UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
Richmond Division

SHARON DALLAS, Administratrix of the Estate of
CHARLES DUYNES, THE DECEDENT, deceased

Plaintiff,

Case No. 3:21cv349

V. **DEMAND FOR TRIAL BY JURY**

SERGEANT CRAFT,
Individually and as an employee for the Sussex I State Prison and the Virginia Department of Corrections,

CORRECTIONS OFFICER MOSS,
Individually and as an employee for the Sussex I State Prison and the Virginia Department of Corrections,

SERGEANT NORRIS,
Individually and as an employee for the Sussex I State Prison and the Virginia Department of Corrections,

CAPTAIN JOHNSON,
Individually and as an employee for the Sussex I State Prison and the Virginia Department of Corrections,

ARMOR CORRECTIONAL HEALTH SERVICES,

BENJAMIN T. ULEP, MD
Individually and as a Medical Doctor for Sussex I State Prison, the Virginia Department of Corrections, and Armor Correctional Health Services,

MICHAEL PICIO, DO
Individually and as a Doctor of Osteopathic Medicine for Sussex I State Prison, the Virginia Department of Corrections, and Armor Correctional Health Services,

SHIRLEY ABOUHASSOUN-SEMLALI, RN
Individually and as a Registered Nurse for Sussex I State Prison, the Virginia Department of Corrections, and Armor Correctional Health Services,

DR. S. PATEL
Individually and as a Medical Doctor for Sussex I State Prison, the Virginia Department of Corrections, and Armor Correctional Health Services,

D. WALKER, RN
Individually and as a medical professional for Sussex I State Prison, the Virginia Department of Corrections, and Armor Correctional Health Services,

TRACIE SEWARD
Individually and as a medical professional for Sussex I State Prison, the Virginia Department of Corrections, and Armor Correctional Health Services,

AYANNA JACKSON
Individually and as a medical professional for Sussex I State Prison, the Virginia Department of Corrections, and Armor Correctional Health Services,

CRYSTAL ALLEN, RN
Individually and as a registered nurse for Sussex I State Prison, the Virginia Department of Corrections, and Armor Correctional Health Services,

MAKESHIA SYKES, RN
Individually and as a registered nurse for Sussex I State Prison, the Virginia Department of Corrections, and Armor Correctional Health Services,

Defendants.

SECOND AMENDED COMPLAINT

COMES NOW Plaintiff SHARON DALLAS, administratrix of the estate of CHARLES DUYNES, Deceased, by counsel, pursuant to Virginia Code § 8.01-50 et. seq., 42 U.S.C. § 1983, Virginia Code § 8.01-195.1 et seq., and Virginia statutory and common law, and moves this Court for judgment against the defendants, jointly and severally; and in support of her Complaint, states as follows:

I. PARTIES

1. At all relevant times, Plaintiff SHARON DALLAS, was a citizen and resident of Norfolk, Virginia. Plaintiff is the mother of the decedent, Charles Duynes ("the decedent"), and has qualified in the Norfolk Circuit Court as the administratrix of the decedent's estate. (Ex. A.) The plaintiff brings suit in her representative capacity on the behalf of the decedent's children as the statutory beneficiaries: Aryonna Duynes, Zaquan Stith, Azayah Palmer, Javil Painter, Adasia Butts, and Antonio Forrest.

2. At all relevant times, the decedent was in the custody and control of the Virginia Department of Corrections (the “VDOC”); Sussex I State Prison; various corrections officers in Sussex I State Prison; and various nurses and/or employees of ARMOR CORRECTIONAL HEALTH SERVICES, INC. (“ARMOR CORRECTIONAL”), all of whom were on duty, and acting within the scope of their employment, and whom were responsible for the decedent’s health, welfare, and well-being during his time in custody at Sussex I State Prison through the time of his death at the prison on June 2, 2019.

3. At all relevant times, Defendants OFFICER MOSS, SERGEANT CRAFT, SERGEANT NORRIS, and CAPTAIN JOHNSON were employed with the VDOC and Sussex I State Prison, were on-duty, were acting within the scope of their employment, and were responsible for the decedent during the decedent’s time in custody in the Sussex I State Prison, and specifically during the several months in which the decedent’s medical condition deteriorated until his ultimate death.

4. Upon information and belief, the following Defendants JOHNSON, CRAFT, and NORRIS were employed by the VDOC, were on-duty during the decedent’s incarceration, and specifically during the several months in which the decedent’s medical condition deteriorated to his untimely death, and were in supervisory positions over the named defendant officers and medical staff; and entrusted with the legal duty to see that the decedent received all constitutionally mandated medical care and monitoring.

5. Defendants JOHNSON, CRAFT, NORRIS, and MOSS were duly appointed and actively employed with the VDOC and Sussex I State Prison, and acting within the scope of their employment, agency, and servitude with the VDOC and Sussex I State Prison.

6. Defendant ARMOR CORRECTIONAL HEALTH SERVICES, INC. (“ARMOR

CORRECTIONAL") is a Corporation Company under the laws of the State of Florida and licensed to do business in the Commonwealth of Virginia.

7. Upon information and belief, ARMOR CORRECTIONAL entered into a written contract with the VDOC and Sussex I State Prison to provide medical care to the inmates incarcerated at Sussex I State Prison.

8. At all times relevant to this Complaint, Defendants BENJAMIN ULEP, MICHAEL PICIO, S. SEMLALI, S. PATEL, D. WALKER, TRACIE SEWARD, A. JACKSON, C. ALLEN, and MAKESHIA SYKES, were duly appointed and actively employed as doctors, nurses, licensed practitioners, and/or trained medical personnel, each acting within the scope of their employment, agency, and servitude for ARMOR CORRECTIONAL, Sussex I State Prison, and the VDOC.

9. The attached documents list signatures of individuals whom are/were employed in a medical capacity for defendant ARMOR CORRECTIONAL or other named defendants. (Ex. B) At all times relevant hereto, these individuals acted within the scope of their employment for Armour Correctional and under color of state law. The specific identifies of these individuals remain unknown to the plaintiff due to the illegible handwriting in the documents produced by the VDOC. The plaintiff contends that these individuals were employees and/or agents of Defendant Armor Correctional. The negligence of these individuals, as described below, is therefore imputed to Defendant Armor Correctional under the theory of *respondeat superior* as set out herein.

10. All named defendants SERGEANT CRAFT, SERGEANT NORRIS, CAPTAIN JOHNSON, BENJAMIN ULEP, MICHAEL PICIO, and S. PATEL are liable under state law for the constitutional acts or omissions occurring at Sussex I State Prison under the theory of

supervisory liability. The aforementioned defendants are subject to supervisory liability under the Virginia wrongful death statute § 8.01-50 and under 42 U.S.C. § 1983 due to their supervisory indifference and/or tacit authorization of the misconduct of his subordinates as specifically set out herein.

11. ARMOR CORRECTIONAL is liable under state law for the acts and omissions of its staff under the theory of *respondeat superior*, as set out herein.

12. At all times relevant to this Complaint, the defendants acted pursuant to and under the color of state law, and pursuant to their authority as correctional personnel and medical personnel.

13. This claim is being brought pursuant to 42 U.S.C. § 1983; the Virginia Wrongful Death Statute, Va. Code § 8.01-50 et. seq.; the Virginia Tort Claims Act, Va. Code § 8.01-195.1 et seq; and Virginia common and statutory law. The allegations and factual contentions contained herein are likely to have further evidentiary support following a reasonable opportunity for further investigation or during the litigation's discovery process.

II. <u>JURISDICTION</u>

14. Jurisdiction exists in this case pursuant to the Eighth Amendment and Fourteenth Amendments to the U.S. Constitution, 42 U.S.C. §§ 1983 and 1988, and 28 U.S.C. 1331 and 1343. Further, this Court has supplemental jurisdiction, pursuant to 28 U.S.C. § 1367(a), over the state law claims, including claims alleged pursuant to Virginia Code § 8.01-50 et seq., or, alternatively, pursuant to Virginia Code § 8.01-25 et seq. All relief available under the foregoing statutes is sought herein by the plaintiff.

15. This cause of action has been filed within the appropriate statute of limitations. *See* Va. Code § 8.01-244; Va. Code 8.01-195.7; *Reid v. Newton*, 2014 U.S. Dist. LEXIS 52072, at *33–

37 (E.D. Va. April 14, 2014); *Dowdy v. Pamunkey Reg'l Jail Auth.*, 2014 U.S. Dist. LEXIS 671127, at *17–18 (E.D. Va. May 15, 2014); *see also Ogunde v. Commonwealth*, 271 Va. 639 (2006). The plaintiff filed notice of the claim to the Commonwealth within one year of the accrual of the cause of action.

III. VENUE

16. Venue is proper pursuant to 28 U.S.C. § 1391(b) because a substantial part of the acts and omissions giving rise to the plaintiff's claims occurred in this district.

17. Assignment to the Richmond Division of the Eastern District of Virginia is proper pursuant to Eastern District of Virginia Local Rules 3(B)(4) and 3(C) because a substantial part of the acts and omissions giving rise to the plaintiff's claims occurred in this division.

IV. FACTUAL BACKGROUND

18. On or about April 26, 2011, the decedent was transferred to the custody of the VDOC. He was 30 years old. The intake physical showed the decedent to be of general good health, with only a dental issue.

19. On or about February 13, 2013, the decedent was transferred to Sussex I State Prison. Upon his transfer, the records indicate that the decedent's only health issue was back pain.

A. On or about October 16, 2018, Defendant Walker and Dr. Picio ignored the decedent's complaints of stomach pain.

20. On or about October 16, 2018, the decedent complained of stomach pain to Nurse D. Walker. The records indicate that the decedent told Nurse Walker that eating, walking, and lying down caused him pain, and that his cramping was so intense that he would have to "ball up" in an attempt to deal with the pain. The decedent noted excessive sweating all over and listed pain at a 10 on a scale of 1 to 10, with 10 being the most severe. A physical examination by Nurse Walker noted tenderness in the right upper quadrant of his abdomen. Following her

examination, Nurse Walker prescribed Mylanta—an over-the-counter medication to address symptoms of stomach acid—and noted that the decedent needed to be seen by a "provider." The encounter was recorded in the decedent's jail records and accessible to all named defendants.

21. Upon information and belief, Nurse Walker's notes of her October 16, 2018 encounter with the decedent were given to Dr. Michael Picio. Dr. Picio reviewed the records, noting that the decedent presented with persistent, intermittent right upper quadrant abdominal pain, and epigastric tenderness to palpation. Again, the October 16, 2018 encounter was recorded in the decedent's jail records and accessible to all named defendants. Neither Nurse Walker nor Dr. Picio facilitated or administered any medical treatment or ordered any diagnostic testing to determine the cause of the decedent's excruciating pain.

B. Dr. Picio examined the decedent on October 22, 2018.

22. Upon information and belief, on October 22, 2018, Dr. Picio examined the decedent. The decedent complained of right upper quadrant abdominal pain. Dr. Picio failed to facilitate or administer any medical treatment, failed to order any diagnostic testing or imaging, failed to order that the decedent be transported to an appropriate outside medical facility equipped to treat the decedent's medical condition, and misdiagnosed the decedent with indigestion.

C. On December 7, 2018, the decedent submitted an emergency written grievance begging for help for his excruciating abdominal pain.

23. On or about December 7, 2018, the decedent submitted an emergency written grievance stating: "I have been experiencing extreme abdominal pain! This pain has been a recurring problem. Right now for the past few hours I've been experiencing excruciating pain on my right hand side. I need medical attention immediately." (Ex. C.) VDOC Corrections Officer Lockhart reportedly received the grievance on December 8, 2018 at 2:13 a.m.

D. On or about December 8, 2018, the decedent sent a JPAY message begging

family members on the outside of the prison to help him get medical attention.

24. At 8:46 a.m. on December 8, 2018, the decedent sent a JPAY message to a family member, stating that he continued to experience intense stomach pain and asking said person to call the prison officials to advise them of the situation as he did not feel he was receiving adequate care to treat his medical condition. (Ex. D.)

E. Later on December 8, 2018, over a month after Defendant Picio saw the decedent, Defendant Tracie Steward saw the decedent.

25. Sometime thereafter, on December 8, 2018, Nurse Tracie Steward finally met with the decedent, who at that time, was complaining of constant abdominal pain, reporting that it felt like something was tugging in his stomach. Nurse Seward again noted that a referral for an examination by a physician was required. Nurse Seward failed to provide any medical treatment, failed to order or request any additional diagnostic testing which would have determined the cause of the decedent's pain, failed to order that the decedent be transported to an appropriate outside medical facility equipped to treat his medical condition, and failed to ensure that the decedent was examined by a medical doctor, as was medically warranted. Nurse Seward's encounter with the decedent and the decedent's complaints were documented in jail records and were accessible by all named defendants.

F. On December 16, 2018, Defendant C. Allen saw the decedent.

26. On or about December 16, 2018, the decedent complained of continued abdominal cramping, nausea, and vomiting to Nurse C. Allen. The decedent described having pain when eating and noted that the Prilosec was not helping and was causing heartburn. Nurse Allen prescribed Simethicone for the decedent's symptoms. Nurse Allen failed to provide any medical treatment, failed to conduct or recommend that any diagnostic testing be performed to determine the cause of the decedent's ongoing symptoms, failed to provide the decedent access to

examination by a medical doctor, and failed to order that the decedent be transported to an appropriate outside medical facility equipped to treat the decedent's medical condition. Nurse Allen noted the information from her encounter with the decedent in jail records, which were accessible to all named defendants.

G. On December 18, 2018, the decedent was merely prescribed six months of omeprazole without any diagnostic testing or further evaluation, and without having seen a physician.

27. Two days later, on or about December 18, 2018, employees and/or agents of Armor Correctional prescribed Omeprazole, for 180 days.

28. Upon information and belief, the decedent continued to complain to employees and/or agents of Armor Correctional, correctional officers, and other inmates about his stomach pain and associated symptoms which continued to get worse. All this information was documented in jail records and were available to all defendants.

H. On January 11, 2019, the decedent complained to employees and/or agents of Armor Correctional of continued complaints of chronic, excruciating symptoms, and told the Armor Correctional employees and/or agents that the prescribed medication did not help.

29. On or about January 11, 2019, the decedent was seen for a follow-up examination with employees and/or agents of Armor Correctional. The Armor Correctional employees and/or agents noted that the decedent's chronic complaints were misdiagnosed as irritable bowel and hypertension. The decedent continued to complain of abdominal pain and cramping, telling the Armor Correctional agents and/or employees that Prilosec did not help his symptoms. Thereafter, Amor Correctional agents and/or employees prescribed Bentyl and HCTZ. This encounter and the decedent's complaints were documented in jail records and were accessible to all named defendants. Once again, Armor Correctional agents and/or employees failed to correctly diagnose, treat, or order any diagnostic testing which would have assisted them in

correctly diagnosing the cause of the decedent's chronic abdominal pain and symptoms, which would have allowed them to have successfully treated him. The Armor Correctional agents and/or employees further failed to order that the decedent be transported to an appropriate outside medical facility with staff equipped to treat the decedent's serious medical condition.

I. On January 27, 2019, the decedent submitted an offender request to be evaluated by a physician.

30. On or about January 27, 2019, and despite multiple defendants having noted that the decedent should be evaluated and treated by a medical doctor, the named defendants continued to deny decedent access to a doctor for purposes of examining and treating his deteriorating medical condition. The decedent submitted an offender request to be physically examined by a doctor on January 27, 2019. The decedent noted that he needed to be examined by a doctor as his stomach pain was "still doing the same thing" and that he continued to experience extreme pain that was not being adequately addressed. (Ex. E.) Defendants failed to act upon this request until February 4, 2019, when Nurse D. Walker noted that the decedent was scheduled for an appointment. The decedent had been complaining of stomach pain and associated symptoms for three (3) months at this point.

J. On January 28, 2019, the decedent sent another JPAY message begging family members on the outside of the jail to advocate for the prison and Armor Correctional employees and/or agents to provide medical attention and treatment for his ongoing, excruciating pain.

31. Again, at approximately 9:25 a.m. on January 28, 2019, the decedent sent a JPAY message to a family member requesting that she call the prison to intervene and get the defendants to provide the necessary medical treatment to diagnose and treat his worsening condition. The decedent explained that he had "crazy pain" in his stomach the night before and that he began to vomit from his nose. (Ex. F.)

K. On January 28, 2019, Defendant Dr. Patel acknowledged that the decedent's laboratory testing results were abnormal.

32. On or about January 28, 2019, the decedent received a note, purportedly from Dr. Patel, stating that decedent's labs were abnormal. The document further noted that the decedent needed to be examined during his next chronic care clinic visit. Available jail documents are silent as to whether Dr. Patel physically examined decedent in an attempt to treat or diagnose the decedent's worsening medical condition. Upon information and belief, Dr. Patel failed to examine, treat, or provide the decedent with any diagnostic testing. Dr. Patel further failed to order that the decedent be transported to an appropriate outside medical facility with staff equipped to treat the decedent's serious medical condition.

L. On February 5, 2019, the decedent filed another written grievance begging for medical treatment for his chronic symptoms, and notifying all defendants that he was not receiving adequate medical evaluation and treatment.

33. On or about February 5, 2019, the decedent filed yet another grievance with the VDOC stating "Look, I need to be seen by a [sic] outside doctor or hospital [sic] its something wrong with my stomach and this prison is not willing to help me with [sic]. I have been in pain for some months now. I let them know my stomach hurt [sic] they put me on blood pressure pills." (Ex. G.) The request was reportedly sent to the medical unit on February 5, 2019.

M. On February 6, 2019, the decedent complained to Defendant D. Walker, again, of ongoing pain and progressing symptoms.

34. On or about February 6, 2019, the decedent complained to Defendant D. Walker of continued and ongoing stomach pain which he suffered with for over one year. The decedent described constant, cramping pain in his right upper quadrant and extending into his lower quadrant. The decedent reported associated vomiting. Defendant Walker noted that the decedent's bowel sounds were decreased. The decedent explained to Nurse Walker that he could

only eat fish and rice because all other food caused his stomach pain and discomfort to become worse. Nurse Walker noted that they were waiting on results from bloodwork on January 2019, and that the decedent's lab work was abnormal. Defendant Walker again documented the decedent's need to be physically examined by a medical doctor. The records from Defendant Walker's examination of the decedent were reviewed by other Armor Correctional agents and/or employees, including Nurse Jodi A. Ganoe and Nurse C. Allen, and were accessible to all named defendants. Neither Defendant Walker, nor any other defendant, requested or attempted to order any diagnostic testing to determine the cause of the decedent's deteriorating medical condition, a condition which was readily diagnosable and treatable if proper medical procedures had been implemented. Defendant Walker and the other named defendants further failed to provide the decedent with medical treatment and failed to order that the decedent be transported to an appropriate outside medical facility with staff equipped to treat the decedent's serious medical condition.

N. On February 12, 2019, Defendant A. Jackson saw the decedent for complaints of ongoing stomach pain and abnormal lab results.

35. On or about February 12, 2019, the decedent followed up with Nurse A. Jackson for his continued stomach pain and to review his abnormal lab results, with the decedent now reporting epigastric discomfort and gas, in addition to his chronic pain. The decedent advised that the prescribed Prilosec did not relieve his pain nor associated symptoms. Nurse Jackson again noted that the decedent needed to be examined by a medical doctor. The records reflect that other Armor Correctional employees and/or agents, including Nurse Baldwin, reviewed the notes from Nurse Jackson's encounter with the decedent, which were accessible to all named defendants. Neither Nurse Jackson, nor any defendant, ordered or conducted any diagnostic testing to determine the cause of the decedent's deteriorating condition. Defendant Jackson and the other

named defendants further failed to provide the decedent with medical treatment and failed to order that the decedent be transported to an appropriate outside medical facility with staff equipped to treat the decedent's serious medical condition.

O. The decedent's serious medical condition deteriorated for months without access to evaluation by a physician or any diagnostic testing, and without any medical treatment beyond medications intended to alleviate the symptoms.

36. On or about April 12, 2019, the records indicate that Armor employees and/or agents prescribed the decedent dicyclomine, ranitidine, Gaviscon foam tab chews, and HCTZ for 180 days (6 months). None of the named defendants provided the decedent with access to a physician, diagnostic testing, an outside medical facility, or any medical treatment for nearly four months.

P. On June 1, 2019, the decedent's deteriorating medical condition rendered him all but totally debilitated. The seriousness of the medical condition was open and obvious to all those who observed him.

37. Thereafter, the record reflects that during the morning hours of June 1, 2019, fellow inmates helped the decedent down the stairs from his cell. The decedent was in tears due to extreme stomach pains—clear and obvious worsening of pain and associated symptoms he had been complaining of since at least October 16, 2018. The decedent was unable to stand or ambulate without assistance. The serious of the decedent's medical condition was open and obvious to all of those who observed him.

38. Corrections Officer Moss who was assigned to the cell block in which the decedent was housed notified his supervisor, Sergeant Craft, that the decedent was throwing up blood.

39. Sergeant Craft failed to respond to the existing emergency by failing to do anything to provide the decedent with access to medical care.

40. Corrections Officer Moss failed to provide the decedent with access to medical care and

treatment as he did absolutely nothing in the face of the information known to him. After an unreasonable amount of time elapsed, Moss merely opened the automatic door to permit several inmates to assist the decedent to the medical unit, given that the decedent was unable to ambulate on his own due to his obvious, serious, and quickly deteriorating medical condition, which was quickly becoming more life threatening.

41. At approximately 10:45 a.m., an inmate assisted the decedent into the medical unit because the decedent was unable to walk. The decedent was placed in a wheel chair. The decedent was crying due to his abdominal pain and was literally begging the corrections officers and Armor correctional employees and/or agents for help.

Q. Defendant S. Semlali saw the decedent on June 1, 2019, after fellow inmates and corrections staff saw the decedent's obvious signs and symptoms of his serious medical condition, which remained obvious, improperly treated, and misdiagnosed.

42. The decedent complained to Nurse S. Semlali of nausea, vomiting, and pain rated at an 8 out of 10. The decedent carried a large bag of liquid to medical, which tested positive for blood. The decedent explained that he vomited up the liquid. Incredibly, Nurse Semlali, despite knowledge of the decedent's complete history, as setout herein, and the decedent's then-existing complaints, told the decedent that nothing was wrong. The decedent threw himself on the floor in a "last-gasp" attempt to get the Armor Correctional employees and/or agents to properly and finally take his complaints seriously and get him the proper medical treatment that they were constitutionally mandated to provide. Contrary to that duty, Nurse Semlali continued to berate the decedent, telling him that nothing was wrong with him, without any medical or factual basis for the opinions she was stating. Nurse Semlali failed to provide any medical treatment to the decedent whatsoever and failed to conduct any diagnostic testing or examination, and rather again provided the decedent with over-the-counter medications, to include Emetrol, Tylenol, and

Pepto Bismol—all medications that had failed to provide any relief in the past. Nurse Semlali merely told the decedent to drink at least 8 ounces of water a day and sent him back to his cell. Nurse Semlali further refused to treat the decedent and refused to send him to a hospital where he could receive the proper care his condition demanded. Nurse Semlali's notes from this encounter were documented in jail records and accessible to all named defendants.

R. Defendant Semlali returned the decedent back to his cell, ignoring her subjective knowledge of the emergency medical condition that then existed.

43. Recognizing the obvious medical emergency which then existed, fellow inmates helped the decedent back to the cell block by wheel chair as the decedent's deteriorating medical condition left the decedent without the ability to walk. Several inmates lifted the decedent out of a wheel chair to get him back into the cell block because the decedent was physically unable to get out of the chair on his own.

44. After assisting the decedent back to his cell, the inmates then advised on-duty corrections officers, including Moss and Norris, about Nurse Somlali's failure to treat or otherwise facilitate treatment for the decedent at an appropriate medical facility that would be able to render the proper medical care which the decedent's presenting condition required.

45. The inmates advised the corrections officers, including Moss and Norris, that Nurse Semlali sent the decedent back to his cell block without checking on him or looking at him.

46. While inmates reported Nurse Semlali's callous and reprehensible behavior to the corrections officers then on duty, the decedent was seen lying on the concrete floor, crying, and spitting up blood, pleading with the corrections officers and medical personnel to take him to the hospital immediately.

47. Upon being advised of the decedent's serious medical condition and Semlali's failure to treat the decedent, Sergeant Craft reported his concerns to Nurse Semlali in medical, but failed to

take any appropriate actions that the circumstances dictated.

48. Upon information and belief, Officer Moss, Sergeant Norris, and Sergeant Craft were all on-duty and aware of the decedent's serious and quickly deteriorating medical condition on June 1, 2019. Moss, Norris, and Craft ignored the decedent's condition for several hours, as the decedent continued to spit up blood, cry, and writhe in pain.

49. After several hours of the decedent writhing in pain and demanding medical treatment, Officer Moss finally contacted Sergeant Craft to advise that the decedent continued to lay on the floor spitting up blood.

50. A group of prisoners again started to voice their complaints and advocate for the corrections officers to facilitate the decedent's access to medical care. Other inmates and one corrections officer eventually helped the decedent back over to the medical unit later that day.

S. Moss, Norris, Johnson, and Craft ignored the decedent's complaints of excruciating and debilitating symptoms for several hours before the decedent saw Defendant Semlali again on June 1, 2019.

51. At approximately 3:34 p.m. on June 1, 2019, the decedent again returned to the medical unit via wheel chair complaining of nausea, vomiting, and stomach pain rated at an 8 out of 10. The decedent was sweating and nauseous. The decedent was carrying another bag of liquid containing his vomit.

52. At last, Nurse Semlali contacted Dr. Ulep, while keeping the decedent in the medical unit for observation, and administered Phenergan for the decedent's symptoms of nausea and vomiting.

53. Neither Nurse Semlali, Dr. Ulep, nor any other medical personnel conducted any examination or diagnostic testing to determine the cause of the decedent's symptoms, nor did they take any action to arrange transport for the decedent to go to the appropriate emergency

room, as the decedent's symptoms clearly warranted inpatient treatment by trained emergency medical staff. Nurse Semlali and Dr. Ulep failed to provide any actual medical treatment for the decedent.

54. At approximately 5:40 p.m. on June 1, 2019, Nurse Semlali noted that the decedent was lying in bed. The decedent told Nurse Semlali that he vomited twice. The decedent refused food and drink.

T. Defendant Makeshia Sykes saw the decedent on multiple occasions during the late-night hours of June 1, 2019 and early morning hours of June 2, 2019.

55. At approximately 11:26 p.m. on June 1, 2019, the decedent reported another episode of vomiting and continued abdominal pain to on-duty medical personnel. Nurse Sykes was aware of the decedent's condition based upon the decedent's medical records and her personal observations of the decedent.

56. Nurse Makeshia Sykes noted that the decedent's stomach was tender to touch. The decedent described belching and flatulence with pain rated at an 8 out of 10. Defendant Sykes merely provided the decedent with over-the-counter Tylenol, making no attempt to treat the decedent under circumstances that demanded that the decedent be seen by a medical facility with emergency medical staff to treat the decedent, or at the very least, attempt to alleviate the decedent's pain and suffering.

57. At approximately 1:36 a.m. on June 2, 2019, Nurse Sykes noted that the decedent was lying on his bed with a towel over his eyes. The decedent was unable to be awakened.

58. At approximately 3:15 a.m. on June 2, 2019, the decedent reported to Nurse Sykes that his abdominal pain was rated at a 10 out of 10, the highest pain level possible.

59. The decedent told Nurse Sykes of another episode of vomiting. Nurse Sykes noted that the decedent was noticeably uncomfortable, shifting weight, closing his eyes even when

speaking, holding his abdomen, and appeared agitated easily. Nurse Sykes merely provided the decedent with medications including Bentyl, Tylenol, and Phenergan, none of which had alleviated the decedent's symptoms in the past.

60. Despite making note of her subjective knowledge of the decedent's deteriorating medical condition, Defendant Sykes made no effort to treat the decedent nor arrange transport to the hospital, which the decedent's condition clearly warranted.

U. Nearly six hours after her first documenting her interaction with the decedent, Defendant Sykes finally notified a medical doctor of the decedent's deteriorating condition.

61. Nurse Sykes, despite the passage of almost 24 hours, in which the decedent was suffering, failed to notify a medical doctor of the decedent's medical emergency until 5:00 a.m. on June 2, 2019. Nurse Sykes noted that the decedent's abdomen was tender to touch with a reported pain level of 10 out of 10. The decedent told Nurse Sykes that he continued to be nauseous and could not have a bowel movement even though he tried. Upon being advised of the decedent's symptoms, a medical doctor immediately recommended that he be transported to MCV Emergency Room via a security van. Nurse Sykes notified the watch commander, Captain Johnson, of this order at 5:10 a.m. on June 2, 2019. Neither Defendant Johnson, nor any other on-duty defendant, facilitated transport of the decedent to a hospital emergency room for more than five hours.

V. Even after it was recommended that the decedent be transported to the emergency room, the defendants waited in excess of 5 more hours before he was to be transported to a hospital.

62. Finally, at approximately 7:55 a.m. on June 2, 2019, after the passage of an additional 3 hours from the time a medical doctor ordered that the decedent to be transported to the emergency room, and after an entire day following the decedent's appearance in the medical unit

with a bag of vomited blood, did any Armor Correctional employees and/or agents contact the watch commander, Captain Johnson, to inquire about the time of the decedent's departure to the emergency room. Captain Johnson reportedly stated that he was working to put security staff in place for the transport.

63. At approximately 9:00 a.m. on June 2, 2019, Nurse S. Semlali noted that the decedent's abdomen was tender to touch. Nurse Semlali further noted that the decedent continued to vomit a light brown liquid that morning.

64. At approximately 9:16 a.m. on June 2, 2019, Nurse Semlali reportedly spoke with Captain Johnson regarding the transport of the decedent to the emergency room. Captain Johnson, again, reported that a team was being put together.

65. At approximately 9:53 a.m. on June 2, 2019, Nurse Semlali transported the decedent to the sally port for transport the emergency room.

W. The decedent went unresponsive five hours after a medical doctor ordered that the decedent be transported to an emergency room for proper medical treatment.

66. At approximately 10:30 a.m. on June 2, 2019, 24 hours after the decedent first went to the medical unit with a bag of bloody vomit and abdominal pain and nearly 8 months after the decedent first reported abdominal pain to medical personnel and corrections staff at Sussex I, Nurse Semlali reportedly received a call from the sally port that the decedent was unresponsive.

67. At approximately 10:35 a.m., Nurse Semlali arrived in the sally port to find the decedent sitting in a wheel chair. The decedent was shaking. Nurse Semlali asked the decedent if he was okay. The decedent did not respond. At approximately 10:40 a.m., Nurse Semlali moved the decedent to the floor, applied AED, and began CPR. Nurse Semlali reportedly asked security to call 911. EMT's arrived responsive to the 911 call at approximately 10:55 a.m. EMT's

reportedly continued CPR, administered Epi and Narcan, and intubated the decedent.

X. The decedent died at 11:11 a.m. on June 2, 2019.

68. EMTs called Dr. Clark at Southside Regional Medical Center at 11:11 a.m. Dr. Clark advised EMTs to stop CPR and called time of death at 11:11 a.m.

Y. On or about July 24, 2019, a medical examiner determined that the decedent's cause of death was hemorrhagic pancreatitis due to obstructive cholelithiasis and cholecystitis.

69. Dr. Jennifer Bowers, licensed medical examiner for the Commonwealth of Virginia, determined that the cause of the decedent's death was hemorrhagic pancreatitis due to obstructive cholelithiasis and cholecystitis.

70. In laymen's terms, the decedent died due to gall stones, a medical condition that should have been easily diagnosed and was completely treatable if diagnosed and managed.

71. The plaintiff called the prison on several occasions over the eight months or more during which the decedent suffered in the defendants' custody. She spoke with on-duty corrections officers and on-duty medical personnel and advised that her son required immediate medical attention. In spite of all of the information known to them, the defendants failed to take the necessary steps to provide the decedent with the medical treatment mandated by federal and Virginia law, and necessary to save the decedent's life.

72. Defendants were legally required to coordinate, facilitate, and provide medical evaluation and testing, including diagnostic testing, given the decedent's known deteriorating state.

73. All of the named defendants were on-duty and tasked with maintaining the health and welfare of the inmates in custody of Sussex I State Prison, and specifically the decedent, at the time of the subject unconstitutional acts and/or omissions.

74. Defendant Corrections Officers Moss, Craft, Sergeant Norris, Johnson, and Lockhart

were on-duty during the time period at the subject of this Complaint, were aware of the decedent's decedent's deteriorating medical condition, were aware that the decedent was not being provided access to necessary medical care, and by either act or omission failed to provide the decedent with the medical care necessary to save the decedent's life, in violation of federal and Virginia law.

75. Defendants Ulep, Picio, Semlali, S. Patel, D. Walker, Tracie Seward, A. Jackson, C. Allen, Makeshia Sykes,—as well as the Armor Correctional employees and/or agents named in the attached medical records referenced in paragraph 12 of this Complaint—were on-duty during the time period at the subject of this Complaint, were aware of the decedent's deteriorating medical condition, were aware that the decedent was not being provided access to necessary medical care, and by either act or omission failed to provide the decedent with the medical care necessary to save the decedent's life, in violation of federal and Virginia law.

V. COUNT I: WRONGFUL DEATH: NEGLIGENCE OF CRAFT, MOSS, NORRIS, AND JOHNSON

76. Paragraphs 1 through 75 are incorporated by reference herein.

77. At all relevant times, CRAFT, MOSS, NORRIS, and JOHNSON were corrections officers engaged in duties of operation of the prison and had a duty to exercise reasonable care in their treatment of the decedent.

78. CRAFT, MOSS, NORRIS, and JOHNSON, through their acts and/or omissions as set out herein, violated public policy, procedures, and standards, as well as the Prison's written policies and procedures in place to ensure the health and well-being of its inmates while incarcerated.

79. At all relevant times, and especially from at least October 2018 until the decedent's untimely death, CRAFT, MOSS, NORRIS, and JOHNSON should have known that the decedent was suffering from a serious medical condition requiring prompt medical evaluation and

diagnostic testing.

80. Notwithstanding their duties, the defendants breached the standard of care when they:

a. Negligently failed to facilitate appropriate medical attention for the decedent as he suffered nausea, vomiting, and excruciating stomach pains for months;

b. Negligently failed to appropriately monitor the decedent while he suffered from concerning medical symptoms;

c. Negligently failed to provide the decedent with the appropriate medical evaluation(s), treatment, and diagnoses, as indicated by his appearance and documented by frequent grievance forms and medical treatment request forms as well as notes made by medical defendants;

d. Negligently failed to provide the decedent proper medical evaluation(s) and diagnostic testing for his obvious and serious symptoms, including abdominal pain, nausea, vomiting blood, and sweating;

e. Negligently failed to facilitate prompt transport to the hospital emergency room based upon the decedent's obvious serious medical condition, and even after it was ordered by a medical doctor;

f. Negligently failed to take all reasonable and necessary steps to prevent the decedent's death;

g. Negligently failed to diagnosis and treat an otherwise benign medical condition that was treatable and non-life-threatening if properly treated.

81. Upon information and belief, Defendant CRAFT was a supervising corrections officer on-duty during the decedent's final hours of life in Sussex I State Prison. CRAFT had personal knowledge of the decedent's serious medical condition at least as early as the early morning

hours of June 1, 2019—a day before the decedent died. CRAFT was first notified by his subordinate that the decedent was throwing up blood and was in immense pain, lying on the floor, leaving him without the ability to ambulate. Defendant CRAFT completely failed to respond to the emergency. CRAFT had further subjective knowledge of the fact that the decedent was never treated by medical personnel and was lying on the floor, crying, and spitting up blood. Other than calling an on-duty nurse, CRAFT failed to respond to the decedent's serious medical needs when the need was obvious to any lay person observing the events; failed to order that the decedent be transported to an appropriate emergency medical facility with the capability to treat the decedent's serious medical condition; and failed provide the decedent with access to adequate medical care through the remaining morning, afternoon, and evening hours of June 1, 2019 and through the night, as the decedent suffered until his ultimate death on June 2, 2019. CRAFT's failure to act constitutes negligence, at a minimum.

82. Upon information and belief, Defendant MOSS was on-duty and in charge of the decedent's cell block in the day leading to the decedent's death. Defendant NORRIS was on-duty and in charge of the yard in the day leading to the decedent's death. Both MOSS and NORRIS had personal knowledge of the decedent's seriously deteriorating medical condition, which was clearly obvious to any lay person, as the corrections officers in charge of monitoring the decedent in the day leading to the decedent's death, through direct contact with and observation of the decedent as well as reports received from other inmates at Sussex I State Prison.

83. MOSS and NORRIS ignored the decedent's serious medical condition throughout June 1, 2019, failed to provide the decedent with access to medical care, and failed to order that the decedent be transported to an emergency medical facility, which the circumstances warranted.

Although MOSS eventually notified Defendant CRAFT of the decedent's serious medical condition, MOSS did nothing to respond to the emergency himself or to provide the decedent with access to medical care. A mere opening of an automatic door and telling another corrections officer do not constitute any action on the party of MOSS. The failure to act on the part of MOSS and NORRIS constitute negligence, at a minimum.

84. Upon information and belief, Defendant JOHNSON, as the watch commander in the hours leading to the decedent's death, was subjectively aware of the decedent's seriously deteriorating medical condition as early as 5:10 a.m. on June 2, 2019, when he was notified of the medical emergency and advised that a medical doctor recommended that the decedent be transported to the emergency room.

85. JOHNSON, as watch commander, had the duty to put a team together to transport the decedent to the emergency room. JOHNSON completely failed to respond to the then existing medical emergency and failed to transport the decedent to the emergency room for over five hours, denying the decedent access to needed medical treatment for his serious medical condition until the decedent ultimately died awaiting transport.

86. JOHNSON's failure to respond to the decedent's serious medical needs ultimately caused the decedent's death, all of which constitutes negligence, at a minimum.

87. The acts and/or omissions of CRAFT, MOSS, NORRIS, and JOHNSON, as set out herein, were undertaken in the course of their employment with the VDOC and Sussex I State Prison.

88. Defendants CRAFT, MOSS, NORRIS, and JOHNSON, through their acts and/or omissions as set out herein, violated public policy, procedures, and standards of care developed to ensure the health and well-being of its inmates while incarcerated, as required by the United

States Constitution and Virginia law.

89. As a direct and proximate result of omissions and negligence of CRAFT, MOSS, NORRIS, and JOHNSON, the decedent died on June 2, 2019, without any medical treatment or diagnostic testing having been administered.

90. As a further direct and proximate result of the negligence and gross disregard for the decedent's medical condition, Defendants CRAFT, MOSS, NORRIS, and JOHNSON, jointly and severally, caused the decedent to suffer grave anxiety, physical suffering, severe mental anguish and pain, and inconvenience, in the months leading up to the decedent's untimely death.

VI. COUNT II: GROSS NEGLIGENCE OF DEFENDANTS CRAFT, MOSS, NORRIS, AND JOHNSON

91. Paragraphs 1 through 90 are incorporated by reference herein.

92. The conduct of Defendants CRAFT, MOSS, NORRIS, and JOHNSON, as set out above, was grossly negligent, willful, and reckless in that CRAFT, MOSS, NORRIS, and JOHNSON were aware that the decedent was complaining of severe stomach pain, was vomiting blood, was unable to walk, was nauseous, was lying on the floor, and was begging for medical help, and completely ignored the obvious serious medical condition before them, completely failing to ensure that the decedent received proper medical evaluations, monitoring, diagnostic testing, and treatment.

93. Upon information and belief, Defendant CRAFT was a supervising corrections officer on-duty during the decedent's final hours of life in Sussex I State Prison. CRAFT had personal knowledge of the decedent's serious medical need at least as early as the early morning hours of June 1, 2019—the day before the decedent died. CRAFT was first notified by his subordinate that the decedent was throwing up blood. Defendant CRAFT completely failed to respond to the emergency himself and failed to give his subordinates instruction on how to respond to the

emergency. CRAFT had further personal knowledge later that day that the decedent was not treated by medical personnel and was lying on the floor, crying, and spitting up blood. CRAFT reportedly called the on-duty nurse, but did nothing to respond to the ongoing emergency him and did not give any instruction to his subordinates on how to respond to the emergency. After calling the on-duty nurse, CRAFT did nothing to respond to the decedent's serious medical need, failed to order that the decedent be transported to an emergency medical facility as the circumstances warranted, and failed to provide the decedent with access to adequate medical care through the remaining morning, afternoon, and evening hours of June 1, 2019 and through the night, as the decedent suffered until his ultimate death on June 2, 2019. CRAFT's failure to act was grossly negligent, willful, and reckless, at a minimum.

94. Upon information and belief, Defendant MOSS was on-duty and in charge of the decedent's cell block in the day leading to the decedent's death. Defendant NORRIS was on-duty and in charge of the yard in the day leading to the decedent's death. Both MOSS and NORRIS had personal knowledge of the decedent's serious medical condition, as the corrections officers in charge of monitoring the decedent in the day leading to the decedent's death, through direct contact and observation of the decedent as well as reports from other inmates at Sussex I State Prison.

95. MOSS and NORRIS ignored the decedent's serious medical condition throughout June 1, 2019 by failing to take adequate steps to provide the decedent with access to proper medical treatment, failing to order that the decedent be transported to an appropriate emergency facility, which the circumstances warranted, and failing to do anything to alleviate the decedent's pain and suffering.

96. Although MOSS eventually notified Defendant CRAFT of the decedent's serious

medical condition, MOSS did nothing to respond to the emergency himself or to provide the decedent with access to medical care. A mere opening of an automatic door and telling another corrections officer do not constitute any action on the party of MOSS. The failure to act on the part of MOSS and NORRIS was grossly negligent, willful, and reckless, at a minimum.

97. Upon information and belief, Defendant JOHNSON was the watch commander in the hours leading to the decedent's death. JOHNSON had a subjective knowledge of the decedent's serious medical condition at least as early as 5:10 a.m. on June 2, 2019, when he was notified of the medical emergency and advised that a medical doctor recommended that the decedent be transported to the emergency room.

98. As watch commander, JOHNSON was charged with putting a team together and facilitating the decedent's transport to the emergency room. JOHNSON completely failed to respond to the medical emergency and failed to order and/or facilitate the decedent's transport to the emergency room for over five hours, denying the decedent access to needed medical treatment for his serious medical condition until the decedent ultimately died awaiting transport. JOHNSON's failure to respond to the decedent's serious medical need was grossly negligent, willful, and reckless, at a minimum.

99. The acts and/or omissions of CRAFT, MOSS, NORRIS, and JOHNSON, as set out herein, were undertaken in the course of their employment with the VDOC and Sussex I State Prison.

100. Each of the named defendants herein, through their acts and/or omissions as set out herein, violated public policy, procedures, and standards of care developed to ensure the health and well-being of its inmates while incarcerated, as required by the United States Constitution and Virginia law.

101. As a direct and proximate result of the defendants' gross negligence, the decedent died on June 2, 2019.

102. As a further direct and proximate result of the defendants' gross negligence, the decedent was caused to suffer grave anxiety, physical suffering, severe mental anguish and pain, and inconvenience, for the months leading up to the decedent's untimely death.

VII. COUNT III: CONSTITUTIONAL VIOLATIONS BY CRAFT, MOSS, NORRIS, AND JOHNSON PURSUANT TO § 1983 VIOLATIONS – DELIBERATE INDIFFERENCE TO SERIOUS MEDICAL NEED

103. Paragraphs 1 through 102 are incorporated by reference herein.

104. At the time of the events giving rise to this litigation, CRAFT, MOSS, NORRIS, and JOHNSON were acting in their individual capacities, as employees of the VDOC and Sussex I State Prison, and under the color of state law.

105. As discussed herein, the decedent had an obvious serious medical need, which was obvious to everyone who encountered him, including CRAFT, MOSS, NORRIS, and JOHNSON.

106. The conduct of CRAFT, MOSS, NORRIS, and JOHNSON, as set out above, in ignoring the decedent's complaints, pleas, and obvious serious medical condition, shows their deliberate indifference to the decedent's mental and physical health needs, including a failure to evaluate, monitor, and treat the decedent's serious medical needs during his confinement. CRAFT, MOSS, NORRIS, and JOHNSON failed to facilitate any diagnostic testing and medical treatment, even after it was brought to their attention that the on-duty medical personnel were not providing the decedent with any treatment, and in doing so, violated the restriction on cruel and unusual punishment provided by the Eighth and Fourteenth Amendment of the United States Constitution.

107. Upon information and belief, Defendant CRAFT was a supervising corrections officer on-duty during the decedent's final hours of life in Sussex I State Prison. CRAFT had personal subjective knowledge of the decedent's serious medical need at least as early as the early morning hours of June 1, 2019—the day before the decedent died. CRAFT was first notified by his subordinate that the decedent was throwing up blood. Defendant CRAFT completely failed to respond to the emergency. CRAFT had further personal knowledge later that day that the decedent was not treated by medical personnel and was lying on the floor, crying, and spitting up blood. CRAFT called the on-duty nurse, but failed to do anything to address the ongoing medical emergency.

108. After calling the on-duty nurse, CRAFT did nothing to respond to the decedent's serious medical need, failed to order that the decedent be transported to an appropriate medical facility equipped to respond to the decedent's serious medical condition, and failed provide the decedent with access to adequate medical care through the remaining morning, afternoon, and evening hours of June 1, 2019 and through the night, as the decedent suffered until his ultimate death on June 2, 2019. Defendant CRAFT was deliberately indifferent to the decedent's serious medical need in failing to respond to the decedent's ongoing medical emergency and in failing to provide the decedent with access to medical care for his serious medical condition.

109. Upon information and belief, Defendant MOSS was on-duty and in charge of the decedent's cell block in the day leading to the decedent's death. Defendant NORRIS was on-duty and in charge of the yard in the day leading to the decedent's death. Both MOSS and NORRIS had personal knowledge of the decedent's serious medical condition, as the corrections officers in charge of monitoring the decedent in the day leading to the decedent's death, through direct contact and observation of the decedent as well as reports from other inmates at Sussex I

State Prison. MOSS and NORRIS ignored the decedent's serious medical condition throughout June 1, 2019, failed to provide the decedent with access to medical treatment, and failed to order that the decedent be transported to an appropriate emergency facility with staff equipped to treat the decedent's serious medical condition.

110. Although MOSS eventually notified Defendant CRAFT of the decedent's serious medical condition, MOSS did nothing to respond to the emergency himself or to provide the decedent with access to medical care or do anything else to alleviate the pain and suffering the decedent was enduring. Defendants MOSS and NORRIS's acts or omissions constitute deliberate indifference to the decedent's serious medical need by failing to respond to the decedent's ongoing medical emergency, in failing to provide the decedent with access to medical care for his serious medical condition, and in failing to order that the decedent be transported to an appropriate outside facility equipped to provide the medical treatment the decedent needed to treat his serious medical condition.

111. Upon information and belief, Defendant JOHNSON was the watch commander in the hours leading to the decedent's death. JOHNSON was subjectively aware of the decedent's serious medical condition at least as early as 5:10 a.m. on June 2, 2019, when he was notified of the medical emergency and advised that a medical doctor recommended that the decedent be transported to the emergency room. As watch commander, JOHNSON was charged with putting a team together and facilitating the decedent's transport to the emergency room. JOHNSON completely failed to take action to respond to the medical emergency and failed to facilitate the decedent's transport to the emergency room for over five hours, denying the decedent access to needed medical treatment for his serious medical condition until the decedent ultimately died awaiting transport.

112. Defendant JOHNSON was deliberately indifferent to the decedent's serious medical need in failing to respond to the decedent's ongoing medical emergency, in failing to provide the decedent with access to medical care for his serious medical condition, and in failing to order and/or provide the decedent with transport to the hospital emergency room, as had been recommended by an outside medical doctor.

113. The acts and/or omissions as set out herein as to CRAFT, MOSS, NORRIS, and JOHNSON were committed in the course of their employment with the VDOC and Sussex I State Prison.

114. As a direct and proximate result of the defendants' deliberate indifference to serious medical need, the decedent died on June 2, 2019.

115. As a further direct and proximate result of the defendants' deliberate indifference, the decedent was caused to suffer grave anxiety, physical suffering, severe mental anguish and pain, and inconvenience, during the months leadings up to the decedent's untimely death.

116. The supervisory defendants' aforesaid actions and omissions constitute a willful, wanton, reckless, and conscious disregard of the decedent's constitutional rights. The plaintiff is therefore entitled to recover punitive damages.

117. The on-duty defendants' violations of the Eighth and Fourteenth Amendments to the U.S. Constitution establish a cause of action, pursuant to 42 U.S.C. § 1983, for relief including compensatory damages, punitive damages, attorney's fees, and costs to the estate.

VIII. COUNT IV: SERGEANT CRAFT, SERGEANT NORRIS, CAPTAIN JOHNSON, DR. PATEL, DR. ULEP, AND DR. PICIO'S CONSTITUTIONAL VIOLATIONS PURSUANT TO § 1983: DELIBERATE INDIFFERENCE – SUPERVISORY LIABILITY

118. Paragraphs 1 through 117 are incorporated by reference herein.

119. At all relevant times, through their actions and omissions set forth above, and while

acting under color of state law, and in their individual capacities, Defendants CRAFT, NORRIS, JOHNSON, PATEL, ULEP, and PICIO, acted in a manner that was deliberately indifference to the decedent's Eighth and Fourteenth Amendment rights.

120. The supervisory defendants had actual knowledge that their subordinates, including, but not limited to, individual named defendants in this matter, were engaged in conduct that posed a pervasive and unreasonable risk of constitutional injury to citizens like the decedent.

121. As noted above, the decedent complained of pain and serious symptoms for 8 months. During that time, the decedent begged for medical help by filing several grievances and by requesting that his family members call the prison to advocate on his behalf. Upon information and belief, fellow inmates reported that the decedent was being denied medical treatment, which was directly reported to CRAFT, NORRIS, and JOHNSON. CRAFT, NORRIS, and JOHNSON were therefore subjectively aware that the decedent had serious, ongoing symptoms that were being left undiagnosed and untreated.

122. The decedent personally complained of the issues to Armor Correctional employees and/or agents and the information was documented in the decedent's medical records. Defendant Doctors PATEL, ULEP, and PICIO were subjectively aware of the decedent's serious medical condition through communications with their subordinates, through communications with the decedent, and through review of the decedent's medical records. PATEL, ULEP, and PICIO were, therefore, subjectively aware that the decedent had serious, ongoing symptoms that were being left undiagnosed and untreated.

123. CRAFT, NORRIS, JOHNSON, PATEL, ULEP, and PICIO had a duty to care for and provide medical care for inmates in their sole and exclusive care.

124. The response of CRAFT, NORRIS, JOHNSON, PATEL, ULEP, and PICO to their

subjective knowledge was so inadequate as to show deliberate indifference to and tacit authorization of the alleged offensive practices of their subordinates in denying the decedent with access to constitutionally mandated medical treatment. CRAFT, NORRIS, JOHNSON, PATEL, ULEP, and PICIO failed to act on their knowledge, failed to carry out their own obligations to properly supervise their subordinates and/or intervene on the decedent's behalf, failed to provide the decedent with access to appropriate, timely medical care, and failed to order that the decedent be transported to an appropriate emergency medical facility, as the decedent's condition clearly warranted.

125. The intentional and deliberate inaction of CRAFT, NORRIS, JOHNSON, PATEL, ULEP, and PICIO caused the decedent to suffer constitutional injury and the ultimate death of the decedent after writhing for hours in pain and suffering.

126. As a result of CRAFT, NORRIS, JOHNSON, PATEL, ULEP, and PICIO's unconstitutional, deliberate indifference to the needs, circumstances, and requirements for providing medical treatment to inmates, CRAFT, NORRIS, JOHNSON, PATEL, ULEP, and PICIO allowed the decedent to suffer for 8 months and die a preventable death from a treatable illness. The decedent suffered a denial of his constitutional rights and severe pain and suffering. CRAFT, NORRIS, JOHNSON, PATEL, ULEP, and PICIO's unconstitutional, deliberate indifference to the decedent's circumstances caused his untimely death.

127. Defendants CRAFT, NORRIS, JOHNSON, PATEL, ULEP, and PICIO's aforesaid actions and omissions constitute a willful, wanton, reckless, and conscious disregard of the decedent's constitutional rights. The plaintiff is therefore entitled to recover punitive damages.

128. Defendants CRAFT, NORRIS, JOHNSON, PATEL, ULEP, and PICIO's violations of Eighth and Fourteenth Amendments to the U.S. Constitution establish a cause of action, pursuant

to 42 U.S.C. § 1983, for relief including compensatory damages, punitive damages, attorney's fees, and costs to the estate.

IX. COUNT V: SERGEANT CRAFT, SERGEANT NORRIS, CAPTAIN JOHNSON, DR. PATEL, DR. ULEP, AND DR. PICIO'S CONSTITUTIONAL VIOLATIONS PURSUANT TO § 1983: DELIBERATE INDIFFERENCE – FAILURE TO TRAIN, SUPERVISE, AND CONTROL

129. Paragraphs 1 through 128 are incorporated by reference herein.

130. At all relevant times, CRAFT, NORRIS, JOHNSON, PATEL, ULEP, and PICIO, had a duty to properly hire, train, supervise, and fire, if necessary, agents and/or employees of the VDOC and Armor Correctional to ensure that inmates in the custody of Sussex I were provided with constitutionally mandated medical care.

131. Defendants CRAFT, NORRIS, JOHNSON, PATEL, ULEP, and PICIO failed to effectively train, supervise, and control the corrections officers and Armor employees and/or agents under their command, to ensure the proper administration of, and understanding of the procedures for providing access to adequate medical care for inmates housed in the correctional facility, including the decedent. Defendants CRAFT, NORRIS, JOHNSON, PATEL, ULEP, and PICIO failed to train, supervise, and order the corrections officers and Armor employees and/or agents under their command to transport the decedent to an appropriate emergency medical facility.

132. As supported by the facts set out above, CRAFT, NORRIS, JOHNSON, PATEL, ULEP, and PICIO had a policy, custom, and/or practice of failing to effectively train, supervise, discipline, and control officers and Armor employees and/or agents under their supervision regarding the appropriate provision of medical care.

133. As discussed herein, CRAFT, NORRIS, JOHNSON, PATEL, ULEP, and PICIO knew or should have known that their subordinate corrections officers and Armor employees and/or

agents required adequate training on the proper administration of medical care.

134. CRAFT, NORRIS, JOHNSON, PATEL, ULEP, and PICIO violated their duty in failing to properly train officers and Armor employees and/or agents at Sussex I State Prison on the proper administration of medical care.

135. In violating their duties, CRAFT, NORRIS, JOHNSON, PATEL, ULEP, and PICIO demonstrated a deliberate indifference to the need to provide proper training for the defendant officers and Armor Correctional employees and/or agents at Sussex I, especially in light of the repeated grievances filed, family member complaints lodged, and inmate complaints lodged, as set out above.

136. As a direct and proximate result of CRAFT, NORRIS, JOHNSON, PATEL, ULEP, and PICIO's violation of their duties to properly train officers and Armor Correctional employees and/or agents at Sussex I, the decedent's constitutional rights were violated, he was denied access to medical treatment, and the decedent died on June 2, 2019.

137. The aforesaid actions and omissions on the part of CRAFT, NORRIS, JOHNSON, PATEL, ULEP, and PICIO constitute a willful, wanton, reckless, and conscious disregard of the decedent's constitutional rights. The plaintiff is therefore entitled to recover punitive damages.

138. CRAFT, NORRIS, JOHNSON, PATEL, ULEP, and PICIO's violations of Eighth and Fourteenth Amendments to the U.S. Constitution establish a cause of action, pursuant to 42 U.S.C. § 1983, for relief including compensatory damages, punitive damages, attorney's fees, and costs to the estate.

X. COUNT VI: NEGLIGENCE OF DEFENDANTS ULEP, PICIO, SEMLALI, PATEL, WALKER, SEWARD, JACKSON, ALLEN, AND SYKES

139. Paragraphs 1 through 138 are incorporated by reference herein.

140. At all relevant times, Defendants ULEP, PICIO, SEMLALI, PATEL, WALKER,

SEWARD, JACKSON, ALLEN, and SYKES had a duty of reasonable care in their treatment of the decedent.

141. As discussed herein, the decedent had an obvious serious medical need. The symptoms of the serious medical need were open and obvious to any person who observed the decedent's obvious pain and suffering as was observed by ULEP, PICIO, SEMLALI, PATEL, WALKER, SEWARD, JACKSON, ALLEN, and SYKES and was documented in the prison medical records. The serious medical need was known to and ignored by ULEP, PICIO, SEMLALI, PATEL, WALKER, SEWARD, JACKSON, ALLEN, and SYKES at the prison.

142. At all relevant times, ULEP, PICIO, SEMLALI, PATEL, WALKER, SEWARD, JACKSON, ALLEN, and SYKES should have known that the decedent was in physical distress given the decedent's verbal complaints, the decedent's written complaints, the decedent's abnormal appearance, physical evidence of the decedent vomiting blood, the decedent's inability to walk, and reports from corrections officers of the decedent's deteriorating condition, and failed to ensure that the decedent received proper physical health evaluations, monitoring, diagnostic testing, and treatment.

143. Notwithstanding their duties, the medical staff personnel;

a. Negligently failed to identify and take all necessary steps to treat or obtain treatment for the decedent's physical health concerns;

b. Negligently failed to monitor the decedent in spite of serious symptoms known to them;

c. Negligently failed to request that the decedent be transported to a hospital emergency room for medical evaluation, diagnostic testing, and treatment in a timely manner;

d. Negligently failed to follow up to make certain that decedent's condition did not worsen after the decedent was sent back to his cell without medical treatment;

e. Negligently failed to respond to reports from corrections officers of the decedent's obvious and serious medical condition; and

f. Negligently failed to ensure that the decedent received necessary emergency medical treatment.

144. Defendants WALKER, SEWARD, JACKSON, and ALLEN should have been aware and were subjectively aware of the decedent's ongoing serious medical condition while on-duty at Sussex I State Prison through interactions with the decedent as well as through their review of the decedent's medical records. Defendant WALKER saw the decedent on October 16, 2018 and February 6, 2019, during which the decedent reported his serious medical condition. Defendant SEWARD learned of the decedent's serious medical condition as early as her encounter with the decedent on December 8, 2018. Defendant ALLEN learned of the decedent's medical need as early as her December 16, 2018 encounter, and then again upon review of the decedent's medical records on February 6, 2019, when ALLEN should have been aware that the decedent was not being provided medical treatment for his ongoing condition over the course of months. Defendant JACKSON learned of the decedent's serious medical condition and need at least as early as her February 12, 2019 encounter with the decedent. In spite of the information known to them, and despite their duty to provide the decedent with medical care, WALKER, SEWARD, JACKSON, and ALLEN failed to provide the decedent with or facilitate access to any medical treatment, evaluation, or testing for the decedent's ongoing serious medical condition and need and failed to order that the decedent be transported to an appropriate emergency medical facility, as was required by the decedent's known condition. The failure to

act on the part of WALKER, SEWARD, JACKSON, and ALLEN, in spite of their duty to act, constitutes negligence.

145. Defendant SYKES should have been and was aware of the decedent's serious medical condition and need for medical treatment at least as early as 11:26 p.m. on June 1, 2019—the night before the decedent died. SYKES knew of the decedent's ongoing serious medical need through her observations of the decedent and the review of the decedent's medical records. In spite of SYKES's documented knowledge of the decedent's repeated vomiting, increasing abdominal pain and tenderness, lack of consciousness, and noticeable discomfort and agitation, SYKES did nothing to treat the decedent over the court of over five hours, as the decedent languished, dying from a treatable medical issue. SYKES failure to provide the decedent with medical treatment and/or access to medical treatment and failure to order that the decedent be transported to an appropriate emergency medical facility, in spite of her duty, constitutes negligence, at a minimum.

146. Defendant SEMLALI should have been and was aware of the decedent's serious medical condition and need for medical treatment at least as early as 10:45 a.m. on June 1, 2019—the day before the decedent died. SEMLALI knew of the decedent's ongoing serious medical need through her observations of the decedent and her review of the decedent's medical records. In spite of SEMLALI's documented knowledge of the decedent's excruciating symptoms, including but not limited to, stomach pain, repeated episodes of vomiting blood, inability to walk, and sweating, and in spite of the decedent's pleas and cries for help, SEMLALI did nothing to provide the decedent with medical treatment over the course of the entire day and night leading to the decedent's death. SEMLALI's failure to provide the decedent with medical treatment and/or with access to medical care and failure to order that the decedent be transported

to an appropriate emergency medical facility as the decedent's condition warranted, constitutes negligence, at a minimum.

147. Defendant PICIO became aware of the decedent's serious medical condition as early as October 16, 2018, when he reviewed the decedent's medical records, and on October 22, 2018, when he saw the decedent. In spite of his knowledge of the decedent's serious complaints, and despite his duty to provide the decedent with medical treatment, PICIO failed to facilitate or administer any medical treatment, failed to order any diagnostic testing or imaging, failed to instruct his subordinates to provide any medical treatment to the decedent, failed to order that the decedent be transported to an appropriate emergency medical facility with staff equipped to provide the necessary medical care for the decedent's condition, and misdiagnosed the decedent with indigestion. PICIO's failure to provide the decedent with access to medical care constitutes negligence, at a minimum.

148. Defendant PATEL became subjectively aware of the decedent's serious medical condition at least as early as January 28, 2019. PATEL documented his subjective knowledge of the decedent's abnormal lab results as well as his knowledge that the decedent needed to be examined, but failed to provide the decedent with any medical treatment, any diagnostic testing or imaging, and access to any medical care whatsoever. PATEL further failed to instruct his subordinates to provide medical treatment to the decedent and failed to order that the decedent be transported to an appropriate outside medical facility, as the decedent's condition required. PATEL's failure to provide the decedent with access to medical care constitutes negligence, at a minimum.

149. Defendant ULEP became aware of the decedent's serious medical condition as early as the afternoon of June 1, 2019—the day before the decedent died. ULEP was notified that the

decedent has serious symptoms, including, but not limited to, nausea, vomiting, stomach pain, and sweating. In spite of this knowledge, ULEP failed to provide the decedent with any medical treatment, any diagnostic testing or imaging, and access to any medical care whatsoever. ULEP further failed to instruct his subordinates to provide any medical treatment to the decedent and failed to order that the decedent be transported to an appropriate outside medical facility, as the decedent's condition required. ULEP's failure to provide the decedent with access to medical care constitutes negligence, at a minimum.

150. As a direct and proximate result of ULEP, PICIO, SEMLALI, PATEL, WALKER, SEWARD, JACKSON, ALLEN, and SYKES's negligence, the decedent died on June 2, 2019.

151. Each of the acts or omissions of ULEP, PICIO, SEMLALI, PATEL, WALKER, SEWARD, JACKSON, ALLEN, and SYKES were committed within the course of their employment with the VDOC, Sussex I State Prison, and Armor Correctional Health Services.

152. As a further direct and proximate result of the negligence of ULEP, PICIO, SEMLALI, PATEL, WALKER, SEWARD, JACKSON, ALLEN, and SYKES, the decedent was caused to suffer grave anxiety, physical suffering, severe mental anguish and pain, and inconvenience, during the months leading to the decedent's untimely death on June 2, 2019.

153. The plaintiff certifies that, pursuant to Virginia Code § 8.01-50.1, he has obtained a written certification from a qualified expert that the actions of ULEP, PICIO, SEMLALI, PATEL, WALKER, SEWARD, JACKSON, ALLEN, SYKES, and ARMOR CORRECTIONAL HEALTH SERVICES deviated from the applicable standard of care and that said deviation was the proximate cause of death of the decedent.

XI. COUNT VII: GROSS NEGLIGENCE OF ULEP, PICIO, SEMLALI, PATEL, AND SYKES

154. Paragraphs 1 through 153 are incorporated by reference herein.

155. The conduct of ULEP, PICIO, SEMLALI, PATEL, and SYKES, as set out above, was grossly negligent, willful and reckless, in that each knew and observed the decedent's obvious and serious need for medical evaluation, diagnostic testing, and treatment. ULEP, PICIO, SEMLALI, PATEL, and SYKES acted in a grossly negligent fashion by failing to provide necessary and adequate medical treatment at any time when the decedent's life could have been saved, by failing to provide timely access to a hospital emergency room, which would have saved the decedent's life and decreased his pain and suffering, and by failing to take any steps, for several months, to prevent the decedent's death.

156. Defendant SYKES should have been and was aware of the decedent's serious medical condition and need for medical treatment at least as early as 11:26 p.m. on June 1, 2019—the night before the decedent died. SYKES knew of the decedent's ongoing serious medical need through her observations of the decedent and the review of the decedent's medical records. In spite of SYKES's documented knowledge of the decedent's repeated vomiting, increasing abdominal pain and tenderness, lack of consciousness, and noticeable discomfort and agitation, SYKES did nothing to treat the decedent over the court of over five hours, as the decedent languished, dying from a treatable medical issue. SYKES failed to provide the decedent with medical treatment and access to medical care and failed to order that the decedent be transported to an appropriate emergency medical facility as the decedent's condition required. SYKES failure to act, in spite of the information known to her and her duty to act, constitutes gross negligence, at a minimum.

157. Defendant SEMLALI should have been and was aware of the decedent's serious medical condition and need for medical treatment at least as early as 10:45 a.m. on June 1, 2019—the day before the decedent died. SEMLALI knew of the decedent's ongoing serious

medical need through her observations of the decedent and her review of the decedent's medical records. In spite of SEMLALI's documented knowledge of the decedent's excruciating symptoms, including but not limited to, stomach pain, repeated episodes of vomiting blood, inability to walk, and sweating, and in spite of the decedent's pleas and cries for help, SEMLALI did nothing to provide the decedent with medical treatment over the course of the entire day and night leading to the decedent's death. SEMLALI failed to provide the decedent with medical treatment and access to medical care and failed to order that the decedent be transported to an appropriate emergency medical facility as the decedent's condition required. SEMLALI's failure to provide the decedent with access to medical care constitutes gross negligence, at a minimum.

158. Defendant PICIO became aware of the decedent's serious medical condition as early as October 16, 2018, when he reviewed the decedent's medical records, and on October 22, 2018, when he saw the decedent. In spite of his knowledge of the decedent's serious complaints, and despite his duty to provide the decedent with medical treatment, PICIO failed to facilitate or administer any medical treatment, failed to order any diagnostic testing or imaging, failed to instruct his subordinates to provide any medical treatment to the decedent, failed to order that the decedent be transported to an appropriate outside medical facility with staff equipped to administer the appropriate medical treatment necessary to treat the decedent's serious medical condition, and misdiagnosed the decedent with indigestion. PICIO's failure to provide the decedent with access to medical care constitutes gross negligence, at a minimum.

159. Defendant PATEL became aware of the decedent's serious medical condition at least as early as January 28, 2019. PATEL documented his subjective knowledge of the decedent's abnormal lab results as well as his knowledge that the decedent needed to be examined, but

failed to provide the decedent with any medical treatment, any diagnostic testing or imaging, and access to any medical care whatsoever. PATEL further failed to instruct his subordinates to provide medical treatment to the decedent and failed to order that the decedent be transported to an appropriate outside medical facility with staff equipped to administer the appropriate medical treatment. PATEL's failure to provide the decedent with access to medical care constitutes gross negligence, at a minimum.

160. Defendant ULEP became aware of the decedent's serious medical condition as early as the afternoon of June 1, 2019—the day before the decedent died. ULEP was notified that the decedent had serious symptoms, including, but not limited to, nausea, vomiting, stomach pain, and sweating. In spite of this knowledge, ULEP failed to provide the decedent with any medical treatment, any diagnostic testing or imaging, and access to any medical care whatsoever. ULEP further failed to instruct his subordinates to provide any medical treatment to the decedent and failed to order that the decedent be transported to an appropriate outside medical facility with staff equipped to administer the appropriate medical treatment. ULEP's failure to provide the decedent with access to medical care constitutes gross negligence, at a minimum.

161. ULEP, PICIO, SEMLALI, PATEL, and SYKES's conduct was clearly in reckless disregard of the rights of the decedent and was designed purely to inflict discomfort, humiliation, embarrassment, and other harm to the decedent.

162. As a direct and proximate result of the defendants' gross negligence, the decedent died on June 2, 2019

163. As a further direct and proximate result of the medical personnel's gross negligence, the decedent was caused to suffer grave anxiety, physical suffering, severe mental anguish and pain, and inconvenience, during the months leading to his untimely death of June 2, 2019.

XII. COUNT VIII: ULEP, PICIO, SEMLALI, PATEL, AND SYKES CONSTITUTIONAL VIOLATIONS PURSUANT TO § 1983: DELIBERATE INDIFFERENCE TO SERIOUS MEDICAL NEED

164. Paragraphs 1 through 120 are incorporated by reference herein.

165. At the time of the events giving rise to this litigation, ULEP, PICIO, SEMLALI, PATEL, and SYKES were acting in their individual capacities and as employees of the VDOC, Sussex I State Prison, and Armor Correctional Health Services, and acted under color of state law.

166. Defendant SYKES became subjectively aware of the decedent's serious medical condition and need for medical treatment at least as early as 11:26 p.m. on June 1, 2019—the night before the decedent died. SYKES knew of the decedent's ongoing serious medical need through her observations of the decedent and the review of the decedent's medical records. In spite of SYKES's documented knowledge of the decedent's repeated vomiting, increasing abdominal pain and tenderness, lack of consciousness, and noticeable discomfort and agitation, SYKES did nothing to treat the decedent over the court of over five hours, as the decedent languished, dying from a treatable medical issue. SYKES failed to provide the decedent with medical treatment and access to medical care and failed to order that the decedent be transported to an appropriate emergency medical facility as the decedent's condition required. SYKES was deliberately indifferent to the information known to her and the decedent's serious medical need.

167. Defendant SEMLALI should have been and was aware of the decedent's serious medical condition and need for medical treatment at least as early as 10:45 a.m. on June 1, 2019—the day before the decedent died. SEMLALI knew of the decedent's ongoing serious medical need through her observations of the decedent and her review of the decedent's medical records. In spite of SEMLALI's documented knowledge of the decedent's excruciating

symptoms, including but not limited to, stomach pain, repeated episodes of vomiting blood, inability to walk, and sweating, and in spite of the decedent's pleas and cries for help, SEMLALI did nothing to provide the decedent with medical treatment over the course of the entire day and night leading to the decedent's death. SEMLALI failed to provide the decedent with medical treatment and access to medical care and failed to order that the decedent be transported to an appropriate emergency medical facility as the decedent's condition required. SEMLALI was deliberately indifferent to the information known to her and the decedent's serious medical need in failing to provide the decedent with any medical treatment for his serious medical condition.

168. Defendant PICIO became aware of the decedent's serious medical condition as early as October 16, 2018, when he reviewed the decedent's medical records, and on October 22, 2018, when he saw the decedent. In spite of his knowledge of the decedent's serious complaints, and despite his duty to provide the decedent with medical treatment, PICIO failed to facilitate or administer any medical treatment, failed to order any diagnostic testing or imaging, failed to instruct his subordinates to provide any medical treatment to the decedent, failed to order that the decedent be transported to an appropriate outside medical facility with staff equipped to administer the appropriate medical treatment necessary to treat the decedent's serious medical condition, and misdiagnosed the decedent with indigestion. PICIO was deliberately indifferent to the information known to him and the decedent's serious medical need in failing to provide the decedent with any medical treatment for his serious medical condition.

169. Defendant PATEL became aware of the decedent's serious medical condition at least as early as January 28, 2019. PATEL documented his subjective knowledge of the decedent's abnormal lab results as well as his knowledge that the decedent needed to be examined, but failed to provide the decedent with any medical treatment, any diagnostic testing or imaging, and

access to any medical care whatsoever. PATEL further failed to instruct his subordinates to provide medical treatment to the decedent and failed to order that the decedent be transported to an appropriate outside medical facility with staff equipped to administer the appropriate medical treatment necessary to treat the decedent's serious medical condition. PATEL was deliberately indifferent to the information known to him and the decedent's serious medical need in failing to provide the decedent with any medical treatment for his serious medical condition.

170. Defendant ULEP became aware of the decedent's serious medical condition as early as the afternoon of June 1, 2019—the day before the decedent died. ULEP was notified that the decedent has serious symptoms, including, but not limited to, nausea, vomiting, stomach pain, and sweating. In spite of this knowledge, ULEP failed to provide the decedent with any medical treatment, any diagnostic testing or imaging, and access to any medical care whatsoever. ULEP further failed to instruct his subordinates to provide any medical treatment to the decedent and failed to order that the decedent be transported to an appropriate outside medical facility with staff equipped to administer the appropriate medical treatment necessary to treat the decedent's serious medical condition. ULEP was deliberately indifferent to the information known to him and the decedent's serious medical need in failing to provide the decedent with any medical care for his serious medical condition.

171. The conduct of ULEP, PICIO, SEMLALI, PATEL, and SYKES, as set out above, shows their deliberate indifference to the decedent's basic needs during his confinement. ULEP, PICIO, SEMLALI, PATEL, and SYKES, as alleged herein, failed to offer basic medical treatment, failed to provide or facilitate any diagnostic testing, failed to monitor the decedent appropriately for worsening symptoms, and failed to promptly transport the decedent to a hospital emergency room before the decedent's untimely death. The conduct of ULEP, PICIO,

SEMLALI, PATEL, and SYKES offends the standards of basic human decency and violates the Constitutional restriction on cruel and unusual punishment and right to due process.

172. As a direct and proximate result of ULEP, PICIO, SEMLALI, PATEL, and SYKES's deliberate indifference to a serious medical need, the decedent died on June 2, 2019.

173. As a further direct and proximate result of ULEP, PICIO, SEMLALI, PATEL, and SYKES's gross negligence, the decedent was caused to suffer grave anxiety, physical suffering, severe mental anguish and pain, and inconvenience, during the several months leading to the decedent's untimely death of June 2, 2019.

174. The aforesaid actions and omissions on the part of ULEP, PICIO, SEMLALI, PATEL, and SYKES constitute a willful, wanton, reckless, and conscious disregard of the decedent's constitutional rights. The plaintiff is therefore entitled to recover punitive damages.

175. ULEP, PICIO, SEMLALI, PATEL, and SYKES's violations of Eighth and Fourteenth Amendments to the U.S. Constitution establish a cause of action, pursuant to 42 U.S.C. § 1983, for relief including compensatory damages, punitive damages, attorney's fees, and costs to the estate.

XIII. COUNT IX: ARMOR CORECTIONAL HEALTH SERVICES' NEGLIGENCE

176. Paragraphs 1 through 175 are incorporated by reference herein.

177. At all relevant times, Armor Correctional Health Services, individually and through its employees, agents, and servants was engaged in the medical treatment of inmates and had a duty to act with reasonable care in its treatment of the decedent.

178. At all relevant times, Armor Correctional Health Services, individually and through its employees, agents, and servants, had a further duty to establish and enforce policies and procedures to avoid its medical staff personnel's violation of a prisoner's constitutional rights

such as the right to due process under the Fifth and Fourteenth Amendment and the right against cruel and unusual punishment prescribed by the Eighth and Fourteenth Amendment.

179. At all relevant times, Armor Correctional Health Services had a duty to train and supervise the employees, agents, and servants, including the defendant medical personnel, and establish policies and procedures to be followed for treatment, supervision, monitoring, diagnostic testing, and transportation to emergency medical facilities for an inmate, such as the decedent, who was demonstrating symptoms of a serious medical condition.

180. Armor Correctional Health Services breached this duty by failing to provide the decedent with medical treatment, adequate monitoring, appropriate diagnostic testing, and access to emergency medical facilities, which demonstrated its callous indifference for the decedent's well-being.

181. As a direct and proximate result of the defendants' negligence, the decedent died on June 2, 2019.

182. As a further direct and proximate result of the medical personnel's negligence, the decedent was caused to suffer grave anxiety, physical suffering, severe mental anguish and pain, and inconvenience, during the several months leading to the decedent's untimely death on June 2, 2019.

XIV. COUNT X: ARMOR CORRECTIONAL HEALTH SERVICES' GROSS NEGLIGENCE

183. Paragraphs 1 through 182 are incorporated by reference herein.

184. Armor Correctional Health Services conduct, as set out above, was grossly negligent, willful, and reckless, in that it, through its employees, agents, and servants, failed to take adequate steps to provide and/or facilitate medical treatment, evaluation, diagnostic testing, and timely access to emergency medical facilities.

185. Armor Correctional Health Services' conduct was in reckless disregard of the rights of the decedent. Its actions were designed purely to inflict discomfort, humiliation, embarrassment, and other harm to the decedent.

186. Armor Correctional Health Services otherwise acted with gross negligence, depriving the decedent of her rights, privileges, and immunities secured by the United States Constitution or laws of the United States.

187. As a direct and proximate result of the defendants' gross negligence, the decedent died on June 2, 2019.

188. As a further direct and proximate result of the medical personnel's gross negligence, the decedent was caused to suffer grave anxiety, physical suffering, severe mental anguish and pain, and inconvenience, during the several months leading to the decedent's untimely death on June 2, 2019.

XV. COUNT XI: PUNITIVE DAMAGES

189. Paragraphs 1 through 188 are incorporated by reference herein.

190. At all relevant times, the defendants acted with actual malice toward the decedent.

191. Defendants further acted consciously in an unjustifiable, willful, wanton, and reckless disregard of the decedent's rights. Defendants were aware of their conduct and were also aware from their knowledge of existing circumstances and conditions that their conduct would likely result in physical, mental, financial, emotional injury, and death to the decedent.

192. The defendants either knew, or through the exercise of reasonable care, should have known of the decedent's serious medical need and their failure to respond appropriately to that risk warrants an award of punitive damages.

193. As a further direct and proximate result of the defendants' acts and omissions, the

plaintiff, by counsel, demands judgment against the defendants, jointly and severally, for compensatory damages in the amount of **FIVE MILLION DOLLARS ($5,000,000.00)** and punitive damages in the amount of **TEN MILLION DOLLARS ($10,000,000.00),** plus all costs and interest as permitted by law.

SHARON DALLAS, Administratrix of the Estate of
CHARLES DUYNES, deceased

By: ____________________/s/________________

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