IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

Leticia Vargas, Administrator of the Estate of Angel Cruz,	)	
	)	18-cv-1865
Plaintiff,	)	
	)	*(Judge Seeger)*
-vs-	)	
	)	
County of Cook, et al.,	)	
	)	
Defendants.	)	

PLAINTIFF'S LOCAL RULE 56.1(a)(2) STATEMENT OF MATERIAL FACTS

Plaintiff submits the following pursuant to Local Rule 56.1(a)(2):

I. Parties

1. Plaintiff Leticia Vargas is the court-appointed independent administrator of the estate of Angel Cruz Jr. (Exhibit 1, Letters of Office, June 6, 2018.)

2. Angel Cruz Jr. was a detainee at the Cook County Jail when he died on March 20, 2016 of pulmonary embolism caused by deep vein thromboses of the legs with obesity contributory. (Exhibit 2, Office of the Medical Examiner, County of Cook, Illinois, Report of Postmortem Examination 9.)

3. Defendant Cook County is a body politic that provides health care to detainees at the Cook County Jail. *Thomas v. Cook County Sheriff's Department*, 604 F.3d 293, 298 (7th Cir. 2010)

4. Defendant Dr. Steve Paschos was, at all relevant times, employed by defendant Cook County at the Cook County Jail as a psychiatrist. (Exhibit 3, Dr. Paschos Dep. 8:6-11; Exhibit 4, Dr. Paschos Interrogatory Answers No. 11.)

5. Defendants Lorraine Chatman, Helen Kanel, and Manuel Manalastas were, at all relevant times, employed by defendant Cook County at the Cook County Jail as nurses. (Exhibit 5, Chatman Dep. 9:20-23, 10:13-15; Exhibit 6, Chatman Interrogatory Answers No. 11; Exhibit 7, Kanel Dep. 6:23-7:8; Exhibit 8, Kanel Interrogatory Answers No. 11; Exhibit 9, Manalastas Dep. 6:1-11; Exhibit 10, Manalastas Interrogatory Answers No. 11.)

6. Angel was processed into the Cook County Jail on March 15, 2016. (Exhibit 11, Cook County Sheriff's Office Booking Card, CCSAO Sheriff 0001.)

7. Intake personnel at the Jail accurately recorded in Jail records that Angel was morbidly obese, exhibiting signs of serious mental illness, had no prior psychiatric treatment, and, immediately before his admission

to the Jail, had been treated at a hospital where he had been diagnosed with schizophrenia, paranoid type. (Exhibit 12, Psychiatric New Patient Evaluation, 3/15/2016, County 0004-0006.)

8. Angel was at the Jail for attempted murder which he attributed to voices "telling me to go and retaliate and seek revenge to those who killed his father long time ago." (Exhibit 12, Psychiatric New Patient Evaluation, 3/15/2016 at 2, County 0005.)

9. Angel was assigned to an "Acute Care Unit" known as "2N" at the Cermak Hospital within the Cook County Jail, and he remained in that unit throughout his stay at the Jail. (Exhibit 13, Bed Assignment Associated View, County 0253; Exhibit 3, Dr. Paschos Dep. 21:20-24.)

10. Shortly before 6:00 p.m. on March 18, 2016, defendant Dr. Paschos made an entry into the medical chart that Angel was covering his room in feces, urine, and trash and was acting violently, including jumping off his bed and attempting to hit his head against the wall. (Exhibit 3, Dr. Paschos Dep. 151:10-17; Exhibit 14, Mental Health Note, County 0033.)

11. Defendant Dr. Paschos ordered that Angel be placed into restraints and instructed personnel at the Jail to immobilize Angel by placing his arms, legs, and chest into leather restraints attached to Angel's bed. (Exhibit 3, Dr. Paschos Dep. 60:22-61:16, 152:18-153:3.)

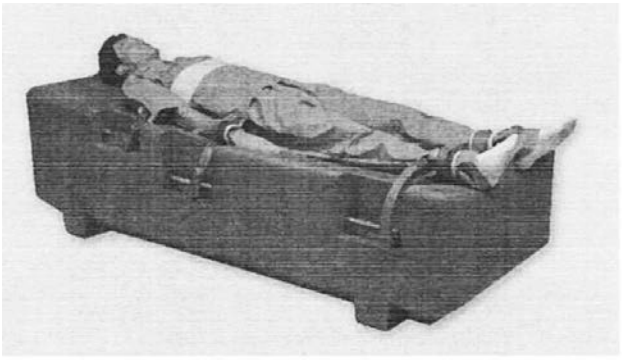
12. The Jail's policy for the use of restraints in effect in March 2016 is contained in Policy I-01. (Exhibit 15, Cermak Health Services Policy I-01, LVARGAS 0407-0415.)

13. A training module for County personnel cautions that restraints may result in "circulatory problems" (Exhibit 16, Restraint & Seclusion, Staff Training Module 8) and should be used "only to stop *current* harm." (*Id.* at 17.)

14. The training module also states the policy that renewal of a restraint order requires a "face to face evaluation" by a physician or a registered nurse every four hours. (Exhibit 16, Restraint & Seclusion, Staff Training Module 22.)

15. The training module states that a nurse must check on a restrained detainee every 2 hours and, *inter alia*, do "range of motion (each limb)." (Exhibit 16, Restraint & Seclusion, Staff Training Module 22)

16. The training module contains the following image of a restrained patient:



(Exhibit 16, Restraint & Seclusion, Staff Training Module 38.)

II. Standards of Care in Effect in March of 2016

17. The standard of care for any patient who is in restraints is to minimize the time that the patient is restrained by treating aggressive behavior with other measures such as verbal redirection or medications. (Exhibit 17, Expert Report of Dr. Evadne Marcolini 5; Exhibit 18, Expert Report of Dr. Daphne Glindmeyer 29.)

18. The standard of care requires that restraints be renewed every four hours, meaning that there must be a medical determination that continued restraints are appropriate. (Exhibit 17, Report of Dr. Evadne Marcolini 5; Exhibit 3, Paschos Dep. 64:8-15, 153:19-21; Exhibit 15, Cermak Health Services Policy I-01 at 6, LVARGAS 0412.)

19. The standards of care to minimize time in restraints and to renew orders every 4 hours was implemented through an official policy at

the Jail known as Cermak Health Services Policy I-01 (Exhibit 15) that was in force and effect in March of 2016. In pertinent part, the Policy provided as follows:

> To extend the duration of a restraint order beyond the initial 4 (four) hours:
>
> 1. The Psychiatrist or restraint-trained RN, in consultation with the on-site or on-call Psychiatrist, will:
>
> a. Write a new order in the chart updating the elements that were included in the original order in Increments not to exceed four (4) hours.
>
> b. Do so only after personal examination and evaluation of the patient.
>
> c. Entire period of restraint may not exceed 24 (twenty-four) hours in increments of 4 hours each.
>
> d. Each renewal must be preceded by a face-to-face medical and behavioral evaluation by the Psychiatrist, Physician in consultation with the on-site or on-call Psychiatrist or RN in consultation with the on-site or on-call Psychiatrist.
>
> e. Every effort must be undertaken to ensure that the patient is only restrained for the duration of time necessary to reduce/minimize risk of physical harm to self or others.
>
> 2. Once this risk is reduced to a level assessed to be sufficient for consideration of reassessment of the need for restraints, the patient is to be evaluated for release from restraints or seclusion.

(Exhibit 15, Cermak Health Services Policy I-01 at 6, LVARGAS 0412.)

20. The standard of care requires that a patient immobilized in restraints receive anticoagulant prophylaxis, such as subcutaneous heparin,

or that the patient be given regular "range of motion exercises" to mitigate the risk of clot formation. (Exhibit 17, Report of Dr. Evadne Marcolini 4.)

21. The requirement for regular "range of motion exercises" was implemented in Cermak Health Services Policy I-01 (Exhibit 15), which provided, in pertinent part as follows:

> Allow all patients to exercise each limb, alternating all four limbs for approximately ten (10) minutes on a rotation basis, every two hours unless clinically contraindicated for reasons of safety to the patient of others, to prevent physical deterioration and to promote circulation during restraint.

Exhibit 15, Cermak Health Services Policy I-01 at 5, LVARGAS 0411.)

22. The "range of motion" exercises would be performed by a nurse on each limb, as the nurse released the detainee's limbs one at a time. (Exhibit 9, Manalastas Dep. 58:10-21.)

23. Jail personnel followed the order of defendant Dr. Paschos and placed Angel into restraints at about 6:00 p.m. on March 18, 2016, immobilizing his arms, legs, and chest while he was laying down on his back on his bed. (Exhibit 19, Sprague Dep. 32:12-18, 33:18-34:1.)

24. Angel remained in restraints for about 17.5 hours until about 11:30 p.m. on March 19, 2016. (Exhibit 9, Manalastas Dep. 35:18-36:6.)

25. Dr. Paschos did not at any time administer or prescribe anticoagulant prophylaxis to Angel. (Exhibit 3, Dr. Paschos Dep. 185:2-9.)

III. Defendant Kanel

26. Defendant Kanel worked as a nurse on 2N on March 18, 2016 from 3:00 p.m. until 11:00 p.m. (Exhibit 7, Kanel Dep. 75:9-19.)

27. During defendant Kanel's shift, the standard of care required that a physician decide whether to renew the restraint order at or about 10:00 p.m. (Exhibit 17, Report of Dr. Evadne Marcolini 5; Exhibit 3, Paschos Dep. 64:8-15, 153:19-21; Exhibit 15, Cermak Health Services Policy I-01 at 6, LVARGAS 0412.)

28. Defendant Kanel made a chart entry renewing the restraint order in Angel's medical records at about 9:55 p.m. on March 18, 2016. (Exhibit 20, Orders showing Psychiatric/Violent Restraints Ordered 3/18/2016 21:55 CDT, County 0119.)

29. Defendant Kanel made this chart entry without assessing Angel's condition: The surveillance video (Video Exhibit 2) shows that defendant Kanel did not enter Angel's cell at any time between 8:11 p.m. and 10:56 p.m. on March 18, 2016.[1] (Kanel is the nurse seen behind the

[1] For the convenience of the Court, plaintiff submits a condensed presentation of the surveillance videos as Video Exhibit 5, Cruz_VideoPresentation_ NoAnnotations.mp4. The condensed video was prepared by video presentation expert Brady Held, whose expert report is submitted as Exhibit 21. Plaintiff offers the condensed video in the same manner as a transcript is used for an audio recording: not as evidence, but to assist the finder of fact. *See* SEVENTH CIRCUIT PATTERN CRIMINAL INSTRUCTIONS 3.14. Plaintiff also submits as Exhibit 22 a chronology of events to aid the Court in viewing the video evidence.

nurses' station at 5:47:11 p.m. on March 18, 2016. (Exhibit 19, Sprague Dep. 60:22-61:1.) Angel's cell is shown when Angel is walked into the cell at 5:51:34 p.m. on March 18, 2016. (Video Exhibit 1; Exhibit 19, Sprague Dep. 63:21-64:1.))

30. Defendant Kanel did not consult with Defendant Dr. Paschos before ordering that Angel continue to be held in restraints: Defendant Dr. Paschos was the on-call psychiatrist on March 18, 2016. (Exhibit 23, Cook County's Answers to Plaintiff's Interrogatories Dated 10/24/19 No. 3.) Defendant Kanel stated that she would call the on-duty psychiatrist only from a phone at the nursing station. (Exhibit 7, Kanel Dep 123:24-124:15.) The surveillance video (Video Exhibit 2) shows that defendant Kanel did not use a phone at the nursing station between 9:00 p.m. and 11:28 p.m. on March 18, 2016.

31. Defendant Kanel wrote the false statement in the order entry (Exhibit 20, Orders showing Psychiatric/Violent Restraints Ordered 3/18/2016 21:55 CDT, County 0119), a nursing note (Exhibit 24, Nursing Note 3/18/2016 22:29 CDT, County 0199), and repeated the falsehood in her deposition testimony (Exhibit 7, Kanel Dep 91:17-20) that she had ordered the continuation of restraints after assessing Angel and consulting by telephone with Dr. Paschos.

32. Dr. Paschos made the false statement at his deposition that defendant Kanel had consulted with him about continuing Angel in restraints. (Exhibit 3, Paschos Dep. 160:21-161:1.)

33. During defendant Kanel's shift, the standard of care required that a nurse exercise each of Angel's limbs ("range of motion exercises") for at least ten minutes every two hours, at about 8:00 p.m. and at about 10:00 p.m. (Exhibit 17, Report of Dr. Evadne Marcolini 4; Exhibit 15, Cermak Health Services Policy I-01 at 5, LVARGAS 0411.)

34. The surveillance video (Video Exhibit 2) shows that defendant Kanel was in Angel's cell from 7:36:56 p.m. to 7:37:35 p.m., from 8:07:28 p.m. to 8:11:13 p.m., and from 10:56:23 p.m. to 10:56:43 p.m. between the time Angel was placed in restraints and the end of her shift at 11:00 p.m. on March 18, 2016.

35. The surveillance video establishes that defendant Kanel did not provide ten minutes of range of motion exercises at 8:00 p.m., at 10:00 p.m., or at any other time. (Video Exhibit 2.)

36. Defendant Kanel wrote the false statements in Angel's medical records that she had conducted range of motion exercises at 8:34 p.m. and at 10:13 p.m. on March 18, 2016. (Exhibit 25, Restraint Assessments at 3, 5, County 0165, 167.)

IV. Defendant Chatman

37. Defendant Chatman worked the "overnight shift" as a nurse on 2N from 11:00 p.m. on March 18, 2016 to 7:00 a.m. on March 19, 2016. (Exhibit 5, Chatman Dep. 14:9-11.)

38. During defendant Chatman's shift, the standard of care required that a physician decide at or about 2:30 a.m. whether to renew the restraint order. (Exhibit 17, Report of Dr. Evadne Marcolini 5; Exhibit 3, Paschos Dep. 64:8-15, 153:19-21; Exhibit 15, Cermak Health Services Policy I-01 at 6, LVARGAS 0412.)

39. Defendant Chatman did not enter an order renewing the restraint order into Angel's medical records until about 3:55 a.m. (Exhibit 20, Orders showing Psychiatric/Violent Restraints Ordered 3/19/2016 03:55 CDT, County 0120.)

40. The surveillance video (Video Exhibit 3) shows that Defendant Chatman did not assess Angel before continuing the restraint order: The surveillance video shows that defendant Chatman was not in Angel's cell between 1:01 a.m. and 4:56 a.m.[2] (Chatman can be seen standing in front of the nurses' station at 12:20:46 a.m. (Video Exhibit 3; Exhibit 5, Chatman

[2] Video Exhibit 5 includes a condensed presentation of Video Exhibit 3. *See* note 1, above.

Dep 120:9-21; Exhibit 26, Exhibit 11 to Chatman Dep.) Angel's cell is shown when Angel is walked into the cell at 5:51:34 p.m. on March 18, 2016. (Video Exhibit 1; Exhibit 19, Sprague Dep. 63:21-64:1.))

41. During defendant Chatman's shift, the standard of care required that a nurse exercise each of Angel's limbs ("range of motion exercises") for at least ten minutes every two hours, at about 12:00 midnight, 2:00 a.m., 4:00 a.m., and 6:00 a.m. (Exhibit 17, Report of Dr. Evadne Marcolini 4; Exhibit 15, Cermak Health Services Policy I-01 at 5, LVARGAS 0411.)

42. The surveillance video (Video Exhibit 3, Video Exhibit 4) shows that defendant Chatman was in Angel's cell from 12:20:55 a.m. to 12:25:44 a.m., 12:28:45 a.m. to 12:31:20 a.m., 12:59:55 a.m. to 1:01:11 a.m., 4:56:55 a.m. to 4:59:18 a.m., 5:59:00 a.m. to 5:59:38 a.m, and 6:02:45 a.m. to 6:06:12 a.m. during her shift.

43. The surveillance video establishes that defendant Chatman did not provide ten minutes of range of motion exercises at 12:00 midnight, 2:00 a.m., 4:00 a.m., and 6:00 a.m., or at any other time. (Video Exhibit 3, Video Exhibit 4.)

44. Defendant Chatman wrote false statements in Angel's medical records that she had provided range of motion exercises at 12:39 a.m., 4:22

a.m., and 5:16 a.m. on March 19, 2016. (Exhibit 25, Restraint Assessments, County 0168, 0171; Exhibit 27, Nursing Note 03/19/2016 05:16 CDT.)

V. Defendant Manalastas

45. Defendant Manalastas worked as a nurse on 2N from 7:00 a.m. until 3:30 p.m. on March 19, 2016. (Exhibit 9, Manalastas Dep. 12:11-20.)

46. During defendant Manalastas's shift, the standard of care required that a physician decide whether to renew the restraint order at or about 8:00 a.m. (Exhibit 17, Report of Dr. Evadne Marcolini 5; Exhibit 3, Paschos Dep. 64:8-15, 153:19-21; Exhibit 15, Cermak Health Services Policy I-01 at 6, LVARGAS 0412.)

47. At about 8:08 a.m., defendant Manalastas continued the order to hold Angel in restraints. (Exhibit 20, Orders showing Psychiatric/Violent Restraints Ordered 3/19/2016 08:08 CDT, County 0120.)

48. Defendant Manalastas did not assess Angel before continuing the order to hold Angel in restraints. (Exhibit 9, Manalastas Dep. 49:12-20, 66:18-24.)

49. Defendant Manalastas did not consult with Dr. Paschos or any other physician before continuing the order: Manalastas falsely stated that he consulted with Dr. Lassen because she was the on-call psychiatrist, (Exhibit 9, Manalastas Dep. 94:8-10, 95:4-10), but Dr. Paschos was the on-

call psychiatrist (Exhibit 23, Cook County's Answers to Plaintiff's Interrogatories Dated 10/24/19 No. 3.) and Dr. Lassen never served as the on-call psychiatrist. (Exhibit 28, Lassen Dep. 13:18-19.)

50. Defendant Manalastas removed Angel from restraints at about 11:30 a.m. on March 19, 2016. (Exhibit 9, Manalastas Dep. 69:3-5.)

51. During defendant Manalastas's shift, the standard of care required that a nurse exercise each of Angel's limbs ("range of motion exercises") for at least ten minutes every two hours, at about 8:00 a.m., 10:00 a.m., and 12:00 noon. (Exhibit 17, Report of Dr. Evadne Marcolini 4; Exhibit 15, Cermak Health Services Policy I-01 at 5, LVARGAS 0411.)

52. The surveillance video (Video Exhibit 4) shows that defendant Manalastas was in Angel's cell from 7:24:21 a.m. to 7:29:35 a.m., 9:31:15 a.m. to 9:35:14, and 11:17:21 a.m. to 11:19:39 a.m. during the time that Angel was restrained on his shift. (Manalastas can be seen pushing a blood pressure machine at 7:23:20 a.m. (Exhibit 9, Manalastas Dep 84:10-85:5.) Angel's cell is shown when Angel is walked into the cell at 5:51:34 p.m. on March 18, 2016. (Video Exhibit 1; Exhibit 19, Sprague Dep. 63:21-64:1.))

53. The surveillance video establishes that defendant Manalastas did not provide ten minutes of range of motion exercises at 8:00 a.m., 10:00 a.m., 12:00 noon, or at any other time. (Video Exhibit 4.)

54. Defendant Manalastas wrote the false statements in Angel's records that he conducted range of motion exercises at 7:55 a.m. and at 9:55 a.m. on March 19, 2016. (Exhibit 25, Restraint Assessments at County 0172, 0173.)

VI. Defendant Dr. Paschos

55. Defendant Dr. Paschos was the on-call psychiatrist on March 18, 2016 and March 19, 2016. (Exhibit 23, Cook County's Answers to Plaintiff's Interrogatories Dated 10/24/19 No. 3.)

56. The Jail's policy required that every four hours, a restraint order must either be renewed or terminated and that this action must be taken in consultation with a psychiatrist. (Exhibit 15, Cermak Health Services Policy I-01 at 6, LVARGAS 0412.)

57. Dr. Paschos was aware that restraint orders had to be reviewed every four hours. (Exhibit 3, Dr. Paschos Dep 63:18-23.)

VII. Expert Opinions

58. Defendants Kanel, Chatman, and Manalastas failed to provide Angel with range of motions exercises while he was restrained. (Exhibit 17, Expert Report of Dr. Evadne Marcolini 3-5; Exhibit 18, Expert Report of Dr. Daphne Glindmeyer 26, 39)

59. Defendants Kanel, Chatman, Manalastas, and Paschos failed to monitor Angel while he was restrained, thereby causing him to be immobilized for longer than necessary. (Exhibit 17, Expert Report of Dr. Evadne Marcolini 3, 5-6; Exhibit 18, Expert Report of Dr. Daphne Glindmeyer 26, 30.)

60. The failure to give plaintiff's decedent medication or executing appropriate limb release, either of which could mitigate the risk of clot formation, does not meet the standard of care and was medically unreasonable. (Exhibit 17, Expert Report of Dr. Evadne Marcolini 4.)

61. Plaintiff's decedent's forced immobility at the jail for 17.5 hours by restraints on his extremities as well as his chest caused blood flow to slow down and was the most significant contributor to the risk of clot formation. (Exhibit 17, Expert Report of Dr. Evadne Marcolini 4.)

62. The failure to give appropriate limb release exercises more likely than not led to the formation of blood clot in the deep veins of Angel's legs, subsequent breaking off, creating an embolus which travelled to the lungs, causing circulatory obstruction and ultimate death. (Exhibit 17, Expert Report of Dr. Evadne Marcolini 5.)

63. The failure by Defendants Kanel, Chatman, Manalastas, and Paschos to consistently assess Angel while he was in restraints failed to

meet these standards of care and contributed to the risk of venous clot formation, pulmonary embolus formation, and ultimate death by circulatory collapse secondary to pulmonary embolus. (Exhibit 17, Expert Report of Dr. Evadne Marcolini 5.)

64. Defendants have produced expert reports from physicians Dr. Lisa Boggio (Exhibit 29), Dr. Eric Gluck (Exhibit 30), and Dr. Melissa Piasecki (Exhibit 31).

65. Defendants' experts do not express any opinion on whether defendants Kanel, Chatman, and Manalastas met the standard of care or provided medical care that was objectively unreasonable.

66. Defendants' expert Dr. Boggio offers the following opinion:

> It is unlikely that the deep vein thrombosis that caused Mr. Cruz's death was formed because of the events revolving around his period of restraint at Cermak Health Services. Emboli, such as the emboli that caused Mr. Cruz's death, typically form 10-14 days from the culprit event. In this case, while we cannot say with absolute certainty that clots causing Mr. Cruz's death did not originate because of the restraints that were employed at Cermak Health Services, it is more likely that the clots were formed because of events that happened prior to March 15, 2016.

(Exhibit 29, Dr. Boggio Report 3.)

67. Dr. Boggio does not offer any support for this claim: her report does not cite any research or texts to support her assertion that "emboli …

typically form 10-14 days from the culprit event." (Exhibit 29, Dr. Boggio Report 3.)

68. Plaintiff's expert, Dr. Marcolini, states that she is "not aware of any facts or data that support this assertion." (Exhibit 33, Dr. Marcolini Rebuttal Report 2.)

69. Defendants' export Dr. Gluck states in his report: "I hold the opinion that it was more likely that the clots that Mr. Cruz incurred first as deep vein thrombi that later became pulmonary emboli originated from the trauma of the events on the morning of March 12, 2016." (Exhibit 30, Dr. Gluck Report 2.)

70. Dr. Gluck does not provide any support for this opinion, which he acknowledges is unlikely (Exhibit 30, Dr. Gluck Report 2), and which plaintiff's expert characterizes as "speculation." (Exhibit 33, Dr. Marcolini Rebuttal Report 2.)

71. The date on which the clot formed is not relevant to the cause of death. As plaintiff's expert explains:

> We do not know if Angel had deep venous thrombi prior to his incarceration, nor do we know if he had cancer, but we do know that when he was immobilized, any preexisting thrombi would have a greater chance of propagation and embolization with immobility without prophylaxis. In short, if we could know that the emboli formed before Angel arrived at the Jail, this would

> not change my opinion that the treatment at the Jail caused Angel's death.

(Exhibit 33, Dr. Marcolini Rebuttal Report 2.)

/s/ Joel A. Flaxman
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