UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF OREGON

LINDA MAE PARIS, in her individual capacity and as a personal representative of the ESTATE OF DONNIE RAY BROWN, deceased,

Plaintiff,

v.

CONMED HEALTHCARE MANAGEMENT, INC., COOS COUNTY, et. al.,

Defendants.

6:14-cv-1620-TC

FINDINGS & RECOMMENDATION

COFFIN, Magistrate Judge:

Plaintiff brings claims on behalf of decedent Donnie Ray Brown's estate against Conmed , Coos County, and certain of their employers arising out of the death of Brown while he was an inmate at Coos County Jail.

Presently before the court are motions for summary judgment filed on behalf of the Conmed defendants (#135) and the Coos County defendants (#130).[1] The standards applicable for such motions are well-known to the parties and are succinctly set forth herein:

[1]Conmed seeks summary judgment on the 42 U.S.C. §1983 claims but not the negligence claims; Coos County seeks summary judgment on both the §1983 claims and the negligence claims.

LEGAL STANDARD REGARDING SUMMARY JUDGMENT

Federal Rule of Civil Procedure 56 allows the granting of summary judgment:

> 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.

Fed. R. Civ. P. 56(c). There must be no genuine issue of material fact. Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 247-48 (1986).

The movant has the initial burden of establishing that no genuine issue of material fact exists or that a material fact essential to the nonmovant's claim is missing. Celotex Corp. v. Catrett, 477 U.S. 317, 322-24 (1986). Once the movant has met its burden, the burden shifts to the nonmovant to produce specific evidence to establish a genuine issue of material fact or to establish the existence of all facts material to the claim. Id.; see also, Bhan v. NME Hosp., Inc., 929 F.2d 1404, 1409 (9th Cir. 1991); Nissan Fire & Marine Ins. Co., Ltd., v. Fritz Cos., Inc., 210 F.3d 1099, 1105 (9th Cir. 2000). In order to meet this burden, the nonmovant "may not rely merely on allegations or denials in its own pleading," but must instead "set out specific facts showing a genuine issue of fact for trial." Fed. R. Civ. P. 56(e).

Material facts which preclude entry of summary judgment are those which, under applicable substantive law, may affect the outcome of the case. Anderson, 477 U.S. at 248. Factual disputes are genuine if they "properly can be resolved only by a finder of fact because they may reasonably be resolved in favor of either party." Id. On the other hand, if, after the court has drawn all reasonable inferences in favor of the nonmovant, "the evidence is merely colorable, or is not significantly probative," summary judgment may be granted. Id.

As noted, however, in addressing the defendants' motion, the court must draw all reasonable inferences from the evidentiary record in favor of the plaintiff.

FACTUAL BACKGROUND

A. Chronology of Events during Brown's Incarceration

Donnie Ray Brown was an inmate at the Coos County Jail serving a 30 day sentence during November 2013.[2] Beginning on November 12, Brown began evidencing signs of distress (difficulty breathing) while on work detail. He was examined that morning by Nurse Marjory Hausler, a Conmed staff nurse assigned to the Coos County jail, and EMT Jim Morgan. Hausler referred Brown to Nurse Practitioner Judith Stensland (who scheduled visits on a weekly basis at the jail but was not regularly stationed there) for further examination when she was scheduled to visit the jail two days later, and discontinued his participation in the work program pending that examination. She also placed him on medical lockdown and moved him to a cell on a lower tier to avoid his climbing the stairs.

On November 14, Ms. Stensland examined Brown and he reported symptoms of shortness of breath, vomiting, diarrhea, abdominal pain, leg swelling, and weakness. Stensland noted his abdomen was somewhat tense, but thought he was tightening his abdomen on purpose and was exaggerating his abdominal pain. She assessed him as having gastroenteritis which she anticipated would resolve withing 3-5 days and expected to see him at her next visit to the jail. In the interim, she planned to keep him off work detail, a decision that Hausler concurred with when she later reviewed Stensland's chart notes.

The November 14th visit was the last time Brown was seen or examined by either Nurse Hausler or Nurse Stensland. Hausler traveled to Nashville, Tennessee to attend a Conmed conference from Monday, November 18 through Thursday, November 21. Neither Ms. Hausler nor anyone at Conmed made arrangements to replace her at the jail with another nurse during her absence. In lieu

[2] With good time and work credits, his release date was scheduled for November 22, 2013.

of a substitute nurse, the medical care oversight for inmates was "delegated"[3] to EMTs[4] employed by Conmed at the facility. Both Hausler and her supervisor, Mary Raines, attended the Nashville conference. Raines made no effort to find a nurse to fill in for Hausler and states she relied on Hausler to decide how to provide coverage in her absence. In the past, that substitute coverage for any absences by Hausler had been provided by Nurse Mary Krahn, who had retired from Conmed in August, 2013. However, shortly after her retirement, Krahn signed a Nursing Independent Contractor Agreement with Conmed , effective September 1, 2013. Under the contract, she was available to provide support at the jail when needed. Nonetheless, Krahn was not contacted by Conmed to fill in for Hausler at the jail during the conference.

While Hausler was attending the conference and the medical needs of the inmates at the jail were being delegated to EMTs, Brown began evidencing more abdominal distress early in the morning of November 18. He told a deputy (Hill) that he was in pain, had trouble sitting up , was observed holding his abdominal area, and stated he felt worse. Hill took Brown to the booking area in a wheelchair, and asserts that he reported his observations to EMT Morgan when he arrived later that morning (7:30 a.m.). Morgan, however, denies that he received any information about Brown that morning, although he states he saw Brown at about 10 a.m. and that Brown showed him some light orange colored urine in his toilet and asked if he was peeing blood.

Morgan apparently diagnosed Brown as being dehydrated, and denied Brown's request to be released to go to the hospital because " nothing shows anything wrong." Although Morgan recorded a set of vital signs on his chart note of his interaction with Brown, a jail video of the encounter does not reflect Morgan taking Brown's vital signs.

It is noteworthy that the day after Brown's death, Ms. Hausler made a late entry chart note in which she documented an alleged conversation with Morgan at approximately 7:30 a.m. on

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[3]I use the term "delegated" cautiously, as Conmed interprets the term to permit off-site supervision under these circumstances.

[4]Emergency Medical Technicians.

November 18th (while Hausler was in Nashville) regarding Brown's condition. Whether this conversation took place is disputed by other evidence in the case, including evidence that Morgan did not even meet with Brown until 10:15 a.m. , phone records do not show any calls or text messages between Hausler and Morgan, and Morgan testified in his deposition that he didn't recall speaking to Hausler.

On November 19, Morgan saw Brown early in the afternoon for a brief period. Brown informed Morgan he had a bowel movement during the night while sleeping. Morgan decided to send Brown back to general population (at the jail) , telling him to drink plenty of water. In her belated chart note about this event , Hausler claims to also have had a conversation with Morgan about this Morgan-Brown interaction. That this contact occurred is disputed by plaintiff based on phone records and Morgan's recollection or lack thereof.

On November 21, Nurse Stensland was scheduled to return to the jail for her weekly visit and Brown was on the call list to see her. She did not come in, however, nor did any substitute. Ms. Hausler subsequently related that Strensland's clinic visit was canceled because Hausler was away at the Nashville conference and "they like me to be there for clinic." That same day , Brown repeatedly asked when he could be seen by a doctor and if he could be released early because of his condition. At 2 p.m., Morgan spoke with Brown and gave him some medication for constipation. At 3 p.m., an inmate told a deputy (Valencia) that Brown needed medical help as he was vomiting blood. Valencia informed Morgan of this, who had Brown taken to the booking area for evaluation: Brown was unable to walk, and was transported to the booking area in a wheelchair, where he was examined by EMTs Morgan and DeLeon. Brown had dried blood on his lips and teeth, a distended abdomen, and indicated that he had pain on the left side of his chest. His skin had a yellowish tint to it. After his exam, Brown was placed in a holding cell for 30 minutes and, because Brown had only one day left to serve on his sentence, a deputy recommended to his supervisor that Brown be released and given a courtesy ride to the hospital. Morgan and DeLeon's chart notes reflect that it was decided that Brown would be released and given a ride to the hospital. There is evidence that

there was some discussion of calling an ambulance but no ambulance was called (DeLeon could not recall the reason). Brown was officially released from custody at 3:50 p.m. Because deputies did not want to transport Brown in his jail uniform, and because of his condition, it took approximately another 20 minutes to dress him in his personal clothing and he was not transported from the jail until 4:14 p.m. He arrived at Coquille Valley Hospital at 4:16 p.m. (the hospital is a few blocks from the jail) and was escorted to the waiting room where he was left by a deputy. Brown died later that evening (10:14 p.m.) as a surgeon was preparing to operate following a CT scan and other testing "to explore his abdomen." An immediate post-mortem exploratory surgery identified the cause of death as "intraabdominal sepsis due to visceral perforation secondary to diodenal perforation that had been present for quite some time, ... at least several days."

B. Mortality and Morbidity Review Process

On December 12, 2013 a Mortality and Morbidity (M & M) Review meeting was conducted by Conmed regarding the circumstances surrounding the death of Donnie Brown. The purpose of such a review, which is required in the event of an inmate death by Conmed's own policy and the National Commission on Correctional Health Care Standards for Jails, includes an evaluation of the facts and circumstances surrounding the event, the adequacy of policies, procedures, staffing, and responses to the inmate's medical condition, and whether changes, corrections, or improvements in any areas were warranted. Attendees at the meeting, either in person or by telephone, included Rich Rosenblatt, the Vice President, Chief Administrative Officer, and General Counsel of Conmed, Donald Rhodes M.D., Chief Medical Officer of Conmed, Nancy Raines RN, the Vice President of Operations in the Northwest for Conmed, Marjory Hausler, the Conmed HSA at the Coos County Jail, EMT James Morgan, Sheriff Craig Zanni, and Sergeant Darius Mede, the Jail Commander.

Absent from the meeting was Dr. Steven Blum, the State Medical Director for Conmed and the

titular on-site Medical Director for the Coos County Jail [5], and Nurse Practitioner Stensland, who had evaluated Brown on November 14, 2013.

Prior to the meeting, Nurse Hausler had prepared a " Pre - M& M Report " which contained a medical history, a summary of the facts and circumstances of Brown's death, and a chart review summary in chronological sequence.

There is evidence that the Hausler report contains significant and material omissions. For example, there is no mention in the report that Ms. Hausler was out of the area attending a conference from November 18-21 and that no replacement RN was assigned to the Jail in her absence, which resulted in EMT Morgan being the senior medical assistant on site during that period. There is also no reference in the report to the cancellation of Nurse Practitioner Stensland's clinic on the morning of November 21st, when she had been scheduled to see Inmate Brown. As noted previously, Stensland was not in attendance at the M &M meeting on December 12, 2013 (notwithstanding that Conmed's policy requires the attendance of "clinical staff members that provided direct care to the inmate.") The November 21st date is significant in that Brown's condition was deteriorating, he repeatedly asked to see a doctor , and his symptoms included vomiting blood. Despite these developments, the cancellation of Nurse Practitioner Stensland's clinic was not mentioned in Hausler's Pre-M & M report.

After the M & M meeting, Hausler prepared a "Report and Recommendations Following M & M" which summarized the findings and recommendation from the review. There is evidence in the record before the court that this report also contains material false statements, including:

"Patient never personally accessed or requested health care. " (Disputed by evidence that Brown

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[5]Dr. Carla Antola had been the on-site Director for the Jail, but she left during the summer of 2013 and had not been replaced. Her duties were assumed by Dr. Blum, but Dr. Blum had visited the Jail only infrequently after Antola's departure. Dr. Antola had been conducting the clinic at the Coos County Jail twice a week, but Dr. Blum did not replicate her practices in that regard. Instead, NP Stensland conducted the clinic on a once /week basis,

repeatedly asked to see a doctor and/or go to the hospital.)

"Observations of the patient's overall activities and behavior ... demonstrated an individual participating without difficulty in the normal daily activities of jail life." (Disputed by evidence that Brown was not eating his meals, had been reported as moaning in pain at night, and that other inmates had urged staff to have him examined by a doctor).

"All Conmed and Coos County jail policies were followed and adequate for the situation." (Disputed by evidence that there was no medical director or nurse on site.)

"Staffing was adequate. Skill level of staff was appropriate." (Disputed by evidence that there was no medical director or nurse on site and skill level of staff was limited to EMTs.)

The result of the M & M Review process was a finding that there were no factors leading to Brown's death that needed to be addressed through changes or adoption of policies, procedures , or training.

C. <u>Coos County Contract with Conmed</u>

In pertinent part, Conmed's proposal in support of its application to provide health care services to Coos County specified that Conmed staffing would include a full-time on site Health Services Administrator [(HSA/Registered Nurse (RN)] who would have general responsibility for the successful delivery of health care services at the facility and Conmed would provide health care services coverage on a 24 hours/day, 7 days/week basis. Conmed further represented that a Medical Director/Physician would play a "key role" in the Medical Department and would play a continuous role in overseeing medical operations at the jail. Conmed specified that the Medical Director would be on site at the jail no less frequently than 2 hours/week for the direct delivery of healthcare services and treatments to inmates. In addition, the Conmed proposal promised that the Medical Director would have ultimate responsibility for supervision of all medical and clinical staff and supporting supervisory nursing personnel. These proposals were expressly incorporated into the

contract when Coos County and Conmed entered into the agreement. The contract was renewed on July 1, 2013 and was in force during the period of Brown's incarceration. The renewal contract summary form specified that the Coos County officials responsible for the performance of the contract were Sheriff Craig Zanni and Sergeant Darius Mede

LEGAL ANALYSIS PERTAINING TO PLAINTIFF'S CONSTITUTIONAL CLAIMS BROUGHT PURSUANT TO 42 U.S.C. §1983

A. Alleged Violations of the Eighth Amendment

To state the obvious, a corrections facility has a constitutional obligation to provide adequate health care to inmates with serious medical needs. Estelle v. Gamble, 429 U.S. 97 (1976). And while ordinary negligence in failing to meet those needs is not actionable under § 1983, a showing of deliberate indifference on the part of corrections officials and/or the private sector caretakers they contractually engage to provide medical services will sustain such an action. See Carnell v. Grimm, 74 F.3d 977, 979 (9th Cir. 1996).; West v. Atkins , 487 U.S. 42, 54 (1988). The proposal by Conmed to provide health care to inmates at the Coos County Jail on its face appears adequate to satisfy constitutional requirements. The contractual agreement envisioned an on-site physician (the Medical Director) who was to supervise all the Conmed medical staff at the facility (nurses and EMTs) and conduct regular visits (no less frequently than 2 hours/week), and a full time on-site Registered Nurse who was to function as the Health Services Administrator (HSA) . However, during critical events culminating in Brown's death while he was serving a term of imprisonment at Coos County Jail, there was no functioning Medical Director at the facility and the promised services from that position had not been meaningfully delivered during the period of his incarceration. Moreover, there was no nurse on-site as the HSA was attending a conference out of state, no arrangements had been made for a substitute to fill in during her absence, and Brown and the other inmates were having their health care needs addressed by EMTs who were neither licensed nor qualified to diagnose or treat any serious medical conditions. There is significant evidence in

the record from which a jury could conclude that decisions to reduce the inmates' health care coverage to sub-standard levels far below contractual and constitutional obligations were deliberately made and demonstrated indifference to inmates', specifically Brown's, serious medical needs.

There is also evidence before the court that , in the aftermath of Brown's death, his chart entries were altered to reflect the taking of vital signs which a jury could find had not been taken, and to reflect telephonic contact between the absentee HSA and EMT Morgan which a jury could find had also not occurred.

Finally, a jury could conclude from the evidentiary record herein that the M & M Review process, which resulted in the ratification of the health care treatment of Brown as being in compliance with all appropriate Conmed policies and procedures, was tainted by the omission of material information and the submission of materially false information.

I will now move from the above general overview and address evidence pertaining to particular defendants. All evidence previously cited is expressly incorporated in the following analysis:

Marjory Hausler

Brown was evaluated by Hausler of November 12, who referred him to NP Stensland for a further examination that was conducted on November 14. From her November 12 evaluation, the jury could conclude that she was aware that he presented with a serious medical condition (difficulty breathing and chest pain). Although plaintiff presents medical expert opinion in the record that Hausler's examination was deficient and did not comply with Nursing Assessment protocols, I do not find that this encounter standing alone is sufficient to support a "deliberate indifference" finding by the jury. It is , however, a factor that interconnects with Hausler's subsequent decision to travel to an out-of-state conference without procuring a replacement RN at the jail, thus delegating the health care needs of Brown and other inmates to staff EMTs (Morgan and DeLeon), who were not

qualified to diagnose or treat him.[6] Hausler's explanation that she "trusted" the experience of EMTs is belied by regulatory and medical standards that clearly preclude EMTs' from performing the functions assigned to them in Hausler's absence. Under these circumstances a jury can reasonably infer that Hausler was deliberately indifferent to Brown's serious medical needs.

Such an inference is also supportable by evidence in the record that Hausler made false entries in Brown's chart notes (i.e., telephonic contacts with Morgan) , omitted material information in her pre- M & M Report (her absence without a replacement from the jail during the events culminating in Brown's death, the assignment of his medical care to EMTs, and the cancellation of Stensland's clinic), and falsified information in the Report and Recommendation following the M & M Review (i.e., patient never requested health care, staffing was adequate, skill level of staff was adequate).

Where intent (such as deliberate indifference) is an element of a claim, fabricated documentation and falsehoods are classic indicators from which a jury may infer the requisite intent. See, e.g. , Farmer v. Brennan, 511 U.S. 825, 842 (1994) (requisite knowledge of intent is a question of fact subject to demonstration in the usual ways including inference from circumstantial evidence); Hutchison v. United States , 838 F.2d 390, 394 (9th Cir. 1988) ; Garret v. Finander, 2016 WL 8135548, *5 (C.D. CA. 2016) . It is also noteworthy that the M & M proceeding is critical to assessing institutional procedures and policies going forward, and the effect of providing falsified information in that process can counter its purpose to the detriment of fulfilling constitutionally mandated adequate health care to inmates at the institution. This is also relevant to the issue of the "deliberate indifference" standard.

Accordingly, I find there is sufficient evidence to allow the §1983 claim to proceed to trial against defendant Marjory Hausler.

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[6]Although there is some evidence in the record that NP Stensland was scheduled to conduct an on-site clinic on November 21, (the day Brown died), this must be balanced by evidence that the clinic was cancelled because Hausler was absent as she was supposed to participate in clinics and that Hausler thus knew that Stensland would not be conducting a clinic on that date .

Judith Stensland

Defendant Stensland evaluated Brown on November 14th and essentially diagnosed him with gastroentritis. Plaintiff's expert, Dr. Marc Stern summarizes and critiques her evaluation in part as follows:

> On November, 14, during the scheduled visit, NP Stensland evaluated Mr. Brown for a history of shortness of breath walking 50 feet, 4 episodes of vomiting, 5 episodes of diarrhea, abdominal pain, leg swelling, and weakness. She recorded his vital signs as :blood pressure 120/92; heart rate 105 (abnormally elevated, but less so than previously); and oxygen saturation 98%. She diagnosed him with 'GI itis' (which she defined in her deposition as being gastroenteritis) and prescribes a medication to reduce diarrhea (but not vomiting) as needed.
>
> The patient's symptoms, all of which, individually or in combination, can be indicative of serious diseases, required significantly more questioning than what is reflected in the record. For example, the combination of shortness of breath and leg swelling, evokes the possibility of a blood clot which traveled from the patient's leg to his lungs. This required more questioning that might help rule this diagnosis in or out (for example, whether or not the patient has a past or family history of blood clots, whether or not there is chest pain on respiration , etc). Other vital signs, including weight, temperature , and respiratory rate were not measured. The patient's heart rate, while lower than on November 12, was still elevated and required some evaluation, the most logical of which would have been measurement of orthostatic vital signs (measuring blood pressure and pulse standing and lying to check to check for dehydration that might result from vomiting and diarrhea and might be the cause of a abnormally elevated heart rate). The NP also failed to do other very relevant examination, such as an examination of the patient's symptom of leg swelling, as the degree and symptom of leg swelling yields important diagnostic information (for example, unilateral swelling has different causes than bilateral swelling; ankle swelling has different causes than thigh swelling; severe swelling has different causes than mild swelling).
>
> It is not surprising that the NP's history and physical examination were lacking in thoroughness: the entire visit lasted nine minutes and 19 seconds, door to door, about two minutes of which would have been spent measuring and recording Mr. Brown's vital signs leaving less time for history and the rest of the physical examination. This would hardly be enough time to complete the tasks the NP recorded in the medical record in a meaningful way, no less include the other missing components.
>
> ....
>
> NP Stensland stated that the fact that '[Mr. Brown] didn't have a fever' figured into her diagnosis that he only suffered from gastroenteritis (Stensland Deposition page 31 at p. 14). How could this logic be correct given that Mr. Brown's temperature was not measured?

The NP ordered nothing to treat Mr. Brown's vomiting.

The NP did not order any follow-up examination or monitoring of his condition.

P .p. 6-7 of Stern Report (footnotes omitted).

Stensland's examination of Brown and his symptoms is evidence that she would have been aware that he had a serious medical need that required continued monitoring. Were this the sole extent of the evidence regarding Ms. Stensland, defendant's argument that such does not rise beyond ordinary negligence to the level of deliberate indifference would have more merit. But there is a dispute in the evidence regarding whether Stensland knew that Ms. Hausler was going to be away from the jail for the week following the November 14th visit and that the November 21 clinic was going to be cancelled. The record reflects that Hausler testified that Stensland knew about her planned absence and the rescheduling of the clinic, while Ms. Stensland denies such knowledge. Drawing all inferences in favor of the non-moving party, for purposes of this motion for summary judgment the court must find that a reasonable jury could conclude that Stensland was in fact aware of Hausler's absence and that the clinic would not be taking place on November 21. From this, the jury could conclude that Stensland was deliberately indifferent in relying on unqualified staff EMTs to monitor , assess, and treat Brown's serious medical condition without the supervision of a qualified medical professional.

James Morgan

In the absence of Hausler, a substitute RN, or a Medical Director, James Morgan was the senior EMT and assumed the function of making health care decisions for Brown and other inmates. In doing so, he made critical assessments of Brown that were beyond the scope of his training, skill levels , licensing, and regulations applicable to his EMT classification. When Brown began

evidencing abdominal distress early in the morning of November 18, he was evaluated by Morgan later that morning. Brown showed Morgan orange colored urine in his toilet and asked if he was passing blood. Without testing the urine, Morgan diagnosed Brown as being dehydrated and denied Brown's request to be released to go to the hospital because there was nothing wrong with him.

This is the same encounter that Hausler subsequently made a late entry chart note purportedly documenting a telephone conversation with Morgan regarding Brown's condition. As discussed previously, there is evidence that the conversation never occurred and that Morgan had not contacted her. Furthermore, there is evidence that Morgan may have falsified the chart notes of this encounter by recording a set of vital signs which is contradicted by video evidence that Brown's vital signs were not taken on this occasion. (See Expert Report of Marc F. Stern, M.D., p.p. 8-9 submitted as Plaintiff's Exh. 1).

On November 19, Brown was evaluated again by Morgan and told him he had an involuntary bowel movement during the night while sleeping. Morgan decided to release Brown back into the general jail population, telling him to drink plenty of water.

As described by plaintiff's expert Marc Stern, the evaluations of Brown by Morgan on these occasions resulted in diagnoses and treatment plans that were outside the scope of Morgan's professional practice. With respect to the November 18 evaluation :

> EMT Morgan provided his diagnoses, medical treatments, and plan for care (including refusing Mr. Brown's request to go to the hospital) independently, without any input from any licensed medical provider.
>
> Given the latest evidence of massive breakdown of muscle that was occurring in Mr. Brown's body ... this change in urine color may have been a sign of muscle breakdown.
>
> Based on [the declarations of inmate witnesses] , Mr. Brown was in considerable pain that was evident to a lay person.... Mr. Brown had severe symptoms which a reasonable lay person, no less someone trained as and EMT, should have responded to with ...at a minimum, immediate communications with the physician, if not evacuation to the ER.

P. p. 9-10 of Stern Report.

With respect to the November 19 evaluation:

> At 13:40 Morgan conducted an evaluation of Mr. Brown, who was still in Medical Observation. Mr. Brown informed him he had been incontinent of stool while sleeping. The cell smelled of stool and EMT Morgan saw that Mr. Brown's soiled clothes were in a plastic bag. Mr. Brown said he was not eating, but was drinking juice and coffee. Based on the fact that he had finally had a bowel movement, EMT Morgan decided that he no longer required Medical Observation, and discharged Mr. Brown back to the general with instructions to 'drink plenty of fluid to help everything flow better.'
>
> EMT Morgan conducted no further symptom evaluation nor any physical evaluation (including measuring any vital signs) despite a very remarkable history of not eating and having fecal incontinence while sleeping. Had he done so, the interim change in Mr. Brown's abdomen would have been evident and alarming.
>
> EMT Morgan provided this care and treatment plan (including discharging him from Medical Observation) independently, without input from any licensed provider.
>
> As discussed later, it is likely by this point in time, Mr. Brown now had a hole in his stomach allowing gastric contents to leak into the peritoneal cavity - an area that is normally sterile and virtually empty. EMT Morgan's medical treatment plan - to drink more water - was therefore patently dangerous. Drinking water would cause more of the gastric contents to leak into the peritoneal cavity. Not only is the water not sterile, but it will carry with its gastric contents which are laden with harmful bacteria and corrosive acid.
>
> None of the required documentation forms for admission to, or discharge from, Medical Observation, were filled out.
>
> EMT Morgan did not arrange any follow-up or monitoring of Mr. Brown's condition. He would thus not be evaluated again by any health care personnel for another 48 hours.

P. p. 10-11 of Stern Report.

On November 21, Brown repeatedly asked a corrections officer when he could see a doctor. At about 2:25 p.m. , Morgan visited Brown's unit and asked if he was constipated. Brown replied in the affirmative and Morgan gave him medication for constipation. He did not conduct any further symptom evaluation, nor any physical examination. At 3:25 p.m., the corrections officer informed Morgan that Brown was vomiting blood. Morgan instructed the officer to escort Brown to the booking area so that he could see him there.

Dr. Stern describes vomiting blood as a medical emergency and states in his report that Morgan should have attended to Brown immediately, called 911, or immediately contacted a licensed health

care provider. P. 12 of Stern Report.

At 3:35 p.m., Brown arrived in the booking area by wheelchair. He had blood in his mouth and was breathing rapidly. Morgan attempted to take his temperature, recording a 90.3 and 90.1, observing that Brown would not keep his mouth closed. In conjunction with custody staff, a decision was made to release Brown early from custody (his sentence would have been satisfied the next day) and give him a courtesy ride to the hospital.

Dr. Stern is highly critical of these actions as he states:

> At approximately 15:35, Mr. Brown arrived in the Booking area by wheelchair. EMT Morgan noted that his skin appeared jaundiced and his abdomen was distended 'but not severely.' EMT Morgan attempted to take his temperature twice, yielding 90.3 and 90.1 (both severely low; hypothermia is defined as core temperature less than 95.0); he reported that Mr. Brown would not keep his mouth closed. EMT DeLeon noted that he had blood in his mouth and was breathing rapidly. Along with custody staff, a decision was made to release Mr. Brown early from custody and drive him to the hospital.
>
> If his low temperature was real, it constituted a life-threatening emergency. It may have been an artifact of Mr. Brown's fast breathing, but that too was an ominous sign: the rapid breathing likely reflected the fact that the acid level was building in Mr. Brown's blood due to wide spread infection and failing of kidneys.
> Despite the serious findings, the EMTs decided to send Mr. Brown to the hospital by van, no ambulance. They made this decision independently, without input from any licensed medical provider.
>
> At this point, neither EMT sent any written clinical information or records with Mr. Brown to the hospital nor contacted the hospital to alert them of his arrival and provide information orally or by fax. This information is necessary for safe continuity of care as captured twice in Conmed Policy, once in Policy 40.60 Hospital and Specialized Ambulatory Care, and again in Policy 50.30 Emergency Services ('The referring healthcare staff member will initiate an Emergency Room/Specialty Referral (C-782). The Medical Record copy of the Referral Form will be sent via fax and/or in a sealed envelope with the officer that is transporting the inmate. The Provider copy will be retained ..... As soon as practical after the inmate leaves for the Emergency Room, healthcare staff will telephone the Emergency Room to give report on the inmate's status.').

P. p. 12-13 of Stern Report.

There was approximately a 50 minute delay in transporting Brown via courtesy ride (as opposed to ambulance) as deputies waited for him to be approved for early release and to change from his jail garb to his personal clothing, a task which was made more difficult because of his condition.

Although Brown suffered no adverse effects in being transported to the hospital in the jail van, the resulting delay in his ER evaluation is relevant to the §1983 deliberate indifference analysis.

The above factual summary of encounters between EMT Morgan and inmate/patient Brown should not be analyzed in isolation or in disconnected fashion. Cumulatively considered, a jury could reasonably find that Morgan was deliberately indifferent to Brown's serious medical needs. Most significantly, there is evidence that Morgan undertook a medical professional task (diagnosing and treating Brown) without consulting with a qualified physician or nurse practitioner that he knew he was not qualified or licensed to perform. See , Toussaint v. McCarthy, 801 F.2d 1080, 1111-12 (9th Cir. 1986) (reversing summary judgment in favor of defendants because if registered nurses provided " a number of [medical] services which they [were] not qualified to perform." this would demonstrate deliberate indifference) , *abrogated in part on other grounds by* Sandin v. Conner, 515 U.S. 472 (1995); See also, Pride v. Correa,, 533 Fed. Appx. 745, 747 (9th Cir. 2013) (triable issue of fact existed as to deliberate indifference when nurse attended meeting as doctor's representative when nurse not qualified to do so).

Robert DeLeon

EMT DeLeon assisted Morgan when Brown was evaluated after reports that he was vomiting blood. Although plaintiff contends that DeLeon was "deliberately indifferent" in participating in the decision to not summon an ambulance but rather to provide a "courtesy ride" to the hospital, I note that Morgan was the senior medical staff member on-site and there is no evidence that DeLeon had the authority to overrule Morgan on the matter. Nor did he diagnose or treat Brown beyond the scope of his qualifications or expertise. While plaintiff generally contends that DeLeon "should not have agreed to staff the medical clinic at the Coos County Jail while Ms. Hausler was out of town for a week." that decision by itself cannot constitute deliberate indifference towards Brown when it is unconnected to any treatment of Brown that went beyond the scope of his EMT license. Nor does testimony by inmates that they told DeLeon that Brown was very sick and needed to see a

doctor fill the gap between mere negligence and deliberate indifference given the evidence that EMT Morgan was the senior staff member who had responded to reports about Brown. In sum, the evidence fails to support the §1983 claim against DeLeon.

Dr. Steven Blum

The following excerpt is incorporated from plaintiff's memorandum in opposition to the motion for summary judgment:

> Dr. Carla Antola worked as Conmed's Medical Director at the Coos County Jail until the summer of 2013. She visited the jail twice a week while she was Medical Director. As set forth below, Conmed did not fill the position after Dr. Antola left.
>
> In 2008, Dr. Steven Blum began working for Conmed as the Medical Director at the Douglas County Jail, and he continues to serve in that role for Conmed. In February 2012, Dr. Blum 'agreed to serve as the State Medical Director for the State of Oregon on behalf of Conmed.' He reported to Dr. Donald Rhodes, the Chief Medical Officer of Conmed. While working for Conmed, Dr. Blum also was a 'full-time employee with the VA as a hospitalist.'
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> Dr. Blum testified that 'I didn't become a specific medical director for any other jails.' He explained that , in November 2013, 'there wasn't an on-site medical director [at the Coos County Jail]. As the state director, I would fill in with - if something needed to be done, but there was no on-site director at that time.' He said that Judith Stensland, a nurse practitioner, 'did all of the day-to- day work. And I was just there, if there was any questions or, you know, if Jude had any questions or Margie [Hausler, the Conmed HSA]. ... And really they kind of - I mean, beyond that there wasn't much that I did on a day to day basis. Jude and Margie were doing fine and I was just there if needed, if Jude had a question about a patient or something.
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> Judith Stensland began working for Conmed at the Douglas County Jail in February 2013. After Dr. Antola left, Ms. Stensland began visiting the Coos County Jail one day per week for about four hours. She would see anywhere from three to ten patients during these visits. She did not supervise Ms. Hausler or perform any administrative duties.
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> The staffing matrix prepared by Conmed indicated that the Medical Director would visit the jail once a week and a Nurse Practitioner would visit twice a week. Dr. Blum visited the Coos County Jail 'probably three times total....' He did not perform any administrative or medical director functions during those visits. He did not consider himself to be a supervisor of Ms. Stensland or Ms. Hausler. He was not the on-call physician for Ms. Stensland or the EMTs in the jail. One of the EMTs, Robert DeLeon, testified that Ms. Hausler 'might have been struggling because we might not have been getting a doctor on a more regular basis.
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> The printed Conmed schedule for November 2013 shows that the job of 'Physician'

> was 'VACANT.' Ms. Hausler testified that Dr. Blum 'was our regional medical director' who 'came out periodically' and was responsible for final medical assessments and judgments at the Coos County Jail. She testified that the schedule said 'VACANT' because 'we only had Nurse Practitioner Jude coming in on a regular basis.' She wrote in Dr. Blum's name on the schedule because he came in to handle the clinic one day that month.
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> Conmed had a written policy detailing the responsibilities of the Medical Director at each facility. Asked if he was the 'Conmed on-site Medical Director (Health Authority) ' mentioned in that policy for the Coos County Jail in November 2013, Dr. Blum responded " 'I don't know. I'm not sure. I guess if there was a question going up the chain of command, it would have been me. ... I would say day-to day stuff would have been Jude, since she was the on-site provider. But if there was any questions, then I would be the next step in the chain of command.' Dr. Blum did approve a Coos County Sheriff's Office policy entitled 'Access to Health Care' by signing as ' Medical Director Coos County Jail.' Dr. Blum explained that 'the company asked me to sign off on this since there was no on-site director.'
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> Dr. Steven Goldberg, the Chief Operating Officer for Conmed , testified that the position of Medical Director of the Coos County Jail 'was being covered by Dr. Blum. It was not formally filled, but the position was being covered by Dr. Blum. ' He acknowledged that he 'was aware of a need for a medical director to fill the position Dr. Blum was covering for.'
>
> Dr. Donald Rhodes, the Chief Medical Officer for Conmed, testified that 'we asked Dr. Blum to help out in the interim while we found a permanent replacement for ' Dr. Antola. Asked if Dr. Blum was the Medical Director of the Coos County Jail, Dr. Rhodes said that 'we werent't big on titles, but I believe he was either given, granted, assigned, that title on an interim basis at some point.... I believe that I considered him to be the Medical Director in Dr. Antola's absence.' Both Dr. Goldberg and Dr. Rhodes agreed that Dr. Blum was responsible for performing the duties of Medical Director at the Coos County Jail.
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> Mary Krahn, a Conmed regional manager, said of Dr. Blum that 'it was hard to tell when he was and when he wasn't ' the Medical Director because ' [s]ometimes - I mean, he would agree to do it after Dr. Goldberg or Dr. Rhodes talked to him He would agree, and then it would get to be too much and then he would un-agree.'

P. p. 9-12 of Plaintiff's Memo in Opposition to Motions for Summary Judgment (#147) (footnotes and citations to record omitted).

The above factual context regarding Dr. Blum's roles for Conmed is not a subject of dispute, and thus the court provides it as background for my legal analysis of plaintiff's §1983 claim against him. The central thrust of Conmed's motion for summary judgment on the claim against Blum is that he was not personally involved in the alleged constitutional violation, and that plaintiff failed to establish a "sufficient causal connection between the supervisor's wrongful conduct and the

constitutional violation." See , Hansen v. Black , 885 F.2d 642, 645-46 (9th Cir. 1989). However, " [a] showing that a supervisor acted, or failed to act, in a manner that was deliberately indifferent to an inmate's Eighth Amendments rights is sufficient to demonstrate the involvement - and the liability - of that supervisor." Starr v. Baca , 652 F.3d 1202, 1206-07 (9th Cir. 2011). The supervisor need not be personally involved in the same way as are the individual medical providers on the scene inflicting constitutional injury. Id. At 1205. The supervisor's participation could include his own action or inaction in the training, supervision, or control of his subordinates, his acquiescence in the constitutional deprivations or conduct that showed a reckless or callous indifference to serious medical needs. See, id., at 1205-06 (emphasis supplied).

Dr. Blum and his employer, Conmed, cannot have it both ways. Either he was or was not the Medical Director for the Coos County Jail during the period of Brown's incarceration. If he was the Medical Director, by Conmed's own description he played a "key role" in the Medical Department and had a "continuous role" in overseeing medical operations at the Jail. The Medical Director had ultimate responsibility for supervision of all medical and clinical staff. As noted in Starr v. Baca, supra , his "inaction' in providing that "supervision or control" could itself be evidence of deliberate indifference. From the evidence set forth in the record, a jury could reasonably find that Dr. Blum was the Medical Director and that his inattention to his duties at the Coos County Jail including his failure to meaningfully oversee or supervise subordinate medical staff at the facility is evidence of deliberate indifference to the serious medical needs of inmates, specifically Donnie Brown, and thus was a causative factor in the deprivation of Brown's constitutional right to adequate medical care.

Conmed Healthcare Management, Inc.

As set forth above, there is sufficient evidence that individual Conmed employees were deliberately indifferent to Brown's serious medical needs and deprived him of his Eighth

Amendment right to adequate medical care under the constitution.

There is also evidence from which a jury could find that the constitutional violation at issue herein was the result of an official policy on Conmed, in particular:

1) failing to adequately staff the Coos County Jail with qualified medical professionals to provide promised health care to inmates;

2) failing to fill the critical role of Medical Director for the Jail as promised in its proposal to Coos County;

3) ratifying and endorsing the understaffing and constitutionally inadequate medical care provided to Donnie Brown by conducting and adopting findings from a mandated M & M Review process that was tainted by material misrepresentations and omissions and which resulted in the conclusion that all Conmed and Coos County Jail policies were followed and adequate for the situation

Post-event evidence may be used to prove the existence of Conmed's policy. See Henry v. County of Shasta, 132 F.3d 512, 518 (9th Cir. 1997). A policy or custom may be inferred if, after Brown's allegedly unconstitutional treatment, Conmed officials took no steps to reprimand those responsible or if it otherwise failed to admit the conduct was in error. See McRorie v. Shimoda, 795 F.2d 780, 784 (9th Cir. 1986). Here, Conmed not only failed to reprimand anyone responsible for the understaffing at the Jail which led to Brown's treatment and death, it affirmatively endorsed and approved their actions as being fully compliant with Conmed policies and procedures.

There is evidence in the record that Conmed Chief Operating Officer, Dr. Steven Goldberg, attended the same conference that Coos County Jail HSA Hausler attended from November 18, 2013 to November 21, 2013 and expressed concern to her at that time when he learned that she had not arranged for a replacement at the Jail during her absence. Yet he testified during his deposition in this case that the people involved in [the M & M Report] made the determination that her absence

did not contribute to [Brown's] death.[7] He further stated that Dr. Donald Rhodes, Conmed's Chief Medical Officer, who had attended the meeting, reported verbally to him "that there were no changes that we were going to make because the procedures and the process medically was sound."

However, the report itself makes no mention of Hausler's absence or the failure to procure a substitute nurse during the events culminating in Brown's death. Nor does it mention the cancellation of Nurse Stensland's clinic on the morning of the day that Brown died. To the contrary, the report summarily concluded that "staffing was adequate" and "skill level of staff was appropriate." Given this context, a jury could reasonably find that officials at the highest level of Conmed deliberately ignored the deficiency in staffing at the jail during the critical events culminating in Brown's death and approved such as compliant with Conmed policies and procedures.

Coos County, Sheriff Craig Zanni, and Sergeant Darius Mede

As discussed previously, Coos County contracted with Conmed to provide healthcare to inmates at its jail facility. Ultimately, however, it is the County which operated the jail and contracting out the health care does not relieve the County of its constitutional duty to provide adequate medical treatment to those in custody. West v. Atkins, 487 U.S. 42, 56 (1988).

The §1983 claim against the County defendants (Coos County, Sheriff Zanni[8], and Sergeant

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[7]"[I]t was my understanding from the report from Dr. Rhodes is that medically this was handled properly and that her being in town or not in town would not have impacted the medical outcome." P. 186 of Deposition of Dr. Goldberg.

[8]Although not specifically named in the caption of the Complaint, Paragraph 76A and Paragraph 77 of the Complaint allege:

"Coos County, by and through its supervisory staff and policy makers including but not limited to Darius Mede was aware of and chose with deliberate indifference to disregard a substantial risk that its defective policies, practices, and customs with respect to the provision of medicl care in the Coos County Jail would cause suffering and death. The defective policies, practices, and customs caused the suffering and death of Mr. Brown.

Coos County and its senior policy makers including but not limited to Darius Mede acted or failed to act in the following particulars which prevented Mr. Brown from being able to access adequate medical care.

a) Failing to oversee and supervise the provision of health care in the Coos County Jail by Conmed....."

Mede) is not premised on their deference to the judgment of qualified medical professionals in their diagnosis and treatment of Donnie Brown. See , Lemire v. California Department of Corrections, 726 F.3d 1062, 1081-1082 (9th Cir. 2013) (no "deliberate indifference" when correctional officers deferred to judgment of medical staff). It is rather based upon their own policies and failures to oversee Conmed and enforce the contractual provisions which required higher levels of medical expertise than it actually delivered.

To state the issue plainly, Coos County could not fulfill its constitutional obligation to provide adequate medical care to its inmates by contracting with EMTs to diagnose and treat inmates at the Jail without the oversight and supervision of qualified medical professionals, such as a physician and nurse, given that such health care would be beyond the scope of their licenses and expertise. The Coos County -Conmed Contract specified that Conmed would provide a Medical Director (physician) responsible for the supervision of its medical staff at the site who would visit the jail no less than once/week and a Registered Nurse (HSA) who would be physically present at the Jail on a full -time basis and be on-call for after hours medical care needs. Sheriff Zanni and Sergeant Mede were assigned the duty of enforcing the contract obligations. There is evidence from which a jury could reasonably conclude that they failed to fulfill their supervisory responsibilities and that this itself constituted deliberate indifference on their part. See, Starr v. Baca, supra.

Specifically, after Dr. Antola left Conmed in the Summer of 2013, no physician performed her duties at the Jail, conducted weekly visits with clinics at the site, or otherwise supervised the medical staff at the Jail. The position of Medical Director was effectively left vacant for months. There is no evidence that Zanni or Mede took any action to enforce this critical component of the promised health care coverage. Moreover, when RN Hausler was absent from the site attending a conference from November 18 to November 21 and Conmed failed to provide a substitute, leaving the health care responsibilities to EMTs, there was likewise no effort made by Sheriff Zanni or

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As Sheriff Zanni is undisputably a "policy maker" for the County regarding its jail-operations, I thus include him in this analysis as a de facto defendant.

Sergeant Mede to enforce Conmed's contractual obligation to provide an on-site RN.

Coos County contends that there is no evidence in the record that Zanni or Mede knew of Hausler's absence and the lack of a substitute RN during the critical period culminating in Brown's death. However, there is evidence from Hausler that they were aware of her absence, and the deposition of Zanni and Mede reflects a lack of recollection on their part about when they became aware of her absence or the non-staffing of the Medical Director position. Moreover , there is evidence that deputy correction officers were fully cognizant of Hausler's absence, as they interacted with EMTs Morgan and DeLeon about Brown's condition. Thus, a jury could reasonably infer from this evidence that the Sheriff and the Jail Administrator were aware of the fact that there was no Medical Director or nurse monitoring the health care needs of inmates during the period of November 18 through November 21.

In addition, following Brown's death, Sheriff Zanni and Sergeant Mede attended the M & M proceeding on December 12, 2013. The meeting concluded with findings that "All Conmed and Coos County Jail polices were followed and adequate for the situation, that "staffing was adequate" and that there were no factors leading to Brown's death that needed to be addressed through changes or adoption of policies, procedures, or training. No disagreement was expressed from any participants in the meetings. While it is uncertain whether Coos County receive a copy of the written "Report and Recommendation Following M&M " containing these and other findings, RN Hausler prepared the report and testified that her written report was based solely on the oral discussions at the December 12 proceeding.

Thus there is evidence from which the jury could reasonably conclude that Sheriff Zanni and Sergeant Mede concurred in the M & M Report's conclusions, despite knowledge that Conmed staffing was inadequate and not in compliance with contractual requirements during the events culminating in Brown's death.[9] As I have set forth previously in the section pertaining to Conmed's

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[9]In addition to Hausler's testimony, that her absence was known by the Sheriff, there is evidence that the Sheriff's Office conducted its own investigation into the circumstances

liability, post -event evidence may be used to prove the existence of policy, and a policy or custom may be inferred if, after allegedly unconstitutional conduct, officials took no steps to reprimand those responsible or otherwise failed to admit the conduct was in error. Henry v. County of Shasta , supra, McRorie v. Shimoda, supra. Here , there is thus evidence that Sheriff Zanni and Sergeant Mede ratified and endorsed Conmed's treatment of Brown's serious medical needs as being in compliance with all Conmed and Coos County Jail policies when they knew otherwise. Accordingly, the jury could find that Sheriff Zanni , Sergeant Mede, and Coos County were deliberately indifferent to the serious medical needs of inmates at the Jail, including Donnie Brown.

Plaintiffs also contend that Coos County had a policy of processing inmates with serious medical needs for early release and transporting them via a "courtesy drop" to the hospital to avoid incurring medical costs to the County (ambulance services, hospital treatment) and that this policy contributed to Brown's death in various ways, including being skeptical of Brown's symptoms as a possible ploy to gain early release and delaying his treatment after Brown presented an emergency situation. Because there is other evidence that precludes summary judgment on the Eighth Amendment §1983 claim against the County defendants, there is no need to parse out a separate analysis of the "courtesy drop" issue. Moreover, evidence of this practice as applied to Brown should not be considered in isolation on the "deliberate indifference " standard but in context with all the other evidence relevant to the §1983 claim against the County defendants.

B. Alleged Violations of the Fourteenth Amendment Pursuant to §1983

Plaintiffs also assert a Fourteenth Amendment violation under §1983 alleging that the Coos County and Conmed defendants violated Donnie Brown's parents' liberty interest in the companionship of their son by their actions/inactions as described above. Both the County and Conmed defendants move for summary judgment on this aspect of plaintiff's §1983 claim, but

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surrounding Brown's death and the jury can reasonably infer the investigation inevitably would have disclosed the staffing details. See p.p. 71-72 of Deposition of Sheriff Zanni, describing that he was contacted the day after Brown's death by a local physician and informed that he should not have died and that "[a]t that point I figured that I'd been asking people to gather stuff."

essentially confine their arguments to a repetition of their position that plaintiffs have failed to prove "deliberate indifference" in the defendants' responses to Brown's serious medical needs. Plaintiffs have not specifically responded to defendants' motions on the Fourteenth Amendment subsection of the §1983 claim, as distinct from the Eighth Amendment component. The Fourteenth Amendment component implicates what appears to be an arguably different standard - "shocking the conscience " - which none of the parties have addressed. Accordingly, since I have found that the "deliberate indifference" standard is supportable by the evidence, I recommend denial of the defendant's motion of this aspect of plaintiff's §1983 claim without prejudice for reconsideration of the applicable standard at the pretrial conference.

LEGAL ANALYSIS OF NEGLIGENCE CLAIMS AGAINST THE COUNTY

Turning to the negligence claim against the County, it is mingled within the confines of plaintiff's Third Claim for Relief Professional Negligence (through failure to provide medical care consistent with the standard of care in the community) and the Sixth and Seventh Claims for Relief (Negligence and Cruel and Unusual Punishment in Violation of the Eighth Amendment). While less than a model of clarity , the allegations therein include (at Paragraph 77):

> Coos County and its senior policy makers including but not limited to Darius Mede acted or failed to act in the following particulars which prevented Mr. Brown from being able to access medical care a) failing to oversee and supervise the provision of health care in the Coos County Jail by Conmed, including acts and omissions listed above in Paragraph 73 [which includes the following]:
>
> Failing to adequately staff the medical care program at the Coos County Jail, including but not limited to failure to provide for the presence of a doctor, nurse practitioner, or registered nurse, from November 15 through November 21, 2014 (sic) including failure to provide for a replacement for Nurse Hausler while she was out of town at a conference.

As discussed extensively in the §1983 analysis above, this staffing deficiency violated the

express contractual requirements between the County and Conmed which Sheriff Zanni and Sergeant Mede had a duty to enforce. Their failure to enforce those provisions requiring a physician and a Registered Nurse to maintain an on-site presence and supervise the medical care provided to inmates, including Brown , can be found by a jury to have violated a duty they owed to the inmates and thus constitute negligence, which is a lower bar than the deliberate indifference standard applicable to the §1983 claim. As I have already determined that the deliberate indifference standard is supported by the evidence in the record, it follows that the negligence claim is likewise supported and it is unnecessary to discuss other evidence relevant to this claim. [10]

PUNITIVE DAMAGES

The Conmed defendants move for summary judgment against plaintiffs' claim for punitive damages. This motion is essentially based on their contention that none of the Conmed defendants showed deliberate indifference to Brown's serious medical needs and thus that standard for punitive damages cannot be met. As set forth above, the court finds sufficient evidence from which the jury could find deliberate indifference on the part of Conmed and all of the Conmed defendants with the exception of Robert Deleon. Thus, this motion should be denied.

CONCLUSION

For the reasons set forth above, the Coos County defendants' motion (#130) should be denied in its entirety and the Conmed defendants' motion (#135) for summary judgment should be denied for all defendants except defendant Robert DeLeon and granted on the §1983 claim against defendant Deleon.

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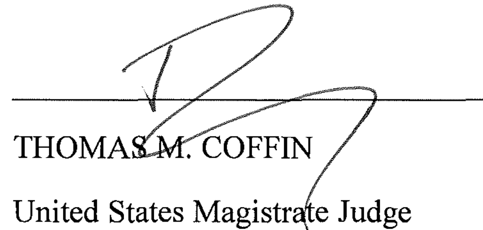
[10] The trial court may require plaintiff to provide more specificity in the Pretrial Order on the negligence claim, now that discovery has concluded, beyond that attributable to defendants Zanni and Mede and the County as set forth in the §1983 analysis.

No part of this court's Findings and Recommendation has relied on plaintiffs' submissions regarding the medical treatment of Coos County Jail inmates other than Donnie Ray Brown, nor on any statements submitted by plaintiff's experts expressing the opinion that defendants acted with "deliberate indifference."

DATED this 28th day of November, 2017.



THOMAS M. COFFIN
United States Magistrate Judge