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

Leticia Vargas, Administrator of the Estate of Angel Cruz,	)	
Plaintiff,	)	
v.	)	No. 18-cv-1865
County of Cook, Augustus Alabi, Lorraine Chatman, Helen Kanel, Cherri Krzyzowski, Manuel Manalastas, and Dr. Steve Paschos,	)	Judge Steven Seeger
	)	JURY DEMANDED
Defendants.	)	

U.S. NORTHERN DISTRICT OF ILLINOIS LOCAL RULE 56.1 STATEMENT OF FACTS BY DEFENDANTS HELEN KANEL, LORRAINE CHATMAN, MANUEL MANALASTAS, AUGUSTUS ALABI, and CHERRI KRZYZOWSKI

HELEN KANEL, MANUEL MANALASTAS, AUGUSTUS ALIBI, CHERRI KRZYZOWSKI, and LORRAINE CHATMAN , by their attorney KIMBERLY M. FOXX, Cook County State's Attorney, through her Assistant State's Attorney, William R. Ragen, pursuant to the United States' Northern District of Illinois Local Rule 56.1 present their Rule 56.1 Statement of Facts:

1. Plaintiff her Amended Complaint on June 22, 2018, bringing causes of action against these nurses alleging they failed to properly perform range of motion exercises and failed to properly assess Mr. Cruz for signs and symptoms of a pulmonary embolism. (ECF #31, pars. 23 and 36) Plaintiff has Amended her Complaint on August 30, 2021 alleging the same failures entitled Plaintiff to relief under 42 U.S.C. § 1983 and Illinois medical malpractice law. (ECF #148)

2. Plaintiff has named 3 experts pursuant to Fed. R. Civ. P 26(a)(2): Dr. Daphne Glindmeyer, Dr. Evadne Marcolini, and Brady Held. (Ex. Y, Plaintiff's Rule 26(a)(2) Disclosures) Dr. Glindmeyer is a licensed physician. (Ex. G, Dr. Glindmeyer Deposition, p. 15:16-23) Dr. Marcolini is a licensed physician. (Ex. K, Dr. Marcolini CV, p. 1) Brady Held is a video technician.

3. On the morning of March 12, 2016, Angel Cruz attempted to murder his mother (Leticia Vargas) and stepfather (Joel Castillo) in a violent physical altercation in which Angel Cruz stabbed Leticia Vargas and Joel Castillo. Mr. Cruz's psychotic state caused him to execute irrational, severe, and uncontrollable physical violence. (Ex. A, Sodt Deposition, pp. 15:21 – 21:22), (Ex. B, Stern Deposition, p. 25:18-13) (Ex. C, Countryside Police Report, see generally) Mr. Cruz was taken into custody by Countryside Police Department and was taken to Hinsdale Hospital for a psychiatric evaluation. (Ex. C, Countryside Police Report, p. 19)

4. Mr. Cruz was admitted to Hinsdale Hospital at 8:56 a.m. on March 12, 2016. Emergency Room physician Sherwin Waldman, M.D. indicated that Mr. Cruz presented to Hinsdale Hospital for psychiatric evaluation after stabbing both his parents this morning. (Ex. D, Hinsdale Hospital Records, p. 17)[1] Per Dr. Waldman, Mr. Cruz presented with homicidal ideations and was at risk of homicide. (Ex. D, Hinsdale Hospital Records, p. 17)

5. On March 12, 2016 at 1:01 p.m. Dr. Zayed caused 27 general orders to be entered for Mr. Cruz as he was admitted to the Intensive Care Unit (ICU) which including admitting to the hospital floor, medical consult, placing Mr. Cruz on a specific diet, complete blood count, basic

[1] There are two sets of Hinsdale Records. The first set was used throughout litigation and is 294 pages long. The second set was produced by counsel for Dr. Zayed, Dr. Yalamanchi, Dr. Farahnz, Nurse Weger, Nurse Barkauskaite, and Nurse Koleva. The second set was produced in the middle of oral fact discovery. It is 360 pages long. As the 294 page first set was used for the majority of depositions, it is the set attached to this Statement of Facts as an exhibit.

metabolic profile, MRSA screen, an anti-vomiting/nausea medication, hypoglycemia protocol, fall risk assessment, skin breakdown assessment, and heparin. (Ex. D, Hinsdale Hospital Records, pp. 74-79) All these 27 orders were entered within one minute. (Ex. D, Hinsdale Hospital Records, pp. 74-79) Dr. Zayed is board certified in internal medicine and practices as a hospitalist. (Ex. E, Dr. Zayed Deposition, pp. 7:17 - 9:2)

6. On March 12, 2016 at 2:29 p.m. Dr. Zayed ordered a psychiatric consult to help manage Mr. Cruz's mental health and determine if he should be treated on the psychiatric unit. (Ex. E, Dr. Zayed Deposition, pp.65:20 - 67:9) During Mr. Cruz's three days at Hinsdale Hospital, however, he was never seen by a psychiatrist. (Ex. E. Dr. Zayed Deposition, p. 67:6 – 67:10) Hinsdale Hospital has a psychiatric unit (Ex. E, Dr. Zayed (Ex. F, Dr. Yalamanchi Deposition, pp. 17:23 – 18:12) Only psychiatrists can admit patients to the psychiatric unit. (Ex. E, Dr. Zayed Deposition, p.23:3-18) (Ex. F, Dr. Yalamanchi Deposition, p. 20:7 – 15) As Drs. Zayed and Yalamanchi are internal medicine physicians, they could not transfer or admit Mr. Cruz to the psychiatric unit. (Ex. E, Dr. Zayed , p.23:3-18) (Ex. F, Dr. Yalamanchi Deposition, p. 20:7 – 15) Plaintiff's psychiatry expert, Dr. Daphne Glindmeyer, testified that the standard of care of a reasonably careful psychiatrist requires the psychiatrist to evaluate the patient within 24 hours or 1-2 hour in case of an emergency. (Ex. G, Dr. Glindmeyer Deposition, pp. 67:23 – 69:4)

7. Mr. Cruz became agitated later in the evening on March 12. At 1:24 a.m. on March 13, Dr. Yalamanchi ordered Mr. Cruz to be placed in restraints. (Ex. F, Dr. Yalamanchi Deposition, p.27:12-19) This is likely the first time Dr. Yalamanchi ever ordered a patient to be placed in restraints. (Ex. F, Dr. Yalamanchi Deposition, p. 28:13-22) There is no indication that Dr. Yalamanchi was present at the time he ordered Mr. Cruz to be placed in restraints. (Ex. H, Aiste Barkauskaite RN Deposition, p, 35:14-24 and pp.36:21- 37:5) (Ex. F, Dr. Yalamanchi

Deposition, p. 30:11-22) The only documentation concerning the reason Mr. Cruz needed to be placed in restraints was given by Nurse Aiste Barkauskaite which reads "Violent/Self Destructive Behavior" and "Patient agitated, hallucinating. Haldol given with no effect. Dr. Nadkarni paged." (Ex. H, Aiste Barkauskaite Deposition, p. 38:14-20 and pp.44:19 – 45:8) (Ex. D, Hinsdale Hospital, p. 154 and 256) There is no record to show that Dr. Nadkarni ever answered the page. (Ex. D, Hinsdale Hospital, *see generally*) Dr. Yalamanchi did not know whether the restrained patient's vitals should be taken, whether the restrained patient's skin should be assessed or whether the patient should undergo any range of motion exercises while restrained. (Ex. F, Dr. Yalamanchi Deposition, pp 34:12 – 35:16)

8. At 5:24 a.m., Dr. Yalamanchi ordered that Mr. Cruz's restraints be continued. This was done over the phone and not in person. (Ex. D, Hinsdale Hospital Records, p. 88) (Ex. F, Dr. Yalamanchi Deposition, pp. 44:2 – 45:1)

9. The first time heparin was given to Mr. Cruz was March 13, 2016 at 9:14 a.m. (Ex. E, Dr. Zayed Deposition, pp. 62:16 – 63:7)

10. There was no range of motion charting from 1:24 a.m. to 3:00 a.m. on March 13, 2016 (Ex. D, Hinsdale Hospital Records, *see generally*) From 3:00 a.m. to 7:00 a.m., it was documented the Mr. Cruz's range of motion was assessed at every 15 minute intervals, but the nurse that made the entries cannot say that Mr. Cruz's limbs range of motion exercises were ever performed between 3:00 and 7:00 a.m. (Ex. H, Aiste Barkauskaite Deposition, pp. 96:97:19) (Ex. D, Hinsdale Hospital Records, pp. 257-264) There was no range of motion charting from 7:00 a.m. until 10:14 a.m. (Ex. D, Hinsdale Hospital Records, *see generally*)

11. Mr. Cruz was released from restraints at 10:14 a.m. on March 13, 2016 (NEED CITE)

12. Mr. Cruz was given Geodon at the following times and amounts: 10 mg intramuscularly at 12:06 a.m. on March 13, 2016; 20 mg intramuscularly at 12:55 a.m. on March 13, 2016; 20 mg intramuscularly at 5:15 a.m. on March 13, 2016; 20 mg intramuscularly at 1:55 a.m. on March 14, 2016; and 20 mg intramuscularly at 8:06 a.m. (Ex. D, Hinsdale Hospital Records, pp. 125-126) (Ex. H, Glindmeyer Report, p. 27) Dr. Glindmeyer opined that Geodon is a second generation antipsychotic that causes a risk of DVT development by the slowing of the transit of blood because it reduces blood pressure, reduces heart rate, and causes an increased risk of stasis. (Ex. G, Glindmeyer Deposition, p. 127:15-21) Once the Geodon medication wears off, the patient's blood pressure and heart rate should return to normal, thus relieving the risk of stasis and DVT formation. (Ex. G, Glindmeyer Deposition, pp. 128:21 – 129:18) Dr. Glindmeyer indicated the more injections of Geodon that a patient receives would increase the risk of stasis. (Ex. G, Glindmeyer Deposition, p. 125:8-12) Dr. Glindmeyer testified that it would be a deviation from the standard of care to exceed 20 mg of Geodon within 12 hours without explaining why in a note. (Ex. G, Glindmeyer Deposition, pp. 123:19 – 124:2) No physician provided a note as to why they gave more than a 20 mg window for either (a) the window between 12:06 a.m. and 5:14 a.m. on March 13 in which 50 mg was administered or (b) the window between 1:55 and 8:06 a.m. on March 14 in which 40 mg was delivered. (Ex. D, Hinsdale Hospital Records, *see generally*)

13. Dr. Glindmeyer testified that Mr. Cruz died of a pulmonary embolism. (Ex. G, Glindmeyer Deposition, pp. 92:18–20) Dr. Glindmeyer testified that the pulmonary emboli that caused Mr. Cruz's death were caused by DVT. (Ex. G, Glindmeyer Deposition, p. 92:21–23) Dr. Glindmeyer testified that the DVTs that caused Mr. Cruz's death could have developed at anytime between March 12, 2016 and March 20, 2016. (Ex. G, Glindmeyer Deposition, p. 93:4-7) Dr.

Glindmeyer testified that she could not specify as to when Mr. Cruz developed the DVTs that caused his death with any greater specificity other than sometime in March 2016. (Ex. G, Glindmeyer Deposition, p. 93:8–12)

14. Dr. Glindmeyer - one of Plaitniff's physician experts - is not a nurse, but is trained as a psychiatrist board certified in adult psychiatry, juvenile psychiatry, and forensic psychiatry. (Ex. G, Glindmeyer Deposition, p. 14:6–12) Dr. Glindmeyer attended Loyola University for a bachelor's degree, Mississippi Gulf Coast Community College for premedical school curriculum, and University of New Orleans for premedical school, but did not obtain a nursing degree at any of these institutions. (Ex. I, Glindmeyer CV)

15. Dr. Glindmeyer is not aware of the courses that are required to obtain any of the nursing degrees available. (Ex. G, Glindmeyer Deposition, p. 105:14 – 22) Dr. Glindmeyer has received no nursing training whether as an RN, LPN, or CRNA. (Ex. G, Glindmeyer Deposition, p. 106:19 – 107:1) Dr. Glindmeyer admits that the training she received as a psychiatrist exceeds the training an RN or an LPN would receive. (Ex. G, Glindmeyer Deposition, p. 107:2–5) Dr. Glindmeyer admits that the training that she received is different than an RN or LPN. (Ex. G, Glindmeyer Deposition, p. 107:2 – 5) Dr. Glindmeyer admitted that a registered nurse would not be required to have the training she has received that caused her to be a medical director of West Jefferson Hospital's Behavioral Medicine Center. (Ex. G, Glindmeyer Deposition, p. 108:14 – 10) Although she has assisted in developing policies and procedures that concerned nursing, that occurred in July 2000 to March 2002 when she was medical director of clinical operations for juvenile corrections for the State of Louisiana (Ex. G, Glindmeyer Deposition, pp. 19:16 – 20:15) (Ex. I, Dr. Glindmeyer CV, p. 6)

16. Dr. Glindmeyer subscribes to the American Psychiatric Association, the Journal of Child and Adolescent Psychiatry, and a journal by the American Psychiatric Association in furtherance of her medical practice. (Ex. G, Glindmeyer Deposition, pp. 19:16 – 20:15) Dr. Glindmeyer does not subscribe to any nursing journals in furtherance of her profession. (Ex. G, Glindmeyer Deposition, *see generally*) (Ex. I, Glindmeyer CV, *see generally*)

17. If Dr. Glindmeyer wanted to become employed as a nurse at the last hospital at which she practiced, she could not become employed as a nurse. (Ex. G, Glindmeyer Deposition, pp. 110:17 – 111:15)

18. Dr, Glindmeyer is aware of all the continuing medical education requirements she must achieve to maintain her license in Texas, Louisiana, and for her board certifications. (Ex. G, Glindmeyer Deposition, pp. 19:16 – 20:15) All the continuing education she does on a yearly basis is either devoted to her practice as a medical doctor or as a medical doctor practicing in psychiatry. (Ex. G, Glindmeyer Deposition, pp. 22:2 – 23:14) Dr. Glindmeyer is unaware of the continuing education that nurses must achieve to maintain their nursing license. (Ex. G, Glindmeyer Deposition, pp. 109:20 – 120:13)

19. In Dr. Glindmeyer's report she qualifies that all her opinions are given to a reasonable degree of psychiatric certainty. (Ex. H, Glindmeyer Report, p. 31) When asked what the standard of care means to her, Dr. Glidnmeyer stated "[t]he standard of care is that which any appropriate reasonable physician would perform for care for an individual. What is prevalent in the community, dictated by our boards, our education, our training, research." (Ex. G, Glindmeyer Deposition, p. 31:5–11)

20. Dr. Evadne Marcolini – Plaintiff's other physician expert – is a medical doctor board certified in emergency medicine and critical care. (Ex. J, Dr. Marcolini Deposition, p. 24:6-

9) She studied at Wheaton College and obtained a bachelor's degree in Economics & Business. She attended the University of Vermont – College of Medicine and obtained a medical degree. . (Ex. K, Dr. Marcolini CV, p. 1) She performed a training in residency as a physician at Maine Medical Center and a training as a postdoctoral fellow in surgical critical care through the University of Maryland. (Ex. K, Dr. Marcolini CV, p. 1) (Ex. J, Dr. Marcolini Deposition, pp. 11:6 - 16:4) Dr. Marcolini did not receive a degree in nursing. (Ex. J, Dr. Marcolini Deposition, pp. 101:24 - 102:1) Dr. Marcolini did not receive training as a nurse in medical school. (Ex. J, Dr. Marcolini Deposition, p. 102:6 - 14)) Dr. Marcolini did not receive training as a nurse during her residency. (Ex. J, Dr. Marcolini Deposition, p. 102:6 - 14) Dr. Marcolini did not receive training as a nurse during her fellowship. (Ex. J, Dr. Marcolini Deposition, p. 102:6 – 14)

21. Dr. Marcolini admitted that she received a higher level of training than a nurse. (Ex. J, Dr. Marcolini Deposition, p. 103:11-13) Dr. Marcolini admitted that a nurse practicing in Illinois would not need to receive as much education as Dr. Marcolini obtained. (Ex. J, Dr. Marcolini Deposition, p. 103:14-18)

22. Dr. Marcolini could not practice as a nurse at either the hospitals at which she is credentialed. (Ex. J, Dr. Marcolini Deposition, p. 103:19-22) Dr. Marcolini indicated that the only way she could practice as a nurse is if she (a) went to nursing school, (b) went through the nursing curriculum, (c) obtained the training a nurse would obtain in nursing school, and (d) became licensed as a nurse. (Ex. J, Dr. Marcolini Deposition, pp. 103:19 – 104:5)

23. Dr. Marcolini has undergone continuing education only in furtherance as a medical doctor. (Ex. J, Dr. Marcolini Deposition, p. 102:15 – 24) She is only aware that nurses must take some pharmacology classes, but cannot say any of the other requite courses beyond that. (Ex. J, Dr. Marcolini Deposition, p. 103:1 – 10)

24. Dr. Marcolini has taught a number of different health care providers. (Ex. J, Dr. Marcolini Deposition, pp. 20:22 – 22:20) None of the types of health care providers Dr. Marclini has taught are nurses. (Ex. J, Dr. Marcolini Deposition, pp. 20:22 – 22:20) In describing the teaching awards she received, Dr. Marcolini has taught emergency medicine residents, physician's assistants, nurse practitioners, medical students, and medical doctors in fellowship. (Ex. J, Dr. Marcolini Deposition, pp. 20:22 – 22:20) Residents and fellows are physicians who have their medical degree or doctorate of osteopathy and are licensed physicians. (Ex. J, Dr. Marcolini Deposition, pp. 20:22 – 22:20) Physician assistants and nurse practitioners practice medicine either independently in some areas or under the supervision of a physician. (Ex. J, Dr. Marcolini Deposition, pp. 20:22 – 22:20)

25. Dr. Marcolini subscribes to the Journal of Emergency Medicine, the Annals of Emergency Medicine, and the American Journal of Emergency Medicine. (Ex. J, Dr. Marcolini Deposition, p. 26:8-13) Dr. Marcolini reviews other journals and even publishes in other journals from time to time. (Ex. J, Dr. Marcolini Deposition, p. 26:14-19) All the journals Dr. Marcolini reviews are emergency medicine journals. (Ex. J, Dr. Marcolini Deposition, p. 26:20-25) Dr. Marcolini's CV lists that she has published 43 peer-reviewed articles. (Ex. K, Dr. Marcolini CV, pp.7-10) All of those publications were submitted and accepted to journals that concern the practice of medicine. (Ex. K, Dr. Marcolini CV, pp.7-10) Dr. Marcolini does not subscribe to or review any nursing journals. (Ex. J, Dr. Marcolini Deposition, *see generally*) Dr. Marcolini has not published in any nursing journals. (Ex. J, Dr. Marcolini Deposition, *see generally*)

26. In Dr. Marcolini's report, she qualifies that all her opinions are given to a reasonable degree of medical certainty. (Ex. L, Marcolini Report, p. 6) During her deposition, Dr. Marcolini testified that the standard of care is the standard by which a physician provides

evaluation, assessment and care for a patient that is accepted by the general medical community and medical experts. (Ex. J, Dr. Marcolini Deposition, p. 34:13-20)

27. Turning back to the care rendered at Hinsdale Hospital, on March 14, Mr. Cruz's irrational behavior began presenting in a violent manner. At 3:43 a.m. on March 14, 2016, Mr. Cruz was noted to be combative, violent, and an immediate danger to staff. (Ex. M, Meghan Weger Deposition, p. 31:7-10) At 6:31 a.m., Nurse Meghan Weger wrote "Code BRT called again, patient jumped to side of bed while still handcuffed trying to get hand out of handcuff, two police officers went into room, were able to get patient back into bed and handcuffed his other hand to the bed. When resident arrived, received orders for 4 point restraints, called attending, explained that patient is more of a safety risk for staff and others and he needs to be released to police custody, he agreed with discharge orders." (Ex. D, Hinsdale Hospital Record, p. 152) (Ex. M, Meghan Weger Deposition, pp.15:15 – 17:23) There is no indication that the resident involved in this encounter authored a note. (Ex. D, Hinsdale Hospital Record, *see generally*) (Ex. M, Meghan Weger Deposition, pp.17:24 – 18:11) Nurse Weger cannot recall if Mr. Cruz was ever placed in four point restraints on this shift. (Ex. M, Meghan Weger Deposition, p. 20:8-10)

28. Mr, Cruz was discharged on March 14 at 8:00 a.m. (Ex. N. Katia Koleva Deposition, pp. 31:1-6) (Ex. D, Hinsdale Hospital Records, pp. 283-287) A physician enters the order to discharge a patient at Hinsdale Hospital. (Ex. N. Katia Koleva Deposition, pp. 31:1-6) The medical record has two versions of the discharge instructions. One set of the discharge instructions is found in the medial record on pages 2 through 11. (Ex. N. Katia Koleva Deposition, p. 26:3-13) The second set is 6 pages and was numbered 283 – 287. (Ex. N. Katia Koleva Deposition, pp. 28:3 – 32:11) Discharge instructions are designed to accompany the patient to where he goes after discharge. (Ex. N. Katia Koleva Deposition, pp. 27:6-9) The discharge

instructions do not mention that Mr. Cruz was placed in four point restraints. (Ex. D, Hinsdale Hospital Records, pp. 2-11 and 283-287) The discharge instructions do not list the second generation or low potency antipsychotics Mr. Cruz received. (Ex. D, Hinsdale Hospital Records, pp. 2-11 and 283-287) Dr. Zayed indicated that Mr. Cruz's condition at discharge was stable. (Ex. D, Hinsdale Hospital Records, pp. 3 and 284) (Ex. E, Dr. Zayed Deposition, p. 69:9-12) There are no medications listed that Mr. Cruz would anticipated to be taken after discharge. (Ex. D, Hinsdale Hospital Records, pp. 2, 6 and 283) (Ex. E, Dr. Zayed Deposition, p. 72:9-12)

29. For the entirety of his admission to Hinsdale Hospital, Mr. Cruz was not seen by a psychiatrist, psychologist, clinical social worker, clinical professional counselor or any other person trained in mental health treatment. (Ex. D, Hinsdale Hospital Record, *see generally*)

30. Mr. Cruz was released to the custody of the Countryside Police Department on March 14, 2016 on or around 8:58 a.m. (Ex. C, Countryside Police Department, p. 40) He remained in the custody of the Countryside Police Department for almost a day. (Ex. C, Countryside Police Department, p. 42)

31. Mr. Cruz presented to Cermak Health Services on March 15, 2016 on or around 6:17 p.m. and was recommended for a mental health assessment. (Ex. O, Cermak Records, pp. 100-105) At 7:04, he was seen by Cristina Valle who noted that discharge instructions from Hinsdale Hospital accompanied Mr. Cruz. (Ex. O, Cermak Records, p. 79) Mr. Cruz was assessed as having active hallucinations, homicidal ideations and that he wanted to kill Jacklyn Montanez because she murdered Mr. Cruz's father. (Ex. O, Cermak Records, p. 79) Mr. Cruz was triaged to intake psychiatry because of the homicidal ideations he expressed. (Ex. O, Cermak Records, p. 79)

32. At 7:27 p.m., on March 15, 2016 Mr. Cruz was evaluated by psychiatrist Dr. Usha Kartan who performed an examination and assessment reviewing his past medical history in which Mr. Cruz told Dr. Kartan that he wanted to hit self to the wall but did not do because the voices told him to stop. (Ex. O, Cermak Records, pp. 4-6) Dr. Kartan assessed that this information was relevant to his assessment of suicide risk, developed the impression Mr. Cruz may have paranoid schizophrenia, and had Mr. Cruz admitted to 2 North which is one of the acute psychiatric wards at Cermak Health Services. (Ex. P, Dr. Lassen Deposition, pp. 13:20 14:1)

33. On or around 10:07 a.m. on March 16, 2016, Dr. Steve Paschos first evaluated Mr. Cruz. (Ex. Q, Dr. Paschos Deposition, pp.89:9 – 109:22) Dr. Paschos asked Mr. Cruz about his present illness, performed a mental status exam, asked Mr. Cruz about prior medications, assessed Mr. Cruz's presentation as flat and incongruent to his elevates and inappropriately bright mood. (Ex. Q, Dr. Paschos Deposition, pp.89:9 – 109:22) (Ex. O, Cermak Records, p. 25) Dr. Paschos observed that Mr. Cruz was disrobing and crouching in the corner of his room. (Ex. Q, Dr. Paschos Deposition, pp.89:9 – 109:22) (Ex. O, Cermak Records, p. 25) Dr. Paschos did not observe that he was responding to internal stimuli in this encounter, was able to ascertain that Mr. Cruz had no homicidal or suicidal ideations and that he was able to contract for safety. (Ex. O, Cermak Records, p. 25) (Ex. Q, Dr. Paschos Deposition, pp.89:9 – 109:22)

34. On or around 9:25 a.m. on March 17, 2016, Dr. Paschos again examined Mr. Cruz. Dr. Paschos indicated that Mr. Cruz initially refused to take his medication that morning, but later agreed to take it. (Ex. O, Cermak Records, p. 27) Mr. Cruz denied any suicidal or homicidal ideations and started crying during the interview. (Ex. O, Cermak Records, p. 27) During this examination Mr. Cruz did not appear to be responding to internal stimuli. (Ex. O, Cermak Records, p. 29)

35. On or around 9:51 p.m. on March 17, 2016, Mr. Cruz was seen sitting on the floor with a blanket wrapped around his neck. (Ex. O, Cermak Records, p. 192) (Ex. R, Helen Kanel RN Deposition, p. 26:16 – 27:6) He was crying, had feces notes next to his feet and smeared ln the cell window and wall. Mr. Cruz was escorted to therapeutic isolation. (Ex. O, Cermak Records, p. 192) (Ex. R, Helen Kanel RN Deposition, p. 26:16 – 30:19)

36. On or around 10:20 p.m. on March 17, 2016, Licensed Clinical Professional Counselor Jason Sprague observed Mr. Cruz as he was in therapeutic isolation pacing in the room that he was disrobing and had urinated at the bottom of the base of the door. (Ex. O, Cermak Records, p. 10) (Ex. S, Jason Sprague, pp. 23:12 – 25:9) Mr. Cruz was unwilling to engage with Mr. Sprague. (Ex. O, Cermak Records, p. 10) (Ex. S, Jason Sprague, pp. 23:12 – 25:9)

37. On or around 9:15 a.m. on March 18, 2016, Dr. Paschos again evaluated Mr. Cruz. (Ex. O, Cermak Records, p. 30) He noted that Mr. Cruz appeared to be very disorganized and that he was responding to internal stimuli. (Ex. O, Cermak Records, p. 30) The evening prior, Mr. Cruz had been very agitated, attempting to leave his cell, banging the door of his cell, and was seen urinating on the floor and internally stimulated. (Ex. Q, Dr. Paschos Deposition, p. 135:12–20)

38. On or around 5:49 p.m., Dr. Paschos noted that “patient extremely disorganized, acutely psychotic, covered in feces, thrashing, placing self at risk of harm and staff at risk of harm, threatening staff, beating his fists on the door and wall. Patient's room covered completely in feces, urine, and trash. Attempted verbal de-escalation. Patient stood on top of the bed and jumped off of the bed attempting to hit head against the wall.” (Ex. O, Cermak Records, p, 33) Dr. Paschos ordered that Mr. Cruz be placed in restraints. (Ex. Q, Dr. Paschos Deposition, pp. 152:18 – 153:18)

39. Dr. Glindmeyer has not ordered a patient to be placed in restraints in the 5 years prior to her March 12, 2021 deposition. (Ex. G, Dr. Glindmeyer Deposition, pp. 69:21-70:6) Dr. Glilndmeyer is unsure if she has ordered a patient be placed a patient in restraints from 2011 – 2016. (Ex. G, Dr. Glindmeyer Deposition, pp. 69:21-70:6) Although Dr. Marcolini is not a psychiatrist, she estimates that she orders patients be placed in restraints 10-20 times a year. (Ex. J, Dr. Marcolini Deposition, pp.116:20-117:4)

40. Around this same time frame, Helen Kanel noted the same occurrence. She noted that Mr. Cruz was smearing feces on himself in cell, punching walls, jumping off of bunk onto floor. (Ex. O, Cermak Records, pp. 20-21) (Ex. R, Helen Kanel Deposition, p. 62:19-22)

41. Around this same time frame, Jason Sprague observed Mr. Cruz standing on the bed, jumping off and attempting to hit head, naked, feces on body and throughout cell. (Ex. O, Cermak Records, p. 48) Mr. Cruz approached door with closed fist, makes striking motions while writer attempts to engage patient. (Ex. O, Cermak Records, p. 48)

42. Mr. Cruz was placed in restraints around 6:00 p.m. (Ex. R, Helen Kanel Deposition, pp.43:9 – 54:1) (Ex. O, Cermak Records, p. 197) Nurse Kanel gave Mr. Cruz juice, medications, and cleaned his hands, leg and face as he had feces on his body. (Ex. R, Helen Kanel Deposition, pp.43:9 – 54:1) (Ex. O, Cermak Records, p. 197)

43. Around 8:34 p.m., Helen Kanel recorded some of the nursing functions she provided Mr. Cruz. (Ex. O, Cermak Records, p. 213) She indicated that she spoke to Mr. Cruz in a calm manner, but that he was unable to control his behavior, that he was unable to understand or respond to directions, and that his behavior was escalating, and that he was in restraints. (Ex. O, Cermak Records, p. 213) Helen Kanel performed range of motion exercises. (Ex. O, Cermak Records, p. 213)

44. Around 10:14 p.m., Nurse Kanel again assessed Mr. Cruz. (Ex. O, Cermak Records, p. 214) As he was uncooperative, still unable to control his behavior, and still unable to contract for safety, he remained in restraints. (Ex. O, Cermak Records, p. 214) Nurse Kanel was unable to perform range of motion exercises because Mr. Cruz was uncooperative, unable to respond calmly, and agitated. (Ex. O, Cermak Records, pp. 214-215)

45. Around 10:29 p.m., Nurse Kanel assessed Mr. Cruz and noted that he remained in 5 point restraints for protection of himself and others. (Ex. O, Cermak Records, p. 199) She noted that he remained disorganized and confused, he was oriented to himself, but not to time or place. Mr. Cruz believed that he was in a movie. (Ex. O, Cermak Records, p. 199) The 5 point restraints that he was in were secure and not constricting. (Ex. O, Cermak Records, p. 199) Dr. Paschos indicated that restraints should be continued. (Ex. O, Cermak Records, p. 199)

46. At 11:55 p.m., Dr. Paschos continued Mr. Cruz's restraints. (Ex. O, Cermak Records, p. 119)

47. Around 12:39 a.m. on March 19, 2016, Lorraine Chatman assessed Mr. Cruz. He still was confused and restless, was unable to understand or respond to directions or reason. (Ex. O, Cermak Records, pp.215-216) Nurse Chatman was able to perform range of motion exercises on or around this time. (Ex. O, Cermak Records, pp. 215-216) She offered food and fluid. As he was unable to understand to directions or reason, he was not released from restraints. (Ex. O, Cermak Records, pp. 215-216)

48. Around 12:43 a.m., Nurse Chatman noted that Mr. Cruz was restless and irritable upon approach. (Ex. O, Cermak Records, p. 200) She also noted that he was winded upon exertion in his struggle against the restraints. (Ex. O, Cermak Records, p. 200)

49. Around 2:06 a.m. on March 19, 2016, Mr. Cruz was agitated, confused and disoriented. (Ex. O, Cermak Records, pp. 216-217) Mr. Cruz was unable to understand or respond to directions or reason. (Ex. O, Cermak Records, pp. 216-217) Range of motion exercises were done around this time. (Ex. O, Cermak Records, pp. 216-217) As he was unable to understand to directions or reason, he was not released from restraints. (Ex. O, Cermak Records, pp.216-217)

50. At 3:55 a.m., Dr. Paschos continued Mr. Cruz's restraints. (Ex. O, Cermak Records, p. 120)

51. Around 4:22 a.m., Mr. Cruz was violent and was unable to display behavior that warrants discontinuance of restraints. (Ex. O, Cermak Records, pp. 218-219) He remained unable to understand or respond to directions or reason. (Ex. O, Cermak Records, pp. 218-219) His condition at this time did not warrant the discontinuance of restraints. (Ex. O, Cermak Records, p. 218)

52. Around 5:16 a.m., Nurse Chatman released Mr. Cruz's right hand to eat breakfast and he ate a small amount. Range of motion exercises were done around this time. (Ex. O, Cermak Records, p. 201) As he was responding to internal stimuli and unpredictable he was unable to contract for his safety. (Ex. O, Cermak Records, p. 201) As he was calmer than earlier, his chest restraint was removed. (Ex. O, Cermak Records, p. 201)

53. Sometime on or before 7:55 a.m., Nurse Manuael Manalastas assessed Mr. Cruz's condition. (Ex. O, Cermak Records, pp. 219-220) He was sedated at this time, had been sleeping, but was easily arousable. (Ex. O, Cermak Records, pp. 219-220) Range of motion exercises were performed. (Ex. O, Cermak Records, pp. 219-220) He provided hygiene measures, offered food and fluids, and toilet. (Ex. O, Cermak Records, pp. 219-220) As Mr. Cruz was asleep, Nurse

Manalastas was unable to assess his capacity to contract for safety and be released from restraints. (Ex. O, Cermak Records, pp. 219-220)

54. At 8:08 a.m., Dr. Lassen continued Mr. Cruz's restraints. (Ex. O, Cermak Records, p. 120)

55. Around 9:55 a.m., Nurse Manalastas observed Mr. Cruz to be sleeping. Range of motion exercises were performed. (Ex. O, Cermak Records, pp. 220-221) As Mr. Cruz was asleep, Nurse Manalastas was unable to assess his status in order to release him from restraints. (Ex. O, Cermak Records, pp. 220-221)

56. Around 11:30 a.m., Nurse Manalastas was able to speak to Mr. Cruz in a calm and quiet manner. (Ex. O, Cermak Records, pp. 221-222) At this time, Mr. Cruz was able to control his behavior and calm down. (Ex. O, Cermak Records, pp. 221-222) As Mr. Cruz was able to understand reason and was able to contract for safety, he was released from restraints. (Ex. O, Cermak Records, pp. 221-222)

57. Around 9:46 p.m. on March 19, 2016, Nurse Augustus Alabi assessed Mr. Cruz and found him to be banging his head and exhibiting labored breathing. (Ex. O, Cermak Records, p. 203)

58. On or around 11:06 p.m. on March 19, 2016, Nurse Cherri Krzyzowski observed Mr. Cruz to be naked in his cell, lying quietly in bed with no signs of aggression or self-inflicting behavior. (Ex. O, Cermak Records, p. 203)

59. On or around 2:40 a.m. on March 20, 2016, Nurse Cherri Krzyzowski observed Mr. Cruz to be standing naked at the cell door. (Ex. O, Cermak Records, p. 205) Mr. Cruz told Nurse Krzyzowski "help me, help me." Upon initial assessment, Mr. Cruz appeared to be agitated and anxious. (Ex. O, Cermak Records, p. 205) At this time, Nurse Krzyzowski noted that he was not

in any respiratory distress. (Ex. O, Cermak Records, p. 205) At this point, Nurse Krzyzowski informed to lie down, and writer would be in to give him some medications. (Ex. O, Cermak Records, p. 205)

60. Shortly thereafter and while Nurse Krzyzowski was preparing medications for Mr. Cruz's anxiety and agitation, Mr. Cruz had gotten into bed and laid down. (Ex. O, Cermak Records, p. 205)

61. Shortly thereafter, Nurse Krzyzowski was informed that Mr. Cruz was now lying on the floor next to toilet. (Ex. O, Cermak Records, p. 205) Nurse Krzyzowski went into Mr. Cruz's room, and noted him to be verbally unresponsive. (Ex. O, Cermak Records, p. 205) Nurse Krzyzowski found that Mr. Cruz had a palpable carotid pulse and was still breathing. (Ex. O, Cermak Records, p. 205) Code Blue was called and paramedics quickly arrived on the unit.

62. Mr. Cruz was sent to Saint Anthony Hospital was pronounced dead. (Ex. X, Medical Examiner Report, p. 19) An autopsy was performed which revealed Mr. Cruz's death as natural and caused by a pulmonary embolism. (Ex. X, Medical Examiner Report, p. 9)

63. Augustus Alibi is a licensed registered nurse. (Ex. U, Augustus Alabi Deposition, p. 8:16-12) Helen Kanel is a registered nurse. (Ex. R, Helen Kanel Deposition, p. 8:2-5) Cherri Krzyzowski is a licensed nurse. (Ex. W, Cherri Krzyzowski Deposition, pp. 12:17 - 13:12) Manuel Manalstas is a licensed nurse. (Ex. X, Manuel Manalastas Deposition, p. 6:1-3) Lorraine Chatman is licensed as a nurse. (Ex. V, Lorraine Chatman Deposition, p. 11:1-9)

64. Range of motion exercises are an activity that are performed by nursing staff. (Ex. G, Dr. Glindmeyer Deposition, p. 76:10-12)

65. The only source of material either expert uses as a basis for their opinions as to what is required of a reasonably careful nurse in performing range of motion exercises is the

Cermak Restraint Policy. (Ex. T, Glindmeyer Report, p. 3-4) (Ex. L, Marcolini Report, p. 3) Dr. Glindmeyer only reviewed the Cermak Policies and Procedures and testified that she did not think the Hinsdale Policy and Procedures concerning restraints would not necessarily be helpful to rendering her opinions (Ex. G, Dr. Glindmeyer Deposition, p 39:5-11) She testified that policies and procedures can be helpful in determining the standard of care if they are consistent with the standard of care. (Ex. G, Dr. Glindmeyer Deposition, p 37:20-38:1) She testified that she did not think it necessary to ask Plaintiff's counsel to obtain them. (Ex. G, Dr. Glindmeyer Deposition, p. 39:12-16) Dr. Glindmeyer also testified that she did not know whether the Hinsdale Hospital practitioners complied with their own policies and procedures and testified that it would not necessarily be relevant to her opinions. (Ex. G, Dr. Glindmeyer Deposition, pp. 39:20-40:2) Dr. Marcolini testified that policies and procedures of a hospital do not create the standard of care. (Ex. J, Dr. Marcolini Deposition, pp. 43:25-44:3) Dr. Marcolini also testified that she was unaware what was contained in the policies and procedures concerning restraints from March 2014. (Ex. J, Dr. Marcolini Deposition, pp. 39:17-40:8)

66. Dr. Glindmeyer testified that the opinions that she is rendering in this case can be found in the Statement of Opinions or in her Conclusions portions of her 31 page report. (Ex. G, Dr. Glindmeyer Deposition, p. 29:5-10) Dr. Glindmeyer testified that her Statement of Opinions can be found on pages 1 and 2 (Ex. G, Dr. Glindmeyer Deposition, p. 27:21-23) Dr. Glindmeyer testified that her Conclusions can be found on pages 26 through 31. (Ex. G, Dr. Glindmeyer Deposition, p. 27:21-23)

67. Dr. Glindmeyer's opinions concerning what constitutes the standard of care concerning the performance of range of motion exercises can be found on page 29 of the Conclusions in her report. (Ex. T, Dr. Glindmeyer Report, p. 29)

68. Dr. Glindmeyer testified that she did not believe that she had an opinion that Defendant Nurse Lorraine Chatman deviated from the standard of care. (Ex. G, Dr. Glindmeyer Deposition, pp. 101:16 – 102:1) Dr. Glindmeyer indicated that she does not believe she talked about whether Defendant Nurse Lorraine Chatman deviated from the standard of care in her report. (Ex. G, Dr. Glindmeyer Deposition, p. 101:12-15) A review of Dr. Glindmeyer's Conclusions or Statement of Opinions reveals that Nurse Lorraine Chatman is not mentioned anywhere in either section. (Ex. T, Dr. Glindmeyer Report, pp. 1-2 and 26-31)

69. Dr. Glindmeyer testified that she does not have an opinion that Defendant Nurse Manuel Manalastas deviated from the standard of care. (Ex. G, Dr. Glindmeyer Deposition, p. 101:8-11) A review of Dr. Glindmeyer's Conclusions or Statement of Opinions reveals that Defendant Nurse Manuel Manalastas is not mentioned anywhere in either section. (Ex. T, Dr. Glindmeyer Report, pp. 1-2 and 26-31)

70. Dr. Glindmeyer testified that she does not have any opinions concerning Defendant Augustus Alabi. (Ex. G, Dr. Glindmeyer Deposition, p. 153:16-20) A review of Dr. Glindmeyer's Conclusions or Statement of Opinions reveals that Defendant Nurse Augustus Alabi is not mentioned anywhere in either section. (Ex. T, Dr. Glindmeyer Report, pp. 1-2 and 26-31)

71. Dr. Glindmeyer does indicate that she believes Nurses Helen Kanel and Cherri Krzyzowski deviated from the standard of care. (Ex. F, Dr. Glidnmeyer Deposition, p. 102:6-12)

72. Dr. Marcolini was asked which individuals she believes deviated from the standard of care and she responded Dr. Paschos, Nurse Chatman, Nurse Manalastas, and Nurse Krzyzowski deviated from the standard of care. (Ex. J. Dr. Marcolini Deposition, p. 31:19-32:6)

73. Dr. Marcolini did not read Defendant Nurse Manalastas's deposition in connection with developing her opinions. (Ex. J, Dr. Marcolini Deposition, p. 135:17-19)

74. Dr. Marcolini did not read Defendant Nurse Chatman's deposition in connection with developing her opinions (Ex. J, Dr. Marcolini Deposition, p. 135:17-19)

75. Dr. Glindmeyer was asked why Plaintiff's counsel did not retain a nurse to provide opinions, but Plaintiff's counsel instructed the witness not to answer that question. (Ex. G, Dr. Glidnmeyer Deposition, p. 154:10-15)

Respectfully submitted,
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EXHIBIT INDEX

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Exhibit F……………………………………………Dr. Ravi Yalamanchi Deposition

Exhibit G……………………………………………Dr. Daphne Glindmeyer Deposition

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Exhibit T………………………………………………Dr. Daphne Glindmeyer Report

Exhibit U………………………………………………Augustus Alabi Deposition

Exhibit V………………………………………………Lorraine Chatman Deposition

Exhibit W……………………………………………...Cherri Krzyzowski Deposition

Exhibit X…………………………………………………Medical Examiner Report

Exhibit Y…………………………………………………Plaintiff's 26(a)(2) Disclosure

CERTIFICATE OF SERVICE

I, William R. Ragen, Assistant State's Attorney, hereby certify that the above and foregoing was served upon the Plaintiff on August 31, 2021, electronically via the ECF-CM system.

/s/ *William R. Ragen*
William R. Ragen