

**IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF GEORGIA
MACON DIVISION**

DINA ines ESTRADA MADRID,
individually and on behalf of the ESTATE
OF JIMMY LUCERO,

Plaintiff,

v.

HOMER BRYSON; STAN SHEPARD;
RANDY BROWN; TIMOTHY YOUNG;
MARY ALSTON; DANIEL FASS;
VICTOR STEVENSON; ROBERT
STOCKFISCH; DAVID ROTH; SELENA
MITCHELL; EDITH WONG; CAROLINE
LEE; MARILYN COOPER; MAE PERRY;
NORMAN HILL; KATHY KING;
PAMELA TIPLER; MICHAEL NAHHAS;
BRANDON ROBERTS; KYLE
BROOKMAN; GEORGIA DEPARTMENT
OF CORRECTIONS; BOARD OF
REGENTS OF THE UNIVERSITY
SYSTEM OF GEORGIA; and DOES 1 –
35,

Defendants.

Civil Action No. 5:18-cv-00228-TES

Jury Trial Demanded

FIRST AMENDED COMPLAINT

Plaintiff Dina ines Estrada Madrid (“Plaintiff”), individually and on behalf of the Estate of Jimmy Lucero, brings this action against Defendants and alleges as follows:

INTRODUCTION AND OVERVIEW

1. At age 19, Jimmy Lucero (“Jimmy”) was sentenced to two years in prison for theft and was subsequently incarcerated under the custody and care of the Georgia Department of Corrections.

2. Immediately upon his incarceration, Jimmy's mental and physical health began to decline.

3. Within just a few months Jimmy began to fall into a catatonic state. He became largely unable to engage in ordinary activities such as eating, drinking, and simply moving. Over approximately six months, Jimmy lost about 100 pounds and ultimately died from malnutrition.

4. During those six months, the State of Georgia and its correctional system entirely failed to provide Jimmy even the most basic medical interventions that were obviously necessary and increasingly urgent until his death.

5. Instead, Jimmy spent months suffering from hallucinations and severe mental health problems without any mental health care.

6. Jimmy's final weeks were spent lying in a bunk, unable to move, unable to speak, unable to eat, unable to drink, urinating on himself, and defecating on himself until he ultimately starved to death.

7. The Defendants named in this lawsuit and discussed below are (1) medical personnel who personally examined Jimmy and knew of his obvious and life threatening medical needs, and (2) supervisors, policy-makers, and government bodies that created policies and procedures that caused a gross, systemic lack of basic medical care for GDC inmates, including Jimmy.

BACKGROUND

I. Policy, Pattern, and Practice of Denying Access to Medical Care by the GDC

8. Due to policies and procedures promulgated and enforced by Defendants Homer Bryson, Stan Shepard, Randy Brown, Timothy Young, Mary Alston, Georgia Department of Corrections (“GDC”), and the Board of Regents of the University System of Georgia (the “Board of Regents”) at the times relevant to this Complaint, the GDC and the Augusta State Medical Prison (“ASMP”) in particular had woefully inadequate staff, resources, and space to provide the constitutionally required basic healthcare to inmates in GDC care and custody.

9. Defendant Dr. Timothy Young has admitted that “if an inmate [at ASMP] has a serious condition, it may be months before they see a doctor.” *See* Anne Maxwell, *SPECIAL REPORT: As conditions at Augusta State Medical Prison deteriorated, administrators continued to receive raises*, NEWS CHANNEL 6 WJBF, February 22, 2018, http://www.wjbf.com/news/csra-news/as-conditions-at-augusta-state-medical-prison-deteriorated-administrators-continued-to-receive-raises_20180305061632598/1009285135 (attached as Exhibit 1). Jimmy Lucero did not have months before his serious medical condition took his life.

10. Dr. Young has admitted that the backlog of inmate requests for medical attention was at 1,000 requests. *Id.*

11. Dr. Young has admitted that “Over the years, I’ve seen numerous cases like that where people died.” *Id.* Jimmy Lucero is one of those cases.

12. According to Dr. Young, the facility really went downhill before Warden Wilkes took over in 2016, when Defendant Stan Shepard was warden—and when Jimmy Lucero was an inmate. *Id.*

13. Dr. Young “says the department really needs more employees and resources inside places like Augusta State Medical Prison, where the building is falling apart and staff can’t cover basic needs.” *Id.*

14. GDC sends more inmates to ASMP for medical care than ASMP has the space required to provide even minimally adequate care to the inmates. Dr. Young explained, “So someone would bring me a list, and say, ‘Okay, we have four beds available to put these patients into, and we have 15 cases scheduled. Which 11 do you want to cancel?’” Anne Maxwell, *Doctor: Healthcare at Augusta State Medical Prison hindered by widespread, systematic problems*, NEWS CHANNEL 6 WJBF, February 2, 2018, http://www.wjbf.com/news/doctor-care-at-augusta-state-medical-prison-hindered-by-widespread-systematic-problems_2018030506165559/1009289994 (attached as Exhibit 2).

15. The facilities that ASMP does have are frequently unusable due to lack of maintenance. For example, Dr. Young explained that the facility’s operating room was “offline” due to a “maintenance issue that has been known about for quite some time.” *Id.*

16. Dr. Young “said the issues at ASMP stem from ‘a catastrophic failure of management.’” Danny Robbins, *Prison hospital doctor resigns, cites security, patient care concerns*, ATLANTA JOURNAL CONSTITUTION, January 26, 2018, <https://www.myajc.com/news/state--regional-govt--politics/prison-hospital-doctor-resigns-cites-security-patient-care-concerns/YSSusa0pRTbLwLRepqNXVM/> (attached as Exhibit 3).

17. When Dr. Young voiced concerns about ASMP’s failure to meet the basic healthcare needs of its inmates, he was met with “overt hostility.” *Id.*

18. Dr. Young has also explained that the GDC completely failed to implement appropriate supervisory and disciplinary measures to ensure adequate healthcare for inmates:

He said he became particularly concerned about patient care when he participated in mortality reviews for inmates who died at ASMP after being moved there from other prisons. The reviews frequently revealed that the inmates' underlying conditions had been misdiagnosed or ignored, yet nothing was done to make sure the doctors responsible were disciplined or fired, he said.

Over time, he said, he came to the conclusion that the reviews were "pointless ... just paperwork exercises to give administrators and managers a job."

Id.

19. Defendant Dr. Alston has also called attention to GDC's indifference to patients' medical needs at ASMP. According to Dr. Alston, garbage stagnating on the floor near the operating room at ASMP draws insects into the operating room that have to be swatted away during procedures. Danny Robbins, *Documents: Unsanitary conditions long ignored at Ga. prison hospital*, ATLANTA JOURNAL CONSTITUTION, December 29, 2017, <https://www.myajc.com/news/state--regional/documents-unsanitary-conditions-long-ignored-prison-hospital/EyABXkbYrxC2JPBpsmHlnM/> (attached as Exhibit 4).

20. Prior to Jimmy's death, Defendants Bryson, Shepard, Brown, Young, Alston, GDC, and the Board of Regents had actual knowledge of the systemic and gross lack of adequate medical care at ASMP and did not respond reasonably to the risks created by those conditions.

21. Rather, Defendants Bryson, Shepard, Brown, Young, Alston, GDC, and the Board of Regents promulgated, enforced, and allowed policies to continue to exist that caused the

conditions discussed above in which GDC and ASMP in particular were unable to provide inmates, including Jimmy, constitutionally required medical care.

22. Despite knowing of the conditions discussed above in which GDC and ASMP in particular were unable to provide inmates (including Jimmy) constitutionally required medical care, Defendants Bryson, Shepard, Brown, Young, Alston, GDC, and the Board of Regents failed to promulgate and enforce policies and procedures reasonably necessary to address the problem.

II. The Denial of Jimmy Lucero's Access to Medical Care

23. Jimmy Lucero was placed in GDC custody in approximately November 2015. He was sentenced to two years in prison for theft.

24. On November 4, 2015, Jimmy weighed 250 pounds.

25. Jimmy quickly began to suffer from depression and as a result lost weight rapidly. Jimmy weighed 203 pounds on January 27, 2016.

26. On March 14, 2016, Jimmy was incarcerated in Wilcox State Prison in Abbeville, Georgia. Jimmy requested mental health help because he was hearing voices. He explained that he had previously requested help and never saw a doctor.

27. On March 29, 2016, over two weeks later, Defendant Stevenson performed a mental health evaluation that he designated as "routine." Defendant Stevenson described Jimmy's symptoms as "paranoia" and "auditory hallucinations."

28. Defendant Stevenson determined Jimmy's eating behavior to be "no problem" despite the fact that Jimmy had lost over 50 pounds in the previous approximately 4 months. Despite the fact that Jimmy was suffering from paranoia and auditory hallucinations, Defendant

Stevenson recommended that Jimmy be returned to Wilcox on Mental Health Level I, that is “mental health services” were “not warranted.”

29. On March 29, 2016, at Wilcox State Prison a layperson would have recognized that Jimmy, who had lost 50 pounds in 4 months and was experiencing hallucinations, was in need of mental health care.

30. At an April 28, 2016 “sick call” Jimmy weighed 180 pounds. A nurse practitioner recommended an urgent surgery consult.

31. At the surgery consult on May 5, 2016, Jimmy stated that “his entire body doesn’t work right,” his “ribs are too small,” and that he drank like he was “brain dead.” The surgeon recommended a psychiatry evaluation.

32. Jimmy was transferred from Wilcox State Prison to Coastal State Prison on May 12, 2016 for an “urgent” mental health evaluation. Jimmy reported that he had “a lot of anxiety, confusion, and visions.”

33. Defendant Roth examined Jimmy and diagnosed only “unspecified mental disorder.” Defendant Roth stated that Jimmy’s psychiatric presentation “may be consistent with cranial lesions or other underlying medical process affecting his [central nervous system].” Defendant Roth requested further evaluation by Defendant Stockfisch. Even a layperson, however, would have recognized that Jimmy was in urgent need of hospitalization.

34. On May 16, 2016, Defendant Stockfisch performed a psychiatric evaluation. According to records, during the evaluation Jimmy “rambled in speech, used odd hand gestures, varied eye contact, often looking around as if responding to internal stimuli.” Notably, Dr.

Stockfisch documented that Jimmy had lost 60 pounds over the past month and had bruising on the right lower flank.

35. Dr. Stockfisch ordered full medical workup and “close observation” until Jimmy’s medical and psychiatric condition was better understood. A Physical Health Referral was placed for “urgent evaluation” of possible “cranial lesions or other underlying medical process affecting his central nervous system.” Jimmy was placed on Mental Health Level II. Even a layperson, however, would have recognized that Jimmy was in urgent need of aggressive mental health care and hospitalization.

36. The urgent medical evaluation was never performed.

37. On May 18, 2016, Defendant Fass examined Jimmy. Defendant Fass was informed that the previous day Jimmy had been found “confused in the rain on the flat top.” Jimmy reported that he was not eating because he “felt sick, his teeth hurt, the air pollutes him and makes him feel dirty.”

38. Rather than urgently get Jimmy to a hospital, however, Defendant Fass’s orders were to simply monitor Jimmy.

39. It is appropriate to monitor a patient when the patient is reasonably well but may be in danger of decompensation or deterioration. Jimmy had already massively deteriorated. There was no need to monitor his condition. Rather, there was an urgent need to treat his condition. On May 28, 2016, when Defendant Fass examined Jimmy, a layperson would have recognized that Jimmy was in urgent need of hospitalization.

40. On May 19, 2016, Jimmy was sent to ASMP where Defendant Shepard was the Warden, Defendant Brown was the Health Services Administrator, Defendant Young was a

Medical Director, and Defendant Alston was a Medical Director. Jimmy now weighed 172 pounds.

41. In the weeks that followed his transfer to ASMP, Jimmy's decline accelerated and he became catatonic—unable to move, speak, eat, or drink. Numerous ASMP medical personnel observed Jimmy in a condition in which a layperson would recognize Jimmy's obvious need for urgent hospitalization and did nothing.

42. On May 25, 2016, Nurse King recorded that Jimmy told her he was "fasting."

43. On May 27, 2016, a Doe Healthcare Provider recorded that Jimmy was "non-verbal" and "refused meal."

44. On May 28, 2016, Nurse Selena Mitchell again noted that Jimmy "refused" to eat.

45. On May 29, 2015, Nurse Edith Wong noted that Jimmy ate "10% of supper" and his affect was "bizarre."

46. On June 1, 2016, Nurse Selena Mitchell noted that Jimmy was standing in his cell naked. She offered Jimmy saltines and he "nodded 'no.'"

47. On June 7, 2016, Nurse Caroline Lee noted that Jimmy did not talk or eat and had been standing in the same spot all day.

48. On June 8, 2016, a Doe Healthcare Provider noted that Jimmy was nonverbal and "did not acknowledge nurse at all."

49. On June 10, 2016, Nurse Marilyn Cooper noted that Jimmy could not shower or eat. He had soiled himself. Nurse Mitchell again noted that Jimmy nodded "no" when asked if he wanted saltines. A physician assistant ordered that Jimmy be given an antibiotic to treat a possible urinary tract infection. What he actually, very obviously needed was urgent

hospitalization and mental healthcare. On at least eight separate occasions, Jimmy was not even given the antibiotic medication as ordered.

50. Jimmy never received care from a physician, psychologist, or psychiatrist at ASMP again.

51. On June 11, 2016, Nurse Lee again noted that Jimmy was nonverbal and did not eat. Nurse Mitchell noted that Jimmy was “mute.”

52. On June 12, 2016, Nurse Mitchell noted that Jimmy did not eat or receive medication. Nurse Lee noted that Jimmy did not take water or food.

53. On June 13, 2016, Nurse Mitchell noted that Jimmy did not get up, did not eat, and did not take his medication.

54. On June 14, 2016, Nurse Wong noted that Jimmy refused food and medicine. Nurse Mae Perry also observed Jimmy and took no action to address his mental decline and starvation.

55. On June 15, 2016, a Doe Healthcare Provider noted that Jimmy was non-responsive and continuing to urinate on himself.

56. On June 16, 2016, a Doe Healthcare Provider noted that Jimmy was “nonverbal,” “continues to urinate on himself,” and continued to be unable to shower or eat.

57. On June 17, 2016, a Doe Healthcare Provider noted that Jimmy was nonverbal, did not eat, continued to urinate on himself, and was in jumper soiled in his own feces. The Doe Healthcare Provider also noted that Jimmy’s thought process was “blocking,” his mood was dysphoric, and he had an “unspecified mental diagnosis.”

58. On June 18, 2016, a Doe Healthcare Provider noted that Jimmy's jumpsuit was stained and foul smelling of feces, and that he could not eat, drink, or take any medication. Although Jimmy was nonresponsive and nonverbal, had not left his bed in days, was urinating on himself, and had not eaten or drank water in days, nursing staff recorded that he did not "voice" any "complaints" or "concerns."

59. On June 19, 2016, a Doe Healthcare Provider recorded that Jimmy remained in a "catatonic state" (among the most severe and dangerous symptoms of mental illness), he was urinating and defecating on himself, his jumpsuit was soiled with urine and feces, he was "entirely mute," and he could not shower or eat. Nurse Norman Hill similarly noted that Jimmy "refuses all interventions and meds" and that he did not shower or eat.

60. On June 20, 2016, Nurse Lee noted that Jimmy "refused" water. Nurse Lee called a Lieutenant to take Jimmy to shower and then for an MRI. Nurse Lee noted that "MD unit Psychiatry notified about inmate not eating, drinking, labs not being drawn and medications not being taken." Jimmy was eventually taken to shower, but the MRI was never performed. Jimmy now weighed 145 pounds, having lost over 100 pounds since entering GDC custody.

61. On June 21, 2016, Nurse Lee noted that Jimmy continued to lay in bed catatonic, urinating on himself.

62. On June 22, 2016, a Doe Healthcare Provider noted that Jimmy continued not to move from bed and his status was "not improved."

63. On June 23, 2016, inexplicably, Defendant L.B. ordered that Jimmy be placed in solitary confinement where he no longer received even the daily nursing checks that previously documented his mental decline and malnutrition (although providing no medical intervention).

On June 23, 2016, a layperson would have recognized that Jimmy was in obvious need of emergency medical care and most certainly should not be left alone. Defendant L.B., however, recorded that there was “no medical contraindication” for segregation. *See* Exhibit 5 (Georgia Department of Corrections Segregation Review and Flow Sheet for Jimmy Lucero, June 23, 2016).

64. On June 27, 2016, after months of starvation with no medical care to speak of, Jimmy finally collapsed unconscious. ASMP personnel did not call an ambulance, and instead drove him to Augusta University Medical Center (“AUMC”) where they reported that he had been on a “hunger strike.”

65. AUMC began treatment for dehydration and malnutrition. Jimmy was so dehydrated he received three liters of intravenous fluids in a few hours without any urine output.

66. The emergency department diagnosed Jimmy with multiple life threatening conditions, including starvation, hypotension, lactic acidosis, severe weakness associated with physical deconditioning, sepsis, and tachycardia. Some of these conditions were acutely life-threatening.

67. Due to months of sedation, catatonia, starvation, and dehydration, Jimmy was in urgent need of aggressive anticoagulation to prevent and treat thrombosis (blood clotting), which can lead to thromboembolism (obstruction of a blood vessel by a blood clot that is dislodged from another site in the circulation).

68. Dr. Roberts ordered a compression device, a blood-thinning medication called enoxaparin, and venous thromboembolism risk assessment due to the risk of thrombosis in dehydrated, malnourished, and catatonic patients.

69. Defendant Brookman signed and entered the order for the venous thromboembolism risk assessment, but he failed to perform the assessment and failed to make sure that an assessment was performed.

70. At 9:00 p.m. on June 27, 2016, Defendant Brookman was supposed to give Jimmy a dose of enoxaparin. Even though Jimmy was catatonic and it had been determined that Jimmy lacked the capacity to make medical decisions, Defendant Brookman did not administer the medication and simply noted that Jimmy “refused” the medication.

71. Again at 11:00 p.m. on June 27, 2016, Defendant Brookman was supposed to give Jimmy a dose of enoxaparin. Even though Jimmy was catatonic and it had been determined that Jimmy lacked the capacity to make medical decisions, Defendant Brookman did not administer the medication and simply noted that Jimmy “refused” the medication.

72. On June 28, 2016, attending physician Dr. Michael Hocker examined Jimmy and found that he had suffered “starvation for months.”

73. Also on June 28, 2016, psychiatrist Dr. Katragadda noted that at ASMP Jimmy was on no medication and had received no psychiatry diagnosis. Dr. Katragadda diagnosed Jimmy with catatonia from severe depression with psychotic features. Jimmy still did not receive any enoxaparin on June 28, 2016.

74. On June 29, 2016, two days after arriving at AUMC, Jimmy finally received a single dose of enoxaparin. Dr. Katragadda evaluated Jimmy again at approximately 10:40 a.m. and found that he had “regressed” and did not have any “decision making capacity.” Dr. Katragadda recommended that Jimmy be given Haldol and intravenous Ativan.

75. At approximately 2:41 p.m., Defendant Dr. Nahhas wrote orders for Jimmy to be discharged from the hospital despite his worsening condition and the complete lack of treatment for blood clotting.

76. Defendant Tipler personally interviewed and examined Jimmy and approved of the discharge orders.

77. It would have been obvious to a layperson that Jimmy was in urgent need of medical care and should not be discharged from the hospital.

78. At approximately 4:15 p.m., Nurse Donna Shafer attempted to discuss Jimmy's discharge with him. In the middle of the effort to discharge Jimmy from the hospital, however, he suffered a massive pulmonary embolism—a blood clot that traveled to an artery in his lungs—and his heart stopped. After nearly an hour of resuscitation efforts, Jimmy was pronounced dead.

PARTIES

I. Plaintiff

79. Jimmy Lucero was at all times relevant to this Complaint, a resident of the State of Georgia in the custody and care of the Georgia Department of Corrections.

80. Dina ines Estrada Madrid ("Plaintiff" or "Dina") is a resident of the State of Georgia. Dina is the surviving parent of Jimmy Lucero and is entitled to bring this action for Jimmy's wrongful death.

II. Defendants

A. Homer Bryson

81. At all times relevant to this Complaint, Homer Bryson (“Defendant Bryson” or “Bryson”) was the Commissioner of the Georgia Department of Corrections. Defendant Bryson was responsible for the operations of GDC. Defendant Bryson is a resident of Nicholson, Georgia. At all relevant times, Defendant Bryson acted under color of state law. Defendant Bryson is being sued for damages in his individual capacity.

82. Defendant Bryson was responsible for policies and procedures of GDC that, among other things:

- a. Caused too few qualified medical personnel to be hired at ASMP;
- b. Caused ASMP to have inadequate space to enable it to provide adequate medical care to its inmates;
- c. Caused ASMP to have inadequate resources to enable it to provide adequate medical care to its inmates; and
- d. Caused GDC to have inadequate training and supervision of its medical personnel resulting in the inadequate delivery of medical care.

83. At the times relevant to this Complaint, Defendant Bryson knew that inmates at Wilcox State Prison, Coastal State Prison, and ASMP were not receiving adequate medical care for serious medical needs and failed to take reasonable steps to address the problem.

84. Defendant Bryson knowingly permitted the policy, custom, and practice of understaffing to persist throughout GDOC’s system, including Wilcox State Prison, Coastal State Prison, and ASMP, where Jimmy Lucero resided at the times relevant to this Complaint.

85. Defendant Bryson knowingly permitted the policy, custom, and practice of denying inmates access to medical care at Wilcox State Prison, Coastal State Prison, and ASMP to persist.

86. Defendant Bryson knowingly permitted the policy, custom, and practice of denying inmates access to mental health care at Wilcox State Prison, Coastal State Prison, and ASMP to persist.

87. Defendant Bryson's actions exhibited deliberate indifference to the safety and well-being of Jimmy Lucero and subjected him to the unnecessary and wanton infliction of pain and ultimately death, which constituted cruel and unusual punishment.

B. Stan Shepard

88. At all times relevant to this Complaint, Stan Shepard ("Defendant Shepard" or "Shepard") was the Warden of ASMP. Defendant Shepard was responsible for the operations of ASMP. Defendant Shepard is a resident of Kite, Georgia. At all relevant times, Defendant Shepard acted under color of state law. Defendant Shepard is being sued for damages in his individual capacity.

89. Defendant Shepard was responsible for, and knowingly promulgated, enforced, and allowed to persist, policies and procedures of ASMP that, among other things:

- a. Caused too few qualified medical personnel to be hired at ASMP;
- b. Caused ASMP to have inadequate space to enable it to provide adequate medical care to its inmates;
- c. Caused ASMP to have inadequate resources to enable it to provide adequate medical care to its inmates; and

d. Caused ASMP to have inadequate training and supervision of its medical personnel resulting in the inadequate delivery of medical care.

90. As the Warden of ASMP, Defendant Shepard was also responsible for the training and supervision of ASMP medical personnel.

91. Defendant Shepard had actual knowledge that his subordinates were failing to provide adequate medical care to Jimmy and he did not attempt to remedy the problem.

92. Defendant Shepard knew that a reasonable person in his position would know that his failure to train and supervise reflected deliberate indifference to serious medical needs.

93. Defendant Shepard's actions exhibited deliberate indifference to the safety and well-being of Jimmy Lucero and subjected him to the unnecessary and wanton infliction of severe pain, which constituted cruel and unusual punishment.

C. Randy Brown

94. At all times relevant to this Complaint Randy Brown ("Defendant Brown" or "Brown") was the Health Services Administrator of ASMP. Defendant Brown was responsible for the administration of health services at ASMP. To the best of Plaintiff's information and belief, Defendant Brown is a resident of the State of Georgia. At all relevant times, Defendant Brown acted under color of state law. Defendant Brown is being sued for damages in his individual capacity.

95. Defendant Brown was responsible for, and knowingly promulgated, enforced, and allowed to persist, policies and procedures of ASMP that, among other things:

a. Caused too few qualified medical personnel to be hired at ASMP;

b. Caused ASMP to have inadequate space to enable it to provide adequate medical care to its inmates;

c. Caused ASMP to have inadequate resources to enable it to provide adequate medical care to its inmates; and

d. Caused ASMP to have inadequate training and supervision of its medical personnel resulting in the inadequate delivery of medical care.

96. As the Health Services Administrator, Defendant Brown was also responsible for the training and supervision of ASMP medical personnel.

97. Defendant Brown had actual knowledge that his subordinates were failing to provide adequate medical care to Jimmy and he did not attempt to remedy the problem.

98. Defendant Brown knew that a reasonable person in his position would know that his failure to train and supervise reflected deliberate indifference to serious medical needs.

99. Defendant Brown's actions exhibited deliberate indifference to the safety and well-being of Jimmy Lucero and subjected him to the unnecessary and wanton infliction of severe pain, which constituted cruel and unusual punishment.

D. Timothy Young

100. At all times relevant to this Complaint Timothy Young, M.D. ("Defendant Young" or "Dr. Young") was a Medical Director at ASMP. Defendant Young was responsible for the supervision and delivery of health services at ASMP. Defendant Young is a resident of Evans, Georgia. At all relevant times, Defendant Young acted under color of state law. Defendant Young is being sued for damages in his individual capacity.

101. Defendant Young was responsible for, and knowingly promulgated, enforced, and allowed to persist, policies and procedures of ASMP that, among other things:

- a. Caused too few qualified medical personnel to be hired at ASMP;
- b. Caused ASMP to have inadequate space to enable it to provide adequate medical care to its inmates;
- c. Caused ASMP to have inadequate resources to enable it to provide adequate medical care to its inmates; and
- d. Caused ASMP to have inadequate training and supervision of its medical personnel resulting in the inadequate delivery of medical care.

102. As the Medical Director, Defendant Young was also responsible for the training and supervision of ASMP medical personnel.

103. Defendant Young had actual knowledge that his subordinates were failing to provide adequate medical care to Jimmy and he did not attempt to remedy the problem.

104. Defendant Young knew that a reasonable person in his position would know that his failure to train and supervise reflected deliberate indifference to serious medical needs.

105. Defendant Young also had actual knowledge of Jimmy's condition in which even a layperson would recognize that Jimmy had serious medical needs and Defendant Young failed to respond reasonably to address those needs.

106. Defendant Young's actions exhibited deliberate indifference to the safety and well-being of Jimmy and subjected him to the unnecessary and wanton infliction of severe pain, which constituted cruel and unusual punishment.

E. Mary Alston

107. At all times relevant to this Complaint Mary Alston, M.D. (“Defendant Alston” or “Dr. Alston”) was a Medical Director at ASMP. Defendant Alston was responsible for the supervision and delivery of health services at ASMP. Defendant Alston is a resident of Grovetown, Georgia. At all relevant times, Defendant Alston acted under color of state law. Defendant Alston is being sued for damages in her individual capacity.

108. Defendant Alston was responsible for, and knowingly promulgated, enforced, and allowed to persist, policies and procedures of ASMP that, among other things:

- a. Caused too few qualified medical personnel to be hired at ASMP;
- b. Caused ASMP to have inadequate space to enable it to provide adequate medical care to its inmates;
- c. Caused ASMP to have inadequate resources to enable it to provide adequate medical care to its inmates; and
- d. Caused ASMP to have inadequate training and supervision of its medical personnel resulting in the inadequate delivery of medical care.

109. As the Medical Director, Defendant Alston was also responsible for the training and supervision of ASMP medical personnel.

110. Defendant Alston had actual knowledge that her subordinates were failing to provide adequate medical care to Jimmy and he did not attempt to remedy the problem.

111. Defendant Alston knew that a reasonable person in her position would know that his failure to train and supervise reflected deliberate indifference to serious medical needs.

112. Defendant Alston also had actual knowledge of Jimmy's condition in which even a layperson would recognize that Jimmy had serious medical needs and Defendant Alston failed to respond reasonably to address those needs.

113. Defendant Alston's actions exhibited deliberate indifference to the safety and well-being of Jimmy Lucero and subjected him to the unnecessary and wanton infliction of severe pain, which constituted cruel and unusual punishment.

F. Daniel Fass

114. At all times relevant to this Complaint Daniel Fass ("Defendant Fass" or "Fass") was a Clinical Director and Supervising Psychologist at GDC. Defendant Fass was responsible for the supervision and delivery of mental health services to GDC inmates, including Jimmy. Defendant Fass is a resident of Savannah, Georgia. At all relevant times, Defendant Fass acted under color of state law. Defendant Fass is being sued for damages in his individual capacity.

115. Defendant Fass personally examined Jimmy under conditions in which it would be obvious to a layperson that Jimmy had serious medical needs and did not respond reasonably to the risk.

116. Defendant Fass knew that Jimmy Lucero had serious medical needs. Defendant Fass denied Jimmy Lucero access to healthcare for those serious medical needs.

117. Defendant Fass's actions exhibited deliberate indifference to the safety and well-being of Jimmy Lucero and subjected him to the unnecessary and wanton infliction of severe pain, which constituted cruel and unusual punishment.

G. Victor Stevenson

118. At all times relevant to this Complaint Victor Stevenson (“Defendant Stevenson” or “Stevenson”) was an institutional psychologist and the Clinical Director of Central State Prison (“Central State”). Defendant Stevenson was responsible for the supervision and delivery of health services at Wilcox State Prison. Defendant Stevenson is a resident of Macon, Georgia. At all relevant times, Defendant Stevenson acted under color of state law. Defendant Stevenson is being sued for damages in his individual capacity.

119. Defendant Stevenson personally examined Jimmy at Wilcox State Prison under conditions in which it would be obvious to a layperson that Jimmy had serious medical needs and did not respond reasonably to the risk.

120. Defendant Stevenson’s actions exhibited deliberate indifference to the safety and well-being of Jimmy Lucero and subjected him to the unnecessary and wanton infliction of severe pain, which constituted cruel and unusual punishment.

H. Robert Stockfisch

121. At all times relevant to this Complaint, Robert Stockfisch, M.D. (“Defendant Stockfisch” or “Dr. Stockfisch”) was an institutional physician at Coastal State Prison (“Coastal State”). Defendant Stockfisch is a resident of Head Island, South Carolina. At all relevant times, Defendant Stockfisch acted under color of state law. Defendant Stockfisch is being sued for damages in his individual capacity.

122. Defendant Stockfisch personally examined Jimmy under conditions in which it would be obvious to a layperson that Jimmy had serious medical needs and did not respond reasonably to the risk.

123. Defendant Stockfisch's actions exhibited deliberate indifference to the safety and well-being of Jimmy Lucero and subjected him to the unnecessary and wanton infliction of severe pain, which constituted cruel and unusual punishment.

I. David Roth, M.D.

124. At all times relevant to this Complaint, David Roth, M.D. ("Defendant Roth" or "Dr. Roth") was an institutional physician at Coastal State Prison. Defendant Roth is a resident of Pooler, Georgia. At all relevant times, Defendant Roth acted under color of state law. Defendant Roth is being sued for damages in his individual capacity.

125. Defendant Roth personally examined Jimmy under conditions in which it would be obvious to a layperson that Jimmy had serious medical needs and did not respond reasonably to the risk.

126. Defendant Roth's actions exhibited deliberate indifference to the safety and well-being of Jimmy Lucero and subjected him to the unnecessary and wanton infliction of severe pain, which constituted cruel and unusual punishment.

J. Selena Mitchell

127. At all times relevant to this Complaint, Selena Mitchell ("Defendant Mitchell" or "Nurse Mitchell") was an institutional nurse at ASMP. Defendant Mitchell is a resident of Hephzibah, Georgia. At all relevant times, Defendant Mitchell acted under color of state law. Defendant Mitchell is being sued for damages in her individual capacity.

128. Defendant Mitchell personally examined Jimmy under conditions in which it would be obvious to a layperson that Jimmy had serious medical needs and did not respond reasonably to the risk.

129. Defendant Mitchell's actions exhibited deliberate indifference to the safety and well-being of Jimmy Lucero and subjected him to the unnecessary and wanton infliction of severe pain, which constituted cruel and unusual punishment.

K. Edith Wong

130. At all times relevant to this Complaint, Nurse Edith Wong ("Defendant Wong" or "Nurse Wong") was an institutional nurse at ASMP. Defendant Wong is a resident of Augusta Georgia. At all relevant times, Defendant Wong acted under color of state law. Defendant Wong is being sued for damages in her individual capacity.

131. Defendant Wong personally examined Jimmy under conditions in which it would be obvious to a layperson that Jimmy had serious medical needs and did not respond reasonably to the risk.

132. Defendant Wong's actions exhibited deliberate indifference to the safety and well-being of Jimmy Lucero and subjected him to the unnecessary and wanton infliction of severe pain, which constituted cruel and unusual punishment.

L. Caroline Lee

133. At all times relevant to this Complaint, Caroline Lee ("Defendant Lee" or "Nurse Lee") was an institutional nurse at ASMP. Defendant Lee is a resident of Augusta, Georgia. At all relevant times, Defendant Lee acted under color of state law. Defendant Lee is being sued for damages in her individual capacity.

134. Defendant Lee personally examined Jimmy under conditions in which it would be obvious to a layperson that Jimmy had serious medical needs and did not respond reasonably to the risk.

135. Defendant Lee's actions exhibited deliberate indifference to the safety and well-being of Jimmy Lucero and subjected him to the unnecessary and wanton infliction of severe pain, which constituted cruel and unusual punishment.

M. Marilyn Cooper

136. At all times relevant to this Complaint, Nurse Marilyn Cooper ("Defendant Cooper" or "Nurse Cooper") was an institutional nurse at ASMP. Defendant Cooper is a resident of Waynesboro, Georgia. At all relevant times, Defendant Cooper acted under color of state law. Defendant Cooper is being sued for damages in her individual capacity.

137. Defendant Cooper personally examined Jimmy under conditions in which it would be obvious to a layperson that Jimmy had serious medical needs and did not respond reasonably to the risk.

138. Defendant Cooper's actions exhibited deliberate indifference to the safety and well-being of Jimmy Lucero and subjected him to the unnecessary and wanton infliction of severe pain, which constituted cruel and unusual punishment.

N. Mae Perry

139. At all times relevant to this Complaint, Nurse Mae Perry ("Defendant Perry" or "Nurse Perry") was an institutional nurse at ASMP. Defendant Perry is a resident of Augusta, Georgia. At all relevant times, Defendant Perry acted under color of state law. Defendant Perry is being sued for damages in her individual capacity.

140. Defendant Perry personally examined Jimmy under conditions in which it would be obvious to a layperson that Jimmy had serious medical needs and did not respond reasonably to the risk.

141. Defendant Perry's actions exhibited deliberate indifference to the safety and well-being of Jimmy Lucero and subjected him to the unnecessary and wanton infliction of severe pain, which constituted cruel and unusual punishment.

O. Norman Hill

142. At all times relevant to this Complaint, Nurse Norman Hill ("Defendant Hill" or "Nurse Hill") was an institutional nurse at ASMP. Defendant Hill is a resident of Augusta, Georgia. At all relevant times, Defendant Hill acted under color of state law. Defendant Hill is being sued for damages in his individual capacity.

143. Defendant Hill personally examined Jimmy under conditions in which it would be obvious to a layperson that Jimmy had serious medical needs and did not respond reasonably to the risk.

144. Defendant Hill's actions exhibited deliberate indifference to the safety and well-being of Jimmy Lucero and subjected him to the unnecessary and wanton infliction of severe pain, which constituted cruel and unusual punishment.

P. Kathy King

145. At all times relevant to this Complaint, Nurse Kathy King ("Defendant King" or "Nurse King") was an institutional nurse at ASMP. To the best of Plaintiff's information and belief, Defendant King is a resident of the State of Georgia. At all relevant times, Defendant King acted under color of state law. Defendant King is being sued for damages in her individual capacity.

146. Defendant King personally examined Jimmy under conditions in which it would be obvious to a layperson that Jimmy had serious medical needs and did not respond reasonably to the risk.

147. Defendant King's actions exhibited deliberate indifference to the safety and well-being of Jimmy Lucero and subjected him to the unnecessary and wanton infliction of severe pain, which constituted cruel and unusual punishment.

Q. Ms. Holmes

148. At all relevant times, Doe 1 (referred to in this Complaint as "Ms. Holmes" or "Defendant Holmes") was an institutional mental health professional at ASMP identified in records available to Plaintiff only as "Ms. Holmes." *See* Exhibit 5. To the best of Plaintiff's information and belief, Defendant Holmes is a resident of the State of Georgia. At all relevant times, Ms. Holmes acted under color of state law. Defendant Holmes is being sued for damages in her individual capacity.

149. Defendant Holmes personally examined Jimmy under conditions in which it would be obvious to a layperson that Jimmy had serious medical needs and did not respond reasonably to the risk.

150. Defendant Holmes's actions exhibited deliberate indifference to the safety and well-being of Jimmy Lucero and subjected him to the unnecessary and wanton infliction of severe pain, which constituted cruel and unusual punishment.

151. The full name of Ms. Holmes is unknown to Plaintiff at this time. Upon ascertaining the full name and true identity of Ms. Holmes, Plaintiff will seek to substitute her true name by Amendment.

R. L. B.

152. At all relevant times, Doe 2 (referred to in this Complaint as “L.B.”) was an institutional healthcare professional at ASMP whose name is not discernable from the records available to Plaintiff. *See* Exhibit 5. To the best of Plaintiff’s information and belief, Defendant L.B. is a resident of the State of Georgia. At all relevant times, Defendant L.B. acted under color of state law. Defendant L.B. is being sued for damages in his or her individual capacity.

153. Defendant L.B. personally examined Jimmy under conditions in which it would be obvious to a layperson that Jimmy had serious medical needs and did not respond reasonably to the risk.

154. Defendant L.B.’s actions exhibited deliberate indifference to the safety and well-being of Jimmy Lucero and subjected him to the unnecessary and wanton infliction of severe pain, which constituted cruel and unusual punishment.

155. The true name of L.B. is unknown to Plaintiff at this time. Upon ascertaining the full name and true identity of L.B., Plaintiff will seek to substitute his or her true name by Amendment.

S. Unidentified ASMP Healthcare Providers

156. At all relevant times, Does 3 through 25 (referred to below as “Doe Healthcare Providers”) were institutional nurses or other healthcare providers who were aware of Jimmy’s serious medical needs and made no effort to address those needs, including each nurse or other person who signed the progress records, physician’s orders, or medication administration records attached as Exhibit 6 and who is not named by his or her true name in this Complaint. At all

relevant times, each of the Doe Healthcare Providers acted under color of state law. Each of the Doe Healthcare Providers is being sued for damages in his or her individual capacity.

157. Each of the Doe Healthcare Providers personally examined Jimmy under conditions in which it would be obvious to a layperson that Jimmy had serious medical needs and did not respond reasonably to the risk.

158. The actions of the Doe Healthcare Providers exhibited deliberate indifference to the safety and well-being of Jimmy Lucero and subjected him to the unnecessary and wanton infliction of severe pain, which constituted cruel and unusual punishment.

159. The true identities of the Doe Healthcare Providers are unknown to Plaintiff at this time. Upon ascertaining their identities, Plaintiff will seek to substitute their true names by amendment.

T. Unidentified GDC Personnel

160. Does 25 through 35 are individuals not otherwise named in this Complaint who were working at the prisons discussed in this Complaint and were aware of Jimmy's serious medical needs and made no effort to address those needs. At all relevant times, 25 through 35 acted under color of state law. Does 25 through 35 are being sued for damages in their individual capacities.

161. Does 25 through 35 knew that Jimmy Lucero had serious medical needs. Does 25 through 35 denied Jimmy Lucero access to healthcare for those serious medical needs.

162. The actions of Does 25 through 35 exhibited deliberate indifference to the safety and well-being of Jimmy Lucero and subjected him to the unnecessary and wanton infliction of severe pain, which constituted cruel and unusual punishment.

163. The identities of 25 through 35 are unknown to Plaintiff at this time. Upon ascertaining their identities, Plaintiff will seek to substitute their true names by amendment.

U. Pamela Tipler

164. At all times relevant to this Complaint, Pamela Tipler, D.O. (“Defendant Tipler” or “Dr. Tipler”) was an osteopathic physician at AUMC. Defendant Tipler is a resident of Philadelphia, Pennsylvania. At all relevant times, Defendant Tipler acted under color of state law and pursuant to a contract with GDC. Defendant Tipler is being sued for damages in her individual capacity.

165. Defendant Tipler personally examined Jimmy under conditions in which it would be obvious to a layperson that Jimmy had serious medical needs and did not respond reasonably to the risk.

166. Defendant Tipler’s actions exhibited deliberate indifference to the safety and well-being of Jimmy Lucero and subjected him to the unnecessary and wanton infliction of severe pain, which constituted cruel and unusual punishment.

V. Michael Nahhas

167. At all times relevant to this Complaint, Michael Nahhas, M.D. (“Defendant Nahhas” or “Dr. Nahhas”) was a physician at AUMC. Defendant Nahhas is a resident of Augusta, Georgia. At all relevant times, Defendant Nahhas acted under color of state law and pursuant to a contract with GDC. Defendant Nahhas is being sued for damages in his individual capacity.

168. Defendant Nahhas personally examined Jimmy under conditions in which it would be obvious to a layperson that Jimmy had serious medical needs and did not respond reasonably to the risk.

169. Defendant Nahhas's actions exhibited deliberate indifference to the safety and well-being of Jimmy Lucero and subjected him to the unnecessary and wanton infliction of severe pain, which constituted cruel and unusual punishment.

W. Brandon Roberts

170. At all times relevant to this Complaint, Brandon Roberts, M.D. ("Defendant Roberts" or "Dr. Roberts") was a physician at AUMC. Defendant Roberts is a resident of New Orleans, Louisiana. At all relevant times, Defendant Roberts acted under color of state law and pursuant to a contract with GDC. Defendant Roberts is being sued for damages in his individual capacity.

171. Defendant Roberts personally examined Jimmy under conditions in which it would be obvious to a layperson that Jimmy had serious medical needs and did not respond reasonably to the risk.

172. Defendant Roberts's actions exhibited deliberate indifference to the safety and well-being of Jimmy Lucero and subjected him to the unnecessary and wanton infliction of severe pain, which constituted cruel and unusual punishment.

X. Kyle Brookman

173. At all times relevant to this Complaint, Kyle Brookman R.N. ("Defendant Brookman" or "Brookman") was a nurse at AUMC. Defendant Brookman is a resident of Evans, Georgia. At all relevant times, Defendant Brookman acted under color of state law and

pursuant to a contract with GDC. Defendant Brookman is being sued for damages in his individual capacity.

174. Defendant Brookman personally examined Jimmy under conditions in which it would be obvious to a layperson that Jimmy had serious medical needs and did not respond reasonably to the risk.

175. Defendant Brookman's actions exhibited deliberate indifference to the safety and well-being of Jimmy Lucero and subjected him to the unnecessary and wanton infliction of severe pain, which constituted cruel and unusual punishment.

Y. Georgia Department of Corrections

176. GDC exists pursuant to O.C.G.A. § 42-2-4 and is charged with the duty and responsibility of administering correctional institutions of the State of Georgia under O.C.G.A. §42-2-5. The GDC will be served with process through its Commissioner, Gregory C. Dozier, located at 7 Martin Luther King Jr. Drive SW, Atlanta, GA 30334. Process will also be served upon the Director of Risk Management, Department of Administrative Services, located at 200 Piedmont Avenue, Suite 1208, Atlanta, GA 30334. Pursuant to O.C.G.A. § 50-21-35, a copy of Plaintiffs Complaint shall be mailed via certified mail with return receipt requested, to the Attorney General Christopher Carr at 40 Capitol Square, SW, Atlanta, Georgia 30334. A certificate attached as Exhibit 7 certifies this Complaint shall be mailed in accordance with the statute.

177. GDC was responsible for policies and procedures of GDC that, among other things:

- a. Caused too few qualified medical personnel to be hired at ASMP;

b. Caused ASMP to have inadequate space to enable it to provide adequate medical care to its inmates;

c. Caused ASMP to have inadequate resources to enable it to provide adequate medical care to its inmates; and

d. Caused GDC to have inadequate training and supervision of its medical personnel resulting in the inadequate delivery of medical care.

178. As a direct and proximate result of GDC's policies and procedures, Jimmy experienced severe pain and suffering and died.

Z. Board of Regents of the University System of Georgia

179. The Board of Regents of the University System of Georgia ("Board of Regents") provides health services to GDC inmates pursuant to a contract with GDC. The Board of Regents may be served with process by way of its Chancellor, Steve Wrigley, the Chief Executive Officer of the Board of Regents, at 270 Washington Street S.W., Suite 7096, Atlanta, GA 30334 and the Director of the Risk Management Division of the Department of Administrative Services of the State of Georgia, at Suite 1504, West Tower, 200 Piedmont Avenue, Atlanta, GA 30334. Pursuant to O.C.G.A. § 50-21-35, a copy of Plaintiffs Complaint shall be mailed via certified mail with return receipt requested, to the Attorney General Christopher Carr at 40 Capitol Square, SW, Atlanta, Georgia 30334. A certificate attached as Exhibit 7 certifies this Complaint shall be mailed in accordance with the statute.

180. The Board of Regents was responsible for policies and procedures of GDC that, among other things:

a. Caused too few qualified medical personnel to be hired at ASMP;

b. Caused ASMP to have inadequate space to enable it to provide adequate medical care to its inmates;

c. Caused ASMP to have inadequate resources to enable it to provide adequate medical care to its inmates; and

d. Caused GDC to have inadequate training and supervision of its medical personnel resulting in the inadequate delivery of medical care.

181. As a direct and proximate result of the Board of Regents' policies and procedures, Jimmy experienced severe pain and suffering and died.

JURISDICTION AND VENUE

182. This Court has jurisdiction of the subject matter of this action under 28 U.S.C. §§ 1331 and 1343 because this action asserts claims arising under the Constitution, laws, or treaties of the United States.

183. This Court has personal jurisdiction over all Defendants because all Defendants are domiciled in the State of Georgia, or acted and caused injury within the State of Georgia.

184. Venue is proper in the Middle District of Georgia, Macon Division under 28 U.S.C. § 1391 and M.D. Ga. L.R. 3 because a substantial part of the events or omissions giving rise to the claims occurred within the Middle District of Georgia, Macon Division at Wilcox State Prison in Abbeville, Georgia.

CLAIMS FOR RELIEF

Count I: (42 U.S.C. § 1983: Violation of Eighth and Fourteenth Amendments by Defendants Fass, Stevenson, Stockfisch, Roth, Young, Alston, Mitchell, Wong, Lee, Cooper, Perry, Hill, King, Tipler, Nahhas, Roberts, and Brookman Based Upon Deliberate Indifference to Serious Medical Needs)

185. Plaintiff incorporates all other paragraphs of this Complaint as if fully stated herein.

186. Defendants Fass, Stevenson, Stockfisch, Roth, Young, Alston, Mitchell, Wong, Lee, Cooper, Perry, Hill, King, Tipler, Nahhas, Roberts, and Brookman (collectively the “Count I Defendants”), acting under color of state law, were responsible for diagnosing, treating, caring for, and maintaining custody of Jimmy.

187. While in the custody and care of the Count I Defendants, Jimmy had serious, life-threatening medical needs that would have been obvious to a layperson.

188. The Count I Defendants had actual knowledge of Jimmy’s serious medical needs.

189. The Count I Defendants were deliberately indifferent to Jimmy’s serious medical needs in at least the following ways:

- a. The Count I Defendants denied Jimmy access to a medical facility appropriate for his serious medical needs;
- b. The Count I Defendants denied Jimmy access to medical personnel qualified to treat his serious medical needs;
- c. The Count I Defendants failed to inquire into the essential facts that were necessary to make a professional judgment about Jimmy’s serious medical needs;
- d. The Count I Defendants caused factors unrelated to inmates’ medical needs to interfere with the exercise of medical judgment regarding Jimmy’s serious medical needs; and
- e. The Count I Defendants failed to carry out medical orders pertaining to Jimmy’s serious medical needs.

190. The Count I Defendants' knowledge of Jimmy's obvious, serious medical needs constitutes actual knowledge of an objectively cruel condition.

191. The Count I Defendants' failure to provide medical care for Jimmy's obvious, serious medical needs was an objectively unreasonable response to a known, substantial risk.

192. Accordingly, the Count I Defendants' deliberate indifference to Jimmy's serious medical needs constitutes the unnecessary and wanton infliction of pain proscribed by the Eighth Amendment.

193. As a direct and proximate result of the Count I Defendants' deliberate indifference to Jimmy's serious medical needs, Jimmy experienced conscious pain and suffering and died.

Count II: (42 U.S.C. § 1983: Violation of Eighth and Fourteenth Amendments by Defendants Bryson, Shepard, Brown, Young, and Alston Based Upon Deliberate Indifference to Serious Medical Needs by Failure to Train and Supervise)

194. Plaintiff incorporates all other paragraphs of this Complaint as if fully stated herein.

195. Defendants Bryson, Shepard, Brown, Young, and Alston (collectively the "Count II Defendants"), acting under color of state law, were responsible for Jimmy's care, and were obligated to provide or obtain adequate and effective medical treatment for him.

196. The Count II Defendants were involved in directing, procuring, and providing medical care for Jimmy.

197. The Count II Defendants were involved in promulgating and enforcing policies and procedures regarding the medical care that Jimmy received.

198. The Count II Defendants promulgated and enforced policies and procedures that caused ASMP to have grossly insufficient qualified staff, space, and resources to provide constitutionally adequate medical care to ASMP inmates including Jimmy.

199. The Count II Defendants promulgated and enforced policies and procedures that caused more inmates to be transferred to ASMP than for whom ASMP could adequately care.

200. The Count II Defendants had actual knowledge of the grossly inadequate medical care provided to inmates at ASMP and did not attempt to remedy the problem.

201. The Count II Defendants were responsible for training and supervising medical staff involved in the medical care of Jimmy.

202. The Count II Defendants knew that their subordinates were failing to provide adequate medical care to Jimmy and did not attempt to remedy the problem.

203. The Count II Defendants knew that reasonable people in their positions would know that their failure to train and supervise reflected deliberate indifference to serious medical needs.

204. The Count II Defendants' response to their subordinates' failure to provide medical care for Jimmy's obvious, serious medical needs was an objectively unreasonable response to a known, substantial risk.

205. Accordingly, the Count II Defendants' deliberate indifference to Jimmy's serious medical needs constitutes the unnecessary and wanton infliction of pain proscribed by the Eighth Amendment.

206. As a direct and proximate result of the Count II Defendants' deliberate indifference to Jimmy's serious medical needs, Jimmy experienced conscious pain and suffering and died.

Count III: (42 U.S.C. § 1983: Violation of Eighth and Fourteenth Amendments by Defendants Georgia Department of Corrections and Board of Regents of the University System of Georgia Based Upon Failure to Adequately Promulgate and Enforce Policies and Procedures)

207. Plaintiff incorporates all other paragraphs of this Complaint as if fully stated herein.

208. Defendants Georgia Department of Corrections and Board of Regents of the University System of Georgia (collectively the "Count III Defendants") were responsible for promulgating and enforcing policies and procedures regarding the medical care that Jimmy received.

209. The Count III Defendants promulgated and enforced policies and procedures that caused ASMP to have grossly insufficient qualified staff, space, and resources to provide constitutionally adequate medical care to ASMP inmates including Jimmy.

210. The Count III Defendants promulgated and enforced policies and procedures that caused more inmates to be transferred to ASMP than for whom ASMP could adequately care.

211. The Count III Defendants knew that the medical care provided to inmates at ASMP was grossly insufficient and failed to promulgate and enforce policies necessary to address the problem.

212. As a direct result of the Count III Defendants' policies and procedures that resulted in inadequate medical care, Jimmy experienced conscious pain and suffering and died.

Count IV: (Professional Negligence by Defendants Georgia Department of Corrections and Board of Regents of the University System of Georgia Pursuant to the Georgia Tort Claims Act)

213. Plaintiff incorporates all other paragraphs of this Complaint as if fully stated herein.

214. Sovereign immunity for medical malpractice by Georgia government entities is waived pursuant to the Georgia Tort Claims Act, O.C.G.A. § 50-21-20 *et seq.*

215. Plaintiff provided Ante Litem notices pursuant to O.C.G.A. § 50-21-26, which are attached as Exhibit 8.

216. Defendants Georgia Department of Corrections and Board of Regents of the University System of Georgia (collectively the “Count IV Defendants”) owed Jimmy a duty to exercise that degree of skill, care, caution, diligence, and foresight ordinarily exercised by physicians, nurses, medical support staff-members, and facilities under like conditions and similar circumstances.

217. The Count IV Defendants, by and through their medical staff, breached their duty to Jimmy by, among other things:

- a. Denying Jimmy access to appropriate medical care;
- b. Failing to appropriately diagnose Jimmy’s serious medical conditions;
- c. Failing to appropriately treat Jimmy’s serious medical conditions;
- d. Failing to execute physicians’ orders; and
- e. Failing to appropriately train and supervise their medical personnel.

218. As a direct result of the Count IV Defendants’ medical negligence, Jimmy experienced conscious pain and suffering and died.

Count V: (Negligence by Defendants Georgia Department of Corrections and Board of Regents of the University System of Georgia Pursuant to the Georgia Tort Claims Act)

219. Plaintiff incorporates all other paragraphs of this Complaint as if fully stated herein.

220. Sovereign immunity for negligence by Georgia government entities is waived pursuant to the Georgia Tort Claims Act, O.C.G.A. § 50-21-20 *et seq.*

221. Plaintiff provided Ante Litem notices pursuant to O.C.G.A. § 50-21-26, which are attached as Exhibit 8.

222. Defendants Georgia Department of Corrections and Board of Regents of the University System of Georgia (collectively the “Count V Defendants”) owed Jimmy a duty to exercise reasonable prudence under the circumstances, including furnishing him food, water, clothing, and appropriate medical care.

223. The Count V Defendants, by and through their employees and agents, breached their duty to Jimmy by, among other things:

- a. Denying Jimmy access to appropriate medical care;
- b. Transferring more inmates to ASMP than ASMP could reasonably care for;
- c. Failing to ensure that ASMP had adequate staff, space, and resources to care for its inmates;
- d. Failing to reasonably maintain ASMP facilities to enable ASMP personnel to provide appropriate medical care to inmates; and
- e. Failing to adequately train and supervise their agents and employees.

224. As a direct result of the Count V Defendants' negligence, Jimmy experienced conscious pain and suffering and died.

RELIEF REQUESTED

WHEREFORE, Plaintiff prays that this Court award the following relief from Defendants:

- a. An award of compensatory damages in an amount to be proven at trial, including interest;
- b. An award of punitive damages in favor of Plaintiffs against all Defendants;
- c. Reasonable costs and attorneys' fees pursuant to 42 U.S.C. § 1988; and
- d. Such other and further relief as the Court may deem just and proper.

Dated: July 2, 2018.

/s/Matthew S. Harman
Matthew S. Harman
Georgia Bar No. 327169

HARMAN LAW LLC
3414 Peachtree Road, NE
Suite 1250
Atlanta, GA 30326
Telephone: (404) 554-0777
Facsimile: (404) 424-9370
Email: mharman@harmanlaw.com

Attorney for Plaintiff