procedures to prevent the deprivation of Mr. Vigil's federal rights as a deaf inmate, LaCabe also failed to train and supervise the deputies regarding: 1) how to properly assess the risk of suicide, including the high risk periods and warning signs for suicide, 2) the risks inherent in isolating a deaf inmate; and 3) the necessity of providing a deaf inmate effective means to communicate his medical or mental health needs; 4) the need to ensure proper observation of and communication with a deaf inmate during his period of incarceration to prevent the risk of suicide, and 5) ensuring that the medical staff is properly trained on the need to ensure effective communication with deaf inmates and the suicide risk posed by those inmates. The fact that rounds were not logged in the logbook—as required by policy—for at least one month prior to Mr. Vigil's suicide leads to the clear inference that there was little to no supervision of the deputies' performance of their duties. Moreover, LaCabe failed to adopt policies or procedures to ensure an adequate amount of officer and medical staffing during a time of high inmate capacity to prevent staff fatigue and ensure the proper

performance of his subordinates' duties, thereby increasing the risk that the warning signs of suicide by an inmate would go unnoticed.

There can be no doubt that there is an affirmative link between LaCabe's failure to implement appropriate policies and procedures, and the failure to adequately train and supervise the deputies, as required by law, and the tragedy that occurred in this case – a deaf inmate who had all the warning signs of a high suicide risk but was never properly evaluated for this risk because he had no effective means of communication. The failure of LaCabe to implement appropriate policies and train and supervise the deputies not only resulted in the failure to prevent Mr. Vigil's suicide, but also increased the danger that he would commit suicide. Under these circumstances, Plaintiffs' have produced genuine issues of fact that Defendant LaCabe should be held individually liable for the failure to train and supervise the DSD deputies. See also *McClelland*, supra, at 697. (Although he may delegate his duty to supervise to subordinates, when the supervisor, such as a police chief or sheriff, retains the ultimate responsibility for what occurs in his department, the perimeters of his duty are uncertain and must be determined at trial.)

Additionally, as the final policymaker of the Denver Police Department, he is also subject to individual liability for the failure to train DPD officers regarding the need to provide accommodations to individuals upon their arrest, including the provision of sign language interpreters. *See* discussion above regarding Roger Krebs and Sarah Burke. Plaintiffs specifically incorporate those facts and Pls.' Add'l Fact Nos. 237-253; 282-285; 287-298.

(b) <u>Individual Liability of Whitman:</u>

As Chief of Police, Chief Whitman is designated by the Denver Charter as the person with authority to promulgate and adopt the internal rules and regulations governing the daily

affairs and activities of the members of the police department. *Cain v. Civil Service Com.*, 159 Colo. 360, 367 (Colo. 1966). Pursuant to Division III, Section 4 of the Denver Police Department Operations Manual, Chief Whitman "is the executive head of the police department" and shall formulate and enforce departmental policies, and promulgate orders to the employees of the police department as may be deemed proper. Pls.' Add'l Fact No. 360

As explained above and in Plaintiffs' Statement of Additional facts, the Denver Police Department failed to implement adequate policies or procedures, and has failed to train its officers, regarding the rights of persons who are deaf and have diabetes, thus causing the harm to Sarah Burks and Roger Krebs as detailed above. Plaintiffs specifically incorporate those facts and Pls.' Add'l Fact Nos. 237-253; 282-285; 287-298. As there is an affirmative link between the DPD's failure to implement appropriate policies and training regarding the need to accommodate deaf individuals and individuals with diabetes, and the harm caused to Sarah Burk and Roger Krebs as a result of not being provided interpreters or access to their medication by the DPD, there are genuine issues of fact with respect to the personal liability of Chief Whitman.

(c) Individual Liability of Lovingier:

In the Denver Sheriff's Department, there are other final decision makers, including Defendant Lovingier who became the Director of Corrections and Undersheriff for the City & County of Denver in spring 2006. Dkt. #197 at 35, ¶ 193. According to Denver's Career Service Authority, the Undersheriff is responsible for "developing objectives while implementing strategies and managing plans, programs, and projects for the Sheriff Department directing operations and support services at DCJ, the Pre-Arraignment Detention Facility/Court Services and Administration/Training." Pls.' Add'l Fact No., 361. The Manager of Safety has delegated to the Undersheriff "personal responsibilities and authority over the Denver Sheriff Department."

Id. The Undersheriff also "[a]pproves standards, procedures, practices and guidelines that impact assigned functional and/or operational areas and directs their implementation." *Id.* at 3. Career Services also describes the scope of the Undersheriff's decision making as follows:

> Decision Making - Commits to action, even in uncertain situations, by making sound and timely decisions necessary to carry out programs, ideas, systems or policies that affect a functional and/or operational area. Legal, public and financial consequences are generally limited to assigned area(s).
>
> *Id.*

As such, Defendant Lovingier was responsible for implementing appropriate policies and procedures at the PADF to ensure the deaf persons and persons with diabetes were provided appropriate accommodations for their disabilities, which he failed to do as described above. As it is unclear regarding his specific responsibilities and Plaintiffs were not able to take his deposition because of the limit on discovery, there are disputed issues of fact regarding his involvement that must be determined at trial. See *McClelland*, 610 F.2d at 697. Accordingly, there are disputed issues of genuine fact regarding Defendant Lovingier's individual liability and the claims against him should not be dismissed.

(d) Individual Liability of Wilson:

Defendant Wilson was the Division Chief of the Denver Sheriff Department Pre-Arraignment Detention Facility (PADF) from July 2006 to February 2009. Dkt. #197-10 at 3, ¶ 2. According to Denver's Career Service Authority, the Division Chief is responsible for "developing objectives, implementing strategies, managing plans, programs, and projects and directing operations and support services" at the PADF "and/or Administration/Training." Pls.' Add'l Fact No. 362. The essential duties of the Division Chief are described as "creates, discovers, and/or incorporates best practices," "[m]akes decisions that directly impact

subordinate staff in designated functional and/or operational areas and delegates decision-making responsibility and authority to subordinate staff as appropriate," and "[p]lans, designs, and develops programs, projects, procedures, and standards utilizing functional/technical expertise and directs and manages their implementation." *Id.* p. 2

Again, Plaintiffs incorporate the facts in Plaintiffs' Additional Facts relating to Sarah Burke and Roger Krebs. As Division Chief, Defendant Wilson was responsible for implementing appropriate policies and procedures at the PADF to ensure the deaf persons and persons with diabetes were provided appropriate accommodations for their disabilities, which he failed to do as described above. As it is unclear regarding his specific responsibilities and Plaintiffs were not able to take his deposition because of the limit on discovery, there are disputed issues of fact regarding his involvement that must be determined at trial. See *McClelland*, 610 F.2d at 697. Accordingly, there are disputed issues of genuine fact regarding Defendant Wilson's individual liability and the claims against him should not be dismissed.

IV. THE STATE NEGLIGENCE CLAIMS

A. Defendants Waived Their Immunity for Negligence in the Operation of a Jail, Training and Supervision.

Defendants argue that the Colorado Governmental Immunity Act ("CGIA"), C.R.S. §§ 24-10-101, *et seq*., bars Plaintiffs' negligent operation of a jail claim, the Seventh Claim for Relief, and also the negligence in training and supervising claim, the Ninth Claim for Relief. For both claims, Defendants assert there is no waiver of governmental immunity under the CGIA for the acts complained of and, therefore, they are not liable to Plaintiffs under either claim. Dkt. #197 at 58-61.[23] The argument is premised on the mistaken assumption that neither the operation of the jail, nor the training and the supervision of those charged with the detaining and safe-

[23] Because of significant overlap in the Defendants' arguments, Plaintiffs have combined their responses.

keeping of inmates is "vested [in the Sheriff Department] by law," and are, therefore, claims for which immunity has not been waived. *Id.* at 59, 61.

With regard to jails and correctional facilities, the sole focus in determining whether the CGIA applies lies in understanding the purpose of these detention facilities. This is because the statutory definition of "operation" means "the act or omission of a public entity or public employee *in the exercise and performance of the powers, duties, and functions vested in them by law with respect to the purposes of any . . . jail*. . . ." C.R.S. § 24-10-103(3)(a) (emphasis added). The CGIA statute also defines what is not included in the meaning of "operation:"

> (I) A failure to exercise or perform any powers, duties, or functions not vested by law in a public entity or employee with respect to the purposes of any public facility set forth in paragraph (a) of this subsection (3);
>
> C.R.S. § 24-10-103(3)(I).

Thus, C.R.S. §§ 24-10-103(3)(a) and 24-10-103(3)(I) must be read together to determine whether there is a waiver.

Although Defendants concede that the misconduct alleged by the Plaintiffs in the Second Amended Complaint and Jury Demand, at ¶¶ 176-181 and ¶¶ 188-194, are within the "powers, duties, and functions" of operating a jail, they claim that the acts are not *vested* in the Sheriff's Department by law and are, therefore, protected by the CGIA. Dkt. #197 at 59. Other than this statutory language, Defendants provide no support for their arguments.

Because there is no statutory definition for the "purpose" of a jail, courts must look to other factors to determine the scope of the purpose. In doing so, there are several special canons of statutory construction that have been adopted by courts in construing the CGIA, and those canons play a role here. "A basic purpose of the GIA is to permit claimants to seek redress for personal injuries caused by a public entity in specific circumstances." *Johnson v. RTD*, 916 P.2d

619, 621 (Colo. App. 1995)(citing *State v. Moldovan*, 842 P.2d 220 (Colo. 1992.)). Further, because the immunity granted under the CGIA is in derogation of Colorado's common law, any "legislative grants of immunity must be strictly construed." *Corsentino v. Cordova*, 4 P.3d 1082, 1086 (Colo. 2000). Necessarily then, provisions of the CGIA waiving immunity must be broadly construed. *Id.*

In addition to these rules of construction, there is some limited case law further defining the purpose of a correctional facility—but not a jail.[24] In both *Flores v. Colo. Dep't of Corrections*, 3 P.3d 464 (Colo. App. 2000), and *Pack v. Arkansas Valley Correctional Facility*, 894 P.2d 34 (Colo. App. 1995),[25] the courts stated that the "purpose of a correctional facility is to manage convicts safely and effectively." *Flores*, 3 P.3d at 466; *accord Pack*, at 37 (the "purpose of the correctional facility [is] to confine inmates safely and effectively"). Moreover, the "purpose" of a correctional facility is "confined to the custodial facility itself." *Pack* at 37.

In *Pack*, the court found no waiver of governmental immunity for a fall in a parking lot *outside* of the correctional facility. The holding was based on its conclusion that maintaining an outside parking lot is only ancillary to the purpose of a correctional facility. *Pack*, 894 P.2d at 37. Relying on *Pack's* determination of the purpose of a correctional facility, *Flores* held that because visitation *within* a state correctional facility "directly assists" the prison in its purpose of managing inmates safely and effectively, sovereign immunity had been waived. *Flores* at 466.

The rationale for the different outcomes in *Flores* and *Pack* turns on the difference between "purpose" and "operation." *Craven v. Univ. of Colo. Hosp. Auth.*, 260 F.3d 1218, 1231-32. Sovereign immunity is waived where the underlying injury is "directly related to the

[24] Plaintiffs note that there do not appear to be any cases explaining the "purpose of a jail." For purposes of the CGIA, however, the statutory scheme treats them identically.
[25] These are the only cases Plaintiffs have been able to locate that are relevant.

purpose" of the facility in contrast to the facility's "operation." *Id.* at 1231 (10th Cir. 2001) (discussing and citing *Flores* and *Pack*).

Here, at a minimum, the DCJ failed Mr. Vigil in three primary areas and thus was negligent in the operation of a jail: (1) effective communication, (2) classification and (3) supervision, each of which is "directly related" to the jail's fundamental purpose of confining Mr. Vigil safely and effectively:

a. Isolating Mr. Vigil in the Special Needs Unit solely on the basis of his disability, a failure in classification;

b. Failing to allow Mr. Vigil to appear before the Administrative Review Board despite his request to do so, another failure in classification;

c. Failing to provide Mr. Vigil or his family any effective way of communicating, a failure in communication;

d. Failing to provide Mr. Vigil with any effective way of communicating with his jailers, another failure in communication;

e. Failing to adequately supervise Mr. Vigil; a failure of supervision; and

f. Acting in a manner without due regard for the safety of Mr. Vigil.

For purposes of its argument as to the negligent operation of a jail, negligent training, and negligent supervision, Defendants also argue that a number of facts are undisputed, despite the evidence to the contrary as set forth in Plaintiffs' response to the undisputed facts. Dkt. #197 at 59- 61. For example, Defendants argue that there is no "prima facie evidence that Vigil was isolated solely on the basis of his deafness." Dkt. #197 at 59. The weight of the evidence is to the contrary. Pls.' Add'l Facts, *passim*. Moreover, despite Denver's assertion that Mr. Vigil's

classification was based on his charges, the amount of his bond, his age, and his never having been jailed before, the only evidence supporting that position is Defendants' rank speculation.

Denver also contends that Mr. Vigil had multiple opportunities to interact with jail staff, nursing staff and other inmates. Dkt. #197 at 59. Again, the facts are to the contrary. Pls.' Add'l Facts, *passim*. It is true that Mr. Vigil used the TDD once while incarcerated at the PADF, but there is no record evidence about its availability to him or how he learned about its existence. His mother also remembers a call where a hearing inmate called the family using a traditional telephone—which means that Mr. Vigil did not have access to the TDD telephone in the same manner as other inmates held at the PADF. Additionally, the TDD that the deputy sheriff gave to Sarah Burke did not work for relay calls, and Defendants failed to provide her with an alternative means of communicating with her husband. Mr. Krebs was also left with no telephonic access when he was held at the PADF.

No working TDD was available to Mr. Vigil when he was being held at DCJ. His mother, Debbie Ulibarri, called the DCJ to find out why her son was not calling her and was told that the there was no equipment for doing so. Pls. Resp. Fact Nos. 55-71. Additionally, the TDD was in the Sergeant's office well away from the tiers, so Mr. Vigil had no visual way to learn about its existence. Additionally, nothing in the Inmate Handbook—which he would not have understood—would have alerted him of its existence. The record is clear that outside the jail, Mr. Vigil routinely used the TDD to contact his family – but he never called once he arrived at DCJ. Thus, it is far from being undisputed, as the Denver Defendants allege, "that deaf inmates had access to TDDs at PADF and the county jail to the same extent that inmates were allowed telephone access." Dkt. #197 at 60.

Defendants agree that Mr. Vigil never met with the ARB, which is used by DCJ to review housing and classification decisions about inmates, but argue that he had no constitutional right to do so. Defendants provide no support for the assertion. Moreover, the Seventh Claim for Relief is not a constitutional claim; it is a negligence claim, and Defendants had a legal duty to properly classify and house Mr. Vigil and to also accommodate his disability.

The Denver Defendants also deny that they failed to supervise Mr. Vigil. Dkt. #197 at 60. This is certainly an area of factual dispute, and it is material. The tier deputies freely acknowledge that mornings are very busy on the tiers. Nonetheless, rounds are to be made every 30 minutes. Pls.' Add'l Fact Nos. 134. If a log book does not indicate that a round occurred, there was no round. *Id*. at 139-140. "All OK" does not mean a round was made. *Id*. Mr. Vigil's cell was nearly at the end of the tier, and it was impossible to see inside his cell without standing directly in front of it. *Id*. at 39. Moreover, although Defendants attempt to restrict the lack of supervision to the morning of Mr. Vigil's suicide, the record about the deficits in supervision are far more extensive and show that morning rounds were rarely made. *Id*. at 141-143.

This is not a case where Plaintiffs are complaining that Defendants briefly took their eyes off Mr. Vigil; instead, Plaintiffs contend that Mr. Vigil was unsupervised—and invisible—for long periods of time. Because of the multitude of evidence supporting Plaintiffs' position, this is a quintessential fact question for the jury.

B. Wrongful Death - Defendants Breached Their Duty to Protect Mr. Vigil .

Proving up a negligence claim requires a showing that: (1) the defendant owed a legal duty to the plaintiff, (2) the defendant breached that duty, (3) the plaintiff suffered injury, and (4) the breach caused the harm to the plaintiff. To establish a prima facie case for negligence, a plaintiff must show that the defendant owed a legal duty of care to the plaintiff, the defendant

breached that duty, the plaintiff suffered injury, and the defendant's breach caused the plaintiff's injury. *Greenberg v. Perkins*, 845 P.2d 530, 533 (Colo. 1993). The question here is whether Denver owed Mr. Vigil a duty to protect him from harming himself. As discussed below, courts already deciding this question have answered in the affirmative.

In the first instance, a court determines whether a defendant owed a legal duty to a plaintiff. *Observatory Corp. v. Daly*, 780 P.2d 462, 465-66 (Colo. 1989). A non-exhaustive list of factors to be considered by a court include: (1) the foreseeability of harm from the failure of the defendant to take protective action, (2) the social utility of the defendant's conduct, (3) the magnitude of the burden of guarding against the harm, (4) "the practical consequences of placing such a burden on the defendant, and other relevant factors as disclosed by the particular circumstances of the case." *Observatory Corp*. at 466. A court's determination as to whether a defendant owed a duty to the plaintiff is "an expression of the sum total of those considerations of policy which lead the law to say that the plaintiff is [or is not] entitled to protection." *University of Denver v. Whitlock*, 744 P.2d 54, 57 (Colo. 1987). If such a duty is found, "then the issues of breach of duty and causation are generally matters for the jury's determination." *Observatory Corp. v. Daly*, 780 P.2d 462, 466 (Colo. 1989). The standard for determining whether a defendant breached the duty is "whether the defendant acted as a reasonable person of ordinary prudence would under the same or similar circumstances." *Greenberg v. Perkins*, 845 P.2d 530, 533-534 (Colo. 1993) (citing *United Blood Servs. v. Quintana*, 827 P.2d 509, 519 (Colo. 1992); *Metropolitan Gas Repair Serv., Inc. v. Kulik*, 621 P.2d 313, 318 (Colo. 1980)).

Denver's discussion about "duty" is confusing at best. They first state that "Colorado state courts have not yet ruled on the *existence* and scope of the legal duty of jail personnel to prevent an inmate's suicide." Dkt. #197 at 56. In the next sentence, however, Denver moves

immediately to a discussion of the scope of the duty owed without any discussion of the existence of such a duty. This position can only be viewed as agreeing that such a duty exists. Indeed, many cases where courts have said as much concluding that because the custodial relationship prevents a prisoner from protecting himself, there is necessarily a special relationship between an inmate and a jail.

And, it is this special relationship which gives rise to a duty to act reasonably in protecting the inmate. "'When a sheriff, by virtue of his office, has arrested and imprisoned a human being, he is bound to exercise ordinary and reasonable care, under the circumstances of each particular case, for the preservation of his life and health.'" *Farmer v. State for Use of Russell*, 7224 Miss. 96, 105, 9 So. 2d 528 (1955) (quoting *Tyler v. Gobin*, 94 F.48, 50 (D. Ind. 1899); "We conclude that the better reasoning supports the rule that the jailer owes a general duty of due care to his prisoner." *Dezort v. Village of Hinsdale*, 35 Ill. App. 703, 708, 342 N.E.2d 468 (1976) (collecting cases); "We have recognized that a sheriff has a duty to exercise reasonable care to preserve his prisoner's health." *Iglesias v. Wells*, 441 N.E.2d 1017, 1019 (Ind. App. 1982); "At common law a jailer has a duty to exercise reasonable diligence with reference to the care of injured, ill or diseased inmate," *Heumphreus v. State*, 334 N.W.2d 757, 759 (Iowa 1983); "'The prisoner by his arrest is deprived of his liberty for the protection of the public; it but just that the public be required to care for the prisoner, who cannot by reason of the deprivation of his liberty, care for himself.'" *Medley v. North Carolina Dep. of Correction*, 330 N.C. 837, 838 (1993)(quoting *Spicer v. Williamson*, 191 N.C. 487, 490, 132 S.E. 291, 293 (1926)); *Murdock v. City of Keene*, 137 N.H. 70, 623 A.2d 755 (N.H. 1993) ("We recognize that a jailer's responsibility to a prisoner includes a duty to prevent the prisoner's own suicide."); *Scott v. New Jersey State Dept. of Corrections*, 841 A.2d 957, 960-61 (N.J. App. 2004); (*see also Giron v.*

Corrections Corp. of Am., 191 F.3d 1281, 1286 (10th Cir. 1999) ("the jury's special verdict on negligence must be read as rejecting the claim that CCA was negligent in failing to prevent the incident, that it had breached its 'duty to exercise reasonable and ordinary care for the protection of the safety and bodily integrity of the person in custody.'"

Other courts have found the source of the duty to provide for the safety of prisoners and inmates in the Eighth and Fourteenth Amendments while recognizing that the "deliberate indifference standard" allows for breaches of that duty under more limited circumstances than in negligence claims. *Ramos v. Lamm*, 639 F.2d 559, 574 (10th Cir. 1980) (Eighth Amendment duty to provide inmate medical care "necessarily requires that the State make available to inmates a level of medical care which is reasonably designed to meet the routine and emergency health care needs of inmates"). *Medley* at 844; *Scott* at 960-61.

There is an additional problem with Defendants' position: its legal analysis is truncated by focusing only on the "foreseeability," of Mr. Vigil's suicide as if that factor alone is dispositive. Dkt. #197 at 57-58. It is not. "No one factor is controlling, and the question of whether a duty should be imposed in a particular case is essentially one of fairness under contemporary standards - - whether reasonable persons would recognize a duty and agree that it exists." *Taco Bell, Inc. v. Lannon*, 744 P.2d 43, 46 (Colo. 1987). Dkt. #197 at 56-58. For example, Defendants plainly had a special relationship with Mr. Vigil, which obligated them to affirmatively act on his behalf. *Perreira v. State of Colorado*, 768 P.2d 1198, 1208-1209 (Colo. 1989). Although this is identified as a factor, it is not acknowledged in the argument.

Moreover, Defendants fail to discuss the test for foreseeability, preferring instead, to list "undisputed facts," which are disputed by Plaintiffs and directed at the notion they knew nothing about Mr. Vigil's suicidal ideation. Dkt. #197 at 57-58. (*See* Plaintiffs' responses and Plaintiffs'

additional facts for a full discussion of why the "facts" relied upon by Defendants on the issue of foreseeability are unreliable.) The test for foreseeability is grounded in the "common sense perceptions of the risks created by various conditions and circumstances and ''includes whatever is likely enough in the setting of modern life that a reasonably thoughtful person would take account of it in guiding practical conduct.'" *Perreira* at 1198 (quoting *Taco Bell, Inc. v. Lannon*, 744 P.2d 43, 48 (Colo. 1987)). With respect to Mr. Vigil, "the common sense perceptions of the risks created by various conditions and circumstances" include the fact that he was isolated and completely incommunicado because of the lack of a sign language interpreter. Other facts included his never undergoing a mental health evaluation, turning age twenty-three (23) while incarcerated, learning that he was facing a potentially lengthy jail sentence, was not allowed to meet with the ARB about his classification, was supposed to be housed near the officer cage in Building 6 but was not, had no access to close captioned television, was housed alone, was in a building where rounds were often not made for hours, segregation nurses who only walked by his cell to check that he was "still breathing," and had absolutely no telephone contact with his family. Moreover, foreseeability is more elastic than Defendants would have it. "[I]t is not necessary that [a defendant] be able to ascertain precisely when or how an incident will occur. *Taco Bell, Inc. v. Lannon*, 744 P.2d 43, 48 (Colo. 1987). At a minimum then, the facts as to foreseeability are in genuine dispute, and the wrongful death claim should withstand summary judgment.

As for social utility, there can be little social utility in allowing Defendants to house an inmate without any regard for his ability to understand his jail environment. The Inmate Handbook was of no use to him without an interpreter because it was well beyond his second-grade reading level. Furthermore, there is little social utility in allowing Defendants to preclude

an inmate from being able to communicate his needs. The next factor, the magnitude of the burden on defendants also supports the wrongful death claim. Denver claims that interpreter services were always available to the Denver Sheriff's Department. Dkt. #197 at 30, ¶¶ 166-67. Therefore, finding a duty to accommodate Mr. Vigil's communication needs so that he could have communicated his medical needs would have imposed no additional burden on Defendants. Nor, would there be any adverse consequences of placing that burden on Defendants. That burden is already theirs under the Rehabilitation Act and the ADA.

Finally, a key factor to be considered in this case was Defendants' routine violations of Mr. Vigil's rights to have his deafness accommodated under the Rehabilitation Act and the ADA. There can be no societal interest in Defendants not being accountable for their policy, practice and pattern of isolating Mr. Vigil solely because of his disability and then cutting him off from all aid by not providing a sign language interpreter.

Perreira v. State, relied upon by Defendants, is instructive in determining the scope of the duty in a negligence case where a mental patient had been involuntarily committed, a close parallel to this case. There, the Colorado Supreme Court was asked to decide whether a state psychiatrist owed a duty to the general public in deciding whether to release the mental patient, and if so, to determine the scope of that duty. 768 P.2d 1198, 1201 (Colo. 1989). The genesis of the lawsuit occurred when the mental patient killed a police officer four months after being released from Fort Logan. *Id*. at 1203-1206. The court found such a duty and reversed the Colorado Court of Appeals who had restricted the scope of the duty to specific threats to specific persons. *Id*. at 1201; *Perreira, at* 5-6 (Colo. App. 1986). The Colorado Supreme Court set the scope of the psychiatrist's duty broadly:

> We hold that when, as here, a staff psychiatrist of a state mental health facility is considering whether to release an involuntarily

> committed mental patient, the psychiatrist has a legal duty to exercise due care, consistent with the knowledge and skill ordinarily possessed by psychiatric practitioners under similar circumstances, to determine whether the patient has a propensity for violence and would thereby present an unreasonable risk of serious bodily harm to others if released from the involuntary commitment, and, further, that in discharging this legal duty the psychiatrist may be required to take reasonable precautions to protect the public from the danger created by the release of the involuntarily committed patient, including the giving of due consideration to extending the term of the patient's commitment or to placing appropriate conditions and restrictions on the [**3] patient's release.
>
> *Perreira v. State*, 768 P.2d 1198, 1201 (Colo. 1989)

The duty imposed in *Perreira* asked no more of a treating psychiatrist than he exercise "due care" in a manner that was consistent with the ordinary knowledge and skill of other practitioners confronted with similar problems. This holding illustrates the difficulty with the argument that the scope of the duty owed by jail personnel to prisoners should be identical to that used in federal civil rights claims—"that officers were aware of a specific risk that the prisoner would commit suicide." *Id.* This improperly conflates civil rights law, which is generally a more difficult standard to satisfy than a state negligence claim. *See, e.g.*, *Braxton v. Wyandotte County Sheriff's Dep't*, 206 Fed. Appx. 791, 793 (10th Cir. 2006) (upholding dismissal of inmate's Eighth Amendment claim because "negligence does not constitute deliberate indifference.").

C. Proximate Cause

Defendants claim that all of Plaintiffs'negligence claims must be dismissed because Mr. Vigil's suicide was the "intervening cause of [his]death that was not reasonably foreseeable by a reasonably careful person under the same or similar circumstances." Dkt. #198 at 62.[26] The

[26] The only legal support for Defendants' proposition is C.JI.- Civ. at 9:20 (4th ed.), which states in pertinent part:

argument ignores Mr. Vigil's custodial status, which created a special relationship[27] at the time of his suicide. *English v. Griffith*, 99 P.3d 90, 94 (Colo. App. 2004); *see also Cockrum v. State*, 843 S.W.2d 433, 435 (Tenn. Ct. App. 1992).

The primary flaw in Defendants' argument is that Denver acted unreasonably in its treatment of Mr. Vigil. Defendants denied him all accommodations, did not even conduct a mental health assessment and prevented him from all effective communication. Under these facts, Defendants cannot argue that they had no way of knowing Mr. Vigil was suicidal. Moreover, the risk of inmate suicide is ever-present, and therefore, foreseeable. Accepting Defendants' argument would vitiate all liability in negligence for a prisoner suicide no matter how egregious a jailer's conduct, surely an unjust result.

> The word "cause" as used in these instructions means an act or failure to act that in natural and probable sequence produced the claimed injury. It is a cause without which the claimed injury would not have happened.
>
> If more than one act or failure to act contributed to the claimed injury, then each act or failure to act may have been a cause of the injury. A cause does not have to be the only cause or the last or nearest cause. It is enough if the act or failure to act joins in a natural and probable way with some other act or failure to act to cause some or all of the claimed injury.
>
> (One's conduct is not a cause of another's injuries, however, if, in order to bring about such injuries, it was necessary that his or her conduct combine or join with an intervening cause that also contributed to cause the injuries, an intervening cause is a cause that would not have been reasonably foreseen by a reasonably careful person under the same or similar circumstances.)
>
> CJI-Civ 9:20.

[27] The special relationship in the tort setting should not be confused with the special relationship in a substantive due process claim.

Although this appears to be a question of first impression in Colorado,[28] courts in other jurisdictions have rejected the intervening cause defense in custodial placements. "If the custodian has a duty to protect the inmate from himself, the fact that the inmate tried to harm himself is a reason for liability rather than a defense." *Myers v. County of Lake*, 30 F.3d 847, 852 (1994) (applying Indiana law). The *Myers* case has some important parallels with Mr. Vigil's case. As with Mr. Vigil, Steven Myers never received a mental health assessment when he arrived at the Lake County Juvenile Center on December 27, 1988. As with the DCJ, this significant failure was a result of being understaffed and underfunded. *Id.* at 851-52. Eight days later, Steven Myers attempted suicide while in jail and was left with permanent and disabling injuries. *Id.* at 848.

The Michigan Supreme Court has also considered and rejected the intervening cause argument in a jail suicide case. The court easoned that the custodial relationship gives rise to a duty to prevent self-inflicted harm, finding the harm from suicide to be eminently foreseeable in the custodial context. *Hickey v. Zezulka*, 487 N.W.2d 106, 118-120 (Mich. 1992). Where a defendant's negligence enhances the opportunity for harm, "it cannot be said that the intervening act is a superseding cause of his injury." *Id.* at 119-120. For similar reasons, the Alaska Supreme Court reached the identical conclusion in *Joseph v. Alaska*, 26 P.3d 459, 466 (Alaska 2001).

Finally, Defendants' lone sentence contending that Plaintiffs are somehow at fault for not providing an expert mental professional to testify about proximate cause does not inform the discussion. It is simply irrelevant under the applicable law.[29]

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[28] "Absent controlling precedent, the federal court must attempt to predict how the state's highest court would resolve the issue." *Royal Maccabees Life Ins. Co. v. Choren*, 393 F.3d 1175, 1180 (10th Cir. 2005).

[29] Plaintiffs also have no doubt that Defendants would strenuously object to any such expert opinion.

V. CONCLUSION

For the foregoing reasons, Plaintiffs agree that all claims against Defendant Foos should be dismissed, that all claims against Lovingier, Wilson, and Whitman in their individual capacities brought by Plaintiffs Ulibarri and the Estate of Shawn Vigil, should be dismissed, and that in all other respects, that this Court deny Defendants' Motions for Summary Judgment.

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Certificate of Service

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