IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF VIRGINIA
Harrisonburg Division

JOANIE C. SULLINS, Individually, and as Personal Representative of the Estate of Brendon Garrett Sullins, Plaintiff, v. **RSW REGIONAL JAIL AUTHORITY,** AND **WILLIAM T. WILSON, SUPERINTENDENT OF THE SHENANDOAH COUNTY, WARREN COUNTY REGIONAL JAIL** AND **OFFICER THOMAS RATIGAN, OFFICER JACOB MEDINA, NURSE PENNY HOLT, NURSE ASHLEY JONES, PAXTYNN E. SCOTT-WILLIAMS &** **JOHN AND JANE DOES 1-10,** Defendants.	Case Number: 5:18-cv-00006 Jury Trial Demanded

FIRST AMENDED COMPLAINT AND JURY DEMAND

1. This action, involving federal civil rights claims under 42 U.S.C. § 1983 as well as Virginia common law claims, is brought by Plaintiff Joanie C. Sullins, Individually, and as Personal Representative of the Estate of her deceased son, Brendon Garrett Sullins (referred to herein as "Brendon"), to redress Defendants' willful, deliberate and callous deprivation of Brendon's constitutional rights, as well as the other tortious acts and omissions committed by Defendants while Brendon was in their custody and control, that proximately caused Brendon's death on or about February 13, 2016.

2. Prior to his death, Brendon was a pretrial detainee, held without bond at the RSW Regional Jail since February 10, 2016, who reported to jail staff at intake that he was a regular user of heroin, and that he had last taken heroin intravenously a couple of hours before booking.

3. His withdrawal symptoms started shortly afterward, and became progressively worse until his death two days later, from complications of opioid withdrawal. The pathological diagnoses listed on the autopsy report include isonatremic dehydration.

4. Proper medical assessment throughout his incarceration, prompt medical care, and a simple infusion of intravenous fluids, a regularly prescribed and effective medical treatment for dehydration, would have saved Brendon's life. This is the treatment that any basically-trained nurse or doctor would administer in the face of manifest extreme dehydration, yet it was never given to Brendon.

5. This basic, simple treatment was never given to Brendon by the staff at RSW Regional Jail Authority, even after jail staff recognized Brendon was withdrawing from heroin, and even as they watched him writhe around on the floor of his medical cell for two days, in obvious pain, on camera, never sleeping, being unable to hold down any liquids, and showing obvious physical signs of dehydration.

6. As Brendon's condition went from bad to worse, jail corrections and medical staff literally simply watched him suffer. Medical staff rarely took his vital signs, and failed to properly assess his condition. Throughout his incarceration and until the time of his death, he received infrequent medical care by nurses, and never saw a doctor. He was placed by nurses on the RSW Regional Jail's withdrawal protocol, but these nurses failed to monitor him, treat him, or even ensure the protocol was followed.

7. By the day of his death, Brendon could not swallow the medications that were provided, but this fact was not reported to medical staff.

8. The video footage of Brendon's cell demonstrates the RSW Regional Jail's, and all Defendants', deliberate indifference to Brendon's serious medical need.

9. Less than 10 minutes before Brendon moves for the very last time, he was sitting on the toilet in his cell with his hands cramped in a claw-like manner, when his legs quickly straighten out and he appears to suffer some sort of muscle spasm before falling off the toilet with his pants down and his lower body fully exposed.

10. After he falls, Defendant Officer Ratigan looks in on him, lying face down on the floor, and walks off before returning and appearing to communicate something to him, and walking away again.

11. After he left, Defendant Officer Ratigan spoke to Defendant Nurse Penny Holt to report Brendon's condition. Rather than going to Brendon's cell to evaluate him in person, however, Defendant Nurse Penny Holt, who was treating another person, merely looked at the monitor and callously told Officer Ratigan to tell Brendon to put his pants back on.

12. After falling off the toilet, Brendon managed to sit up only briefly, for less than 30 seconds, before falling down again. He continued to writhe around in obvious pain and distress for approximately two minutes, then, abruptly, stopped moving (never to move again).

13. Approximately two hours later, Defendant Officer Medina brought Brendon's lunch into his cell and found him lying, dead, on the floor of his cell, with his pants around his ankles and his lower body fully exposed. Due to the length of time Brendon had been dead in his cell before being discovered, rigor mortis had already set in.

14. As a direct and proximate result of the Defendants' breaches of the standard of care and deliberate indifference to Brendon's imminent medical needs, Brendon suffered needlessly in his cell, without basic medical care, until his death on February 13, 2016.

15. Brendon Sullins suffered intense physical and emotional pain and suffering, including

drug withdrawal pains and consciousness of his own impending death, and he, his mother, and his children, otherwise suffered injury and damage.

16. Plaintiff seeks damages from Defendants Wilson, Ratigan, Medina, Holt, Jones, Scott Williams, and John and Jane Does 1-10 in their individual capacities, and from the RSW Regional Jail Authority, and Defendant Wilson in his official capacity, including payment of reasonable attorneys' fees and costs pursuant to 42 U.S.C. §§ 1983 and 1988. Plaintiff seeks punitive damages, for his civil rights and gross negligence claims. Plaintiff also seeks damages from the above-listed individual Defendants in their individual capacities pursuant to Virginia § 8.01-50 (wrongful death action).

JURISDICTION AND VENUE

17. This Court has subject matter jurisdiction over Plaintiff's claims pursuant to 28 U.S.C. § 1331 (federal question), as well as 28 U.S.C. § 1343 (civil rights actions), insofar as this case involves an action arising under the laws of the United States, including the 14th Amendment to the United States Constitution and federal civil rights statutes, including 42 U.S.C. § 1983. Pursuant to 28 U.S.C. § 1367, this Court has supplemental and/or pendent subject matter jurisdiction over the remaining claims.

18. The Court's personal jurisdiction over RSW Regional Jail Authority is manifest. The Court has personal jurisdiction over Defendants William T. Wilson, Officer Thomas Ratigan, Officer Jacob Medina, Nurse Penny Holt, Nurse Ashley Jones and Paxtynn E. Scott-Williams aka Elizabeth Paxtynn Scott-Williams, and John and Jane Does 1-10, insofar as they are Citizens of, reside in, and/or are employed by and/or do business within Warren County, Virginia, and committed the tortious actions and omissions at issue within the Commonwealth of Virginia.

19. Venue in this action properly lies in this judicial district pursuant to 28 U.S.C. § 1391(b), as substantially all of the events or omissions giving rise to the claim occurred within this

judicial district.

THE PARTIES

20. Plaintiff Joanie C. Sullins is, and at all relevant times has been, a Citizen of Elkins, West Virginia, residing at 30 Moore Street. Ms. Sullins is the mother of decedent Brendon Garrett Sullins and qualified as the personal representative of his estate in the Commonwealth of Virginia on July 19, 2016. Attached to the original complaint as **Exhibit A** was a copy of the order of the Certificate/Letter of Qualification for Prosecution or Defense of Civil Action.

21. Defendant RSW Regional Jail Authority is a regional jail authority, organized under Virginia Code § 53.1-95.2, that is owned, controlled, funded, and sponsored by the RSW Counties (Rappahannock, Shenandoah & Warren), pursuant to the RSW Regional Jail Authority Service Agreement (dated June 4, 2010). The RSW Regional Jail Authority operates the RSW Regional Jail, located at 6601 Winchester Road, Front Royal, Virginia, 22630. As used herein, RSW Regional Jail shall refer to the authority and the jail itself.

22. Defendant William T. Wilson was Superintendent of the RSW Regional Jail at the time of the incident, and through March 26, 2017. At that time, he was replaced as Superintendent by Russell W. Gilkison. As Superintendent of the RSW Regional Jail at the relevant time, Defendant Wilson had ultimate power and control over the medical care and attention, if any, provided to the inmates at RSW Regional Jail. Defendant Wilson is sued in his individual and official capacity for developing, maintaining and enforcing knowingly deficient policies, practices, and customs in medical care and drug addiction treatment for inmates who are drug dependent, and/or are at an increased medical risk. These policies and practices were applied to Brendon, and violated Brendon's constitutional rights and caused Brendon's death. Defendant Wilson is also sued because he is the governmental official whose edicts and acts represent the official policy, practices, customs and regulations of the RSW Regional Jail, and those policies, practices, customs, and regulations violated

Brendon's constitutional rights and caused Brendon's death. At all relevant times, Defendant Wilson was also responsible for the misconduct, acts, and omissions of his employees, agents, and/or servants. Defendant Wilson is upon information and belief an adult Citizen of the Commonwealth of Virginia. Defendant Wilson is sued in his individual and official capacities.

23. Defendant Officer Thomas Ratigan is upon information and belief an adult Citizen of the Commonwealth of Virginia and was at all relevant times an employee of the RSW Regional Jail, acting within the scope of his employment and under color of law. Defendant Ratigan is sued in his individual capacity.

24. Defendant Officer Jacob Medina is upon information and belief an adult Citizen of the Commonwealth of Virginia and was at all relevant times an employee of the RSW Regional Jail, acting within the scope of his employment and under color of law. Defendant Medina is sued in his individual capacity.

25. Defendant Penny Holt is upon information and belief an adult Citizen of the Commonwealth of Virginia and was at all relevant times an employee of Defendant RSW Regional Jail. At the time of the incident, Defendant Holt was the Director of Nursing at RSW Regional Jail. Defendant Holt was at all relevant times acting within the scope of her employment and under color of law. Defendant Holt is sued in her individual capacity.

26. Defendant Nurse Ashley Jones is upon information and belief an adult Citizen of the Commonwealth of Virginia and was at all relevant times an employee of Defendant RSW Regional Jail. Defendant Jones was at all relevant times acting within the scope of her employment and under color of law.

27. Defendant Paxtynn E. Scott Williams is upon information and belief an adult Citizen of the Commonwealth of Virginia and was at all relevant times an employee of Defendant RSW Regional Jail, acting within the scope of her employment and under color of law. Defendant Scott-

Williams is sued in her individual capacity.

28. Defendants Nurse Penny Holt, Nurse Ashley Jones and Paxtynn Scott-Williams, and John and Jane Does 1-10, are referred to collectively as "Jail Medical Staff." These Defendants were employed as healthcare providers by the RSW Regional Jail.

29. Defendants Officer Ratigan, Officer Medina, and John and Jane Does 1-10, are referred to collectively as "Correctional Staff." These Defendants were employed as corrections officers by the RSW Regional Jail.

30. The true names and identities of John and Jane Does 1-10 are presently unknown to Plaintiff. Upon information and belief, at all relevant times herein John and Jane Does 1-10 were employees, agents and/or servants of the RSW Regional Jail, acting at all relevant times within the scope of their employment or agency and under color of law. Upon information and belief, John and Jane Does 1-10 include, *inter alia*, guards, correctional officers or other law enforcement officials, supervisors, managers, jail commanders, medical directors, health services administrators, doctors, nurses, pharmacists, and other health care professionals.

31. Upon information and belief, the Defendants above, including those named as well as John and Jane Does 1-10 acted with deliberate indifference, as well as reckless disregard, to Brendon's serious medical needs and safety, failed and/or delayed providing medical care to Brendon, violated Brendon's civil rights, wrongfully caused Brendon's death, and/or encouraged, directed, enabled, and/or ordered other defendants to engage in such conduct. John and Jane Does 1-10 are being sued in their respective individual. Plaintiff will seek to amend this Complaint after the true names and identities of John and Jane Does 1-10 are ascertained.

FACTS

Background of RSW Regional Jail Medical Staffing

32. Located at 6601 Winchester Road, Front Royal, Virginia, the RSW Regional Jail

opened in July 2014 with an initial capacity for 375 inmates. At all relevant times, the jail contained cells and dormitories to house inmates. It also had support space which includes food service, laundry, intake and release, medical services, recreation and education, central storage, visitation, magistrate, administration, and staff services.

33. The initial staffing plan for the 375 bed jail included approximately 149 employees in the building each day covering shifts for the 24 hour facility.

34. The approximate average daily inmate population for the period from the opening of the facility through July 1, 2015, was 320 inmates.

35. RSW Regional Jail purports to provide medical care pursuant to standards prescribed by the American Medical Association and the Virginia Department of Corrections. However, at all relevant times, the RSW Regional Jail was inadequately staffed with medical providers and was unable and unwilling to provide an adequate and Constitutional level of medical care to inmates like Brendon demonstrating a serious medical need.

36. The RSW Regional Jail's lack of healthcare staffing is evident from the RSW Regional Jail Authority's Finance and Personnel Committee ("F&P Committee") meeting minutes, which reveal the jail's grossly insufficient staffing in the year prior to and up to the incident.

37. As early as the April 23, 2015 F&P Committee minutes, Defendant Holt indicated that, due to the lack of nurses, they were "struggling to get intake screens done within three days of booking."

38. Between April 2015, and the date of the incident, the F&P Committee minutes frequently discuss this nursing shortage as well as the difficulties the RSW Regional Jail experienced in hiring nurses—essentially because they did not want to pay for them.

39. The August 27, 2015, F&P Committee minutes noted that three persons had been offered the posted [Licensed Practical Nurse] LPN position, but that all three declined due to the

salary level offered.

40. The September 24, 2015, minutes of the F&P Committee state that "***RSW had gone from crisis mode to a critical shortage of nursing staff. Nursing hours have been cut due to a lack of staff and established guidelines … are not being met.***" (emphasis added).

41. The minutes of that meeting state that: "[d]ue to the critical situation of the nursing vacancies staff solicited emergency proposals for temporary staff from three medical staffing companies. Two companies respond back with proposals. The cost for a LPN is approximately $37-45 per hour; however, a Med Tech is $32 per hour."

42. A Med Tech, also known as a medication aide, is not a nurse and cannot provide medical care to inmates. Rather, a Med Tech would be used at the facility, in lieu of nurses, to hand out medications at "med passes," twice daily. According to Nurse Holt, this purportedly "would allow current staff to focus on ensuring that intake screening and sick calls are done in a timely manner until we can fill the vacancies."

43. Sweeping aside the critical nursing shortage on the basis of purely financial considerations, RSW Regional Jail, at Defendant Wilson's direction, opted to contract a (non-nurse) Med Tech for $32 per hour rather than the LPN (Licensed Practical Nurse) for $37-45 per hour.

44. The November 19, 2015, minutes of the F&P Committee indicate that a contracted Med Tech started work at the facility on October 8, 2015. The January 28, 2016, F&P Committee minutes note that, on December 7, 2015, the contracted Med Tech was converted to be an RSW Regional Jail employee. A new LPN/RN had reportedly also started at the facility on November 17, 2015. However, another LPN/NR position was still vacant and the facility was still understaffed.

45. Presciently, in the January 28, 2016, F&P Committee minutes, Defendant Penny Holt noted an ***"increase in individuals needing withdrawal protocols, which increases services requiring medications. Heroine [sic] and opiates are the primary withdraws[] that***

are being seen." **(emphasis added).**

46. While not mentioning Brendon's name or (remarkably) referencing the incident in any way, the February 25, 2016, F&P Committee minutes (the first such meeting after Brendon's death) make clear that the RSW Regional Jail was facing a crisis, stating bluntly:

> Since [Defendant Holt] began in February 2015 Medical has only been fully staffed for approximately six to eight weeks. … . ***Ms. Holt has tried to do some creative scheduling, but cannot meet all needs.*** The Jail will be down another LPN position beginning February 27th when a LPN goes on leave for four to six weeks. There are a few options for this ***crisis.*** An agency LPN can be used to work the 2:00 pm - midnight shift. A LPN can be moved to work the evening shift Monday through Friday, but that leaves no coverage on the weekend. ***This creates a big vulnerability due to weekends being the time of greater intakes and potential for those with substance abuse to withdraw and those on vital medication such as insulin not getting screened until the next day. Offering overtime to the two remaining LPN's would not be enough to cover the two vacancies***. Currently, the Medical Technician is working Monday through Friday and covering every other Saturday so that Ms. Holt can see patients and do intake screenings.

(emphasis added)

47. RSW Regional Jail was critically short-staffed and unable to provide needed care immediately prior to and at the time of Brendon's death.

48. Defendant Wilson was fully aware of the critical nursing vacancies, but did nothing to remedy them because he prioritized finances over the provision of adequate medical care.

49. Defendant Wilson was present at the F&P Committee meetings, including the meetings discussed above wherein medical staff shortages were discussed, and actually provided updates on nurse hiring. At the August 27, 2015 meeting, discussed above, the issue was so central that Defendant Wilson's Superintendent's "Monthly Report" specifically included a "Nursing Staff Update." In that report, Defendant Wilson reported that they had "conducted six interviews for the Licensed Practical Nurse (LPN) position, three were not eligible. The position was offered to the other three, but all three declined due to the offered salary. Further, another nurse has recently put

in her resignation letter and plans to go to Loudoun County due to salary."

50. Upon information and belief, immediately prior to the incident, RSW Regional Jail's medical department was critically understaffed.

51. RSW Regional Jail did not have a doctor on staff. Instead of employing a doctor, RSW Regional jail contracted with a third-party, Mediko, P.C., for a contracted physician to remain on call to provide nursing staff with medical assistance when requested. The contract physician would go to RSW Regional Jail once a week (on Wednesday) for four hours, to provide medical care to a list of inmates provided by medical staff.

Brendon Sullins' Background

52. Brendon Sullins was born on March 15, 1989, in Front Royal, Virginia, to Garry and Joanie Sullins.

53. Brendon's mother, Joanie Sullins, the Plaintiff in this case, adored her son Brendon,

and fondly remembers Brendon playing with his older brother as children. The brothers were very close.

54. Brendon was a very active child with many friends. He rarely sat still, and was always busy. He loved the water, and could frequently be found swimming at the pool or in the Shenandoah River.

55. He attended Warren County High School, and remained in Front Royal, Virginia, his whole life.

56. The most important thing in Brendon's life was his two daughters, MF and BS, who were the loves of his life.

57. Brendon provided for his daughters, and did his best to give them whatever he could. Brendon loved taking them to his friend's farm, outside Front Royal, to see the animals, and to play in the waters of the Shenandoah River.

58. Prior to his death, Brendon worked for Valley View Landscaping, where he had a great bond with, and great respect for, his boss.

59. Brendon Sullins was only 26 years old when he died as a result of Defendants' deliberate indifference to his serious medical needs, when Defendants failed to provide him with needed hydration and medical care, causing his death.

Brendon Sullins' Arrest and Death in Custody

60. Brendon was arrested by the Front Royal Police Department in the very early morning hours of February 10, 2016, and charged with Possession of Narcotics. He was held without bond and placed into the complete custody, control, care and protection of the Jail Medical Staff and Correctional Staff of the RSW Regional Jail in Warren County, who were at all relevant times acting under color of law.

61. Mr. Sullins was booked into the RSW Jail on Wednesday, February 10, 2016, at 1:50

am. At intake, Brendon's interviewer checked "Yes" to "Are you currently under the influence of any drugs or alcohol?" and typed "[heroin] 12:00 PM on 2/09/2016." She further checked "Yes," to "Inmate appears to be under the [influence] of drugs or alcohol" and typed "herion." [sic]. The Medical History and Assessment form, dated February 10, 2016, lists Heroin, IV [intravenous], taken 1 gram every 1-2 days. The form was signed by Brendon and Defendant Nurse Jones, as well as by John Doe, M.D.

62. By 11:00 am the next day, February 11, 2016, Brendon had started to show symptoms of heroin withdrawal, including nausea, vomiting, and diarrhea.

63. Brendon reported to Defendant Nurse Jones at 11:00 am, on February 11, 2016. He complained of [nausea, vomiting] and one episode of diarrhea. He stated that he could not sleep, that he last did heroin at 2/10/2016, at 0000, and that he "usually does a gram, 2-3 times per day." His vital signs were 132/79, [heart rate] 86 [respiratory rate] 16 [temperature] 98.^{0}F [oxygen] 98% RA. Per the withdrawal protocol, he was prescribed and given 25 mg of Phenergan and 2 mg of Imodium, placed on the withdrawal protocol, and referred from general population to cell 5 of the medical unit.

64. Defendant Nurse Jones also completed a Physician Communication Form on February 11, 2016, stating "Response Needed," and listed the concern as "New patient on heroin withdrawal: -Phenergan 25 mg 1 tablet PO Q6 PRN x 4 days; - Imodium 2mg PO Q6 PRN x 4 days; - Clonidine per protocol if BP is >= 140/110." ***No physician response/order is filled in, and no physician signed the form.***

65. Cell 5 of the medical unit is monitored by video camera. The video feed shows live feed to the staff at the jail, but only records movement when the camera senses motion. There is no audio.

66. From the time Brendon was placed in Cell 5 until after his death, his movements

were recorded by video. This graphic video shows Brendon's last hours, and clearly demonstrates the pain and suffering he experienced, and the deliberate indifference of Corrections Staff (occasionally present in his cell) and Jail Medical Staff (who could see him on video) who uniformly ignored his suffering and failed to provide needed hydration and medical care.

67. Brendon was placed into Cell 5 on February 11, 2016, at approximately 2:57 pm. Starting at this time, Brendon, who was in the midst of acute opiate withdrawal, can be seen in his cell vomiting, attempting to vomit, attempting to drink water, and interacting with other persons who enter his cell, including Corrections Staff and Jail Medical Staff.

68. On February 12, 2016, Brendon continued to suffer, and can frequently be seen on video vomiting and sitting on the toilet in his cell. From the video, it is apparent that Brendon experienced diarrhea on February 12, 2016, because he can frequently be seen sitting on the toilet, and wiping inside his pants—giving the clear impression that he had an accident.

69. Defendant Officer Medina reported that he took Brendon to the nurse about halfway through the day on Friday, February 12, 2016, because Brendon had complained that he could not move his hands. Defendant Officer Medina demonstrated to an investigator, post-incident, the appearance of Brendon's hands, and indicated that, during the visit, Defendant Nurse Holt moved Brendon's hands, reported that she saw his hands move, and then gave Defendant Officer Medina a look like there was nothing wrong with him. Defendant Nurse Holt then said it was just [withdraws] [sic] going through him.

70. Defendant Officer Medina told the investigator, post-incident, that every time he saw Brendon after this visit, Brendon's hands were still in the same cramped position. In spite of the fact that this continued, neither he, nor other Corrections Staff, reported this, or Brendon's continued vomiting and diarrhea of which they were aware, to anyone again until after Brendon's death.

71. A handwritten nurse's note from approximately 11:10 am, February 12, 2016, signed by Defendant Penny Holt, states:

> [Patient] stated he was short of breath and continued to have nausea and diarrhea. [Officer] brought [patient] to medical was pale, skin warm, ***dry***, no obvious [respiratory] distress. [Vital Signs--] 143/86 84, 18, 98[4]. Sa02 98%. [Breathing] clear, no cough noted. [Capillary] refill brisk; [patient] states he feels so sick; explained to […] that he was going through withdrawal from opiates. Stated that he has been dosing 1-2 grams per day for 'quite some time.' ***Will continue with withdrawal protocols and monitor.*** P Holt RN

(emphasis added).

72. In actuality, as Brendon had previously reported to Nurse Jones at 11:00 am on February 11, 2016, his actual dosage was 2-3 grams a day (which was in Brendon's records).

73. While the withdrawal protocol (and the applicable standard of care for persons going through withdrawal) required that a detainee's blood pressure is to be checked once every nurse's shift, there is no further medical record of Brendon's vital signs being taken after this encounter even though he remained in this cell until his death almost 24 hours later.

74. Brendon's vital signs were not taken once every nurse's shift, as required.

75. From February 12, 2016, until his death, Brendon's hands frequently appeared in the video to be misshapen and cramped into a claw-like shape, tell-tale signs of Brendon's increasing dehydration. During this time as his dehydration became more and more acute, he followed a course which would have been seen in his vital signs: His heart rate would have increased, his blood pressure would have declined, and he would have been breathing faster than normal.

76. Given his diarrhea, vomiting, and inability to drink (and keep down) water, dehydration would be expected. Brendon complained to staff numerous times about his stomach pain and diarrhea, but the Correctional Staff and Jail Medical Staff did nothing.

77. Brendon's medical orders, filled out by Defendant Nurse Jones on February 11, 2016, stated "New patient on heroin withdrawal" and ordered "Phenergan 25 mg 1 tablet PO Q6

PRN x 4 days; - Imodium 2mg PO Q6 PRN x 4 days; - Clonidine per protocol if BP is >= 140/110."

78. Phenergan (Promethazine) is used to treat and prevent nausea and vomiting. Imodium is an anti-diarrheal. "PRN" means that they should be taken "pro re nata," or, as needed. These drugs are meant to prevent vomiting and diarrhea, which can, as they did here, lead to dehydration and death. Nurse Jones thus recognized that Brendon was at risk for dehydration as the result of withdrawals.

79. Nonetheless, once he was brought to his cell, neither Corrections Staff nor Jail Medical Staff reported Brendon's complaints, or assessed his physical condition.

80. As Brendon's condition went from bad to worse, the Correctional Staff and Jail Medical Staff did little but watch him suffer. Throughout his incarceration and until the time of his death, he received infrequent, ineffective medical care, and never saw a doctor.

81. He was placed by nurses on the RSW Regional Jail's withdrawal protocol, but Jail Medical Staff failed to monitor him (by for example, assessing his vital signs every nurse's shift, or even confirming that he was taking fluids and his prescribed medications).

82. In fact, at least by the day of his death, Brendon could not swallow the prescribed medication that was brought in the morning. Defendant Officer Medina admitted in his interview with investigators that Brendon "usually threw up the medication because he was nauseous," and that Brendon threw up the medication administered on the morning of February 13, 2016.

83. This was observed by both Defendant Officer Medina and Defendant Paxtynn Scott-Williams, the nurse tech who brought the medication at approximately 7:00 a.m.

84. Defendant Paxtynn Scott-Williams told investigators that she relied on inmate self-reporting of symptoms to determine which medication to provide.

85. Both Defendant Officer Medina and Defendant Paxtynn Scott-Williams failed to

report to medical staff that Brendon usually threw up his medication, and that he had thrown up his medication on February 13, 2016.

86. While the fact that Brendon was vomiting and experiencing diarrhea is evident based on the video of his cell, these Defendants' failure to report that Brendon was not taking his medication, along with the failure of Jail Medical Staff to monitor Brendon and take his vital signs once every nurse's shift, was yet another failure that contributed to Brendon's deteriorating condition and death. If Brendon's dehydration had been treated at any time during his incarceration, Brendon's death would have been prevented. The lack of a simple IV stood between life and death for Brendon.

87. Less than 10 minutes before Brendon is recorded moving for the very last time in his life, he was sitting on the toilet in his cell with his hands cramped up, when his legs quickly straighten out and he appears to suffer some sort of muscle spasm before falling off the toilet with his pants down and his lower body fully exposed.

88. After he falls, Defendant Officer Ratigan looks in on him, lying face down on the floor, and walks off before returning and appearing to communicate something to him, and walking away again.

89. Jail records reveal that Defendant Officer Ratigan went to Defendant Nurse Penny Holt to report Brendon's condition. Rather than going to Brendon's cell to evaluate him in person, Defendant Nurse Penny Holt merely looked at the monitor, and callously told Officer Ratigan to tell Brendon to put his pants back on.

90. As the surveillance video clearly shows, after falling off the toilet, Brendon managed to sit up only briefly, for less than 30 seconds, before falling down again. He continued to writhe around in obvious pain and distress for approximately two minutes, then, abruptly, stopped moving.

91. Brendon, in fact, never moved again.

92. Approximately 2 hours later, Defendant Officer Medina brought Brendon's lunch into his cell and found him lying, dead, on the floor of his cell, with his pants around his ankles and his lower body fully exposed.

93. Brendon was pronounced dead by medic unit # 1122 Elizabeth Grubbs at 11:19 am on February 13, 2016. Due to the length of time Brendon had been dead in his cell before being discovered, rigor mortis had already set in.

94. Notably, Brendon's death occurred on a Saturday. Defendant Penny Holt, herself, recognized that weekends were the "big vulnerability" at the jail due to the lack of nursing staff available at that time and the numbers of persons with substance abuse who undergo withdrawals during weekends.

95. The final entry in Brendon's medical chart, created after his death by Penny Holt, RN, lists the "visit date" as February 13, 2016, at 11:00 am, and the "record created" date of February 17, 2016, at 4:14 pm, and states:

> Inmate Sullins came to Medical Observation on February 11th after being assessed by Nurse Jones in intake. Patient was placed on opiate withdrawal protocol which included Phenergan and Imodium. Last dose of Phenergan and Imodium was at 0700 this am. Patient has been seen at intervals on the camera up to bathroom and taking fluids. Patient had also begun removing his clothing and refused officers wear clothing. Incident: At approximately 1050, I was called for an emergency call by Ofc. Medina in Medical Observation Room 5. Upon arrival patient was found to be in rigor, cold, without respiration. CPR immediately begun by myself and called staff to contact EMS with a Code Blue. I asked staff to get AED and Ofc. Medina began respiration. It is noted that the patient was found without clothing and off the mat when we arrived on the scene. AED was placed on patient by me and analysis began, CPR was stopped and all clear. Analysis was recorded as "no shock advised" and CPR continued. As CPR continues, I called contacted Dr. Tripp at Warren Memorial to advise that the patient was without respiration or pulse and that the patient was in rigor. He stated that EMS would take over when they arrived. Medical chart was reviewed while talking with Dr. Tripp on the phone. EMS arrived, took over the scene and pronounced patient at the scene. Room was secured by officers. Dr. Teklu, Medical Director, RSW was notified of death.

96. Notably, this note does not mention the February 12, 2017, encounter, when

Brendon was brought in to see Defendant Nurse Holt, and the officer who brought him in indicated that Brendon was complaining about his hands (which she denied).

97. Defendant Penny Holt, herself, recognized that was already "dry" at the time of that visit, as she documented at that time.

98. This later note also misleadingly reports that Brendon's "[l]ast dose of Phenergan and Imodium was at 0700 this am" without noting that he spit this medication out as he was unable to swallow it; and that he was seen "at intervals on the camera up to the bathroom and taking fluids" without noting that he ***suffered from vomiting and diarrhea the entire time he was in the cell***.

99. Brendon's death certificate lists the immediate cause of death as "complications of opiate withdrawal."

100. The pathological diagnoses in the autopsy report include post-mortem laboratory values demonstrating that Brendon suffered acute renal failure and fatal electrolyte derangement. Brendon's potassium and kidney labs were off the charts, and likely to cause heart failure. The diagnoses include: "Isonatremic dehydration." This diagnosis, combined with his lab values (documented post-*mortem*), indicate that Brendon became increasingly dehydrated during his stay at RSW Regional Jail, and the Brendon's serious medical need would have been evident to everyone who saw him.

101. If Brendon's medical condition was properly assessed, and medical care provided during the time he was at RSW Regional Jail, including but not limited to treatment for dehydration including an IV of simple saline, his death would have easily been avoided.

COUNT I

Deprivation of Brendon Sullins' 14th Amendment Rights to Adequate Medical Care, Safe Conditions of Confinement, Personal Security, Physical Integrity and Privacy
(Brought Under 42 U.S.C. § 1983 against Defendants Ratigan, Medina, Holt, Jones, Scott-Williams, & John and Jane Does 1-10, in their individual capacities)

102. The allegations in all prior paragraphs are incorporated by reference as though fully set forth herein.

103. This Count arises under 42 U.S.C. § 1983, and is alleged against Defendants Ratigan, Medina, Holt, Jones, Scott-Williams, & John and Jane Does 1-10, jointly and severally, for their actions which amount to deliberate indifference to Brendon's serious medical needs. These Defendants refused to safeguard Brendon Sullins and protect him from serious medical harm, thereby causing the deprivation of Brendon's constitutional rights to personal security and protection under the Fourteenth Amendment to the Constitution.

104. At all times referenced in this Count, Defendants Ratigan, Medina, Holt, Jones, Scott-Williams, & John and Jane Does 1-10 were acting under color of the laws of the Commonwealth of Virginia.

105. Defendants Ratigan, Medina, Holt, Jones, Scott-Williams, & John and Jane Does 1-10, were responsible for providing Brendon Sullins, who was in their custody and control, with appropriate medical care in a safe environment while he was confined pursuant to their authority. Defendants took complete custody of, and exerted physical control over, Brendon. Thus, there was created a special relationship between Brendon, on the one hand, and Defendants, on the other hand.

106. That special relationship and the responsibility for providing reasonably safe conditions of Brendon's custody and confinement imposed upon Defendants the obligation to protect Brendon—throughout his custody and confinement—from deprivation of his clearly-

established constitutional rights to personal security, physical integrity and personal privacy under the Due Process Clause of the Fourteenth Amendment to the Constitution.

107. Brendon was at all times a pre-trial detainee at the RSW Regional Jail, and was therefore owed the protections of due process of law pursuant to the Fourteenth Amendment to the U.S. Constitution. Detainees are constitutionally entitled to incarceration in an environment that offers reasonable protection from harm. With regard to pre-trial detainees, the Supreme Court has indicated that Fourteenth Amendment also prohibits imposing conditions or practices on detainees that are not reasonably related to the legitimate governmental objectives of safety, order and security. *Bell v. Wolfish*, 441 U.S. 520 (1979).

108. During Brendon's detention at the RSW Regional Jail, he was placed in a medical cell, denied access to medical attention, and was unable to seek outside medical attention himself due to his medical deteriorating medical condition. Although Defendants Ratigan, Medina, Holt, Jones, Scott-Williams, & John and Jane Does 1-10 knew that Brendon's medical condition demanded constant surveillance, supervision, and intervention, they were deliberately indifferent to these needs.

109. Defendants Ratigan, Medina, Holt, Jones, Scott-Williams, & John and Jane Does 1-10 also acted with deliberate indifference, and conscious-shocking indifference, as well as reckless disregard to Brendon's serious medical needs, rights and safety by: failing to adequately supervise him when he was suffering from opiate withdrawal and dehydration in his cell, by failing to assess his medical condition in the face of obvious serious medical need, by failing to report his medical condition to a doctor or other qualified professional; and by denying him the medical attention he requested and/or demonstrably needed, including by withholding needed medication and hydration to him, and by failing to send him for medical care as his medical condition deteriorated further. Their actions consisted of willful and wanton conduct, and recklessness that evinces a conscious

disregard for the safety of others.

110. Defendants Ratigan, Medina, Holt, Jones, Scott-Williams, & John and Jane Does 1-10 were subjectively aware that Brendon was suffering in his cell. His condition was plainly visible to Correctional Staff, present in his cell at various times, and Jail Medical Staff, who were able to and did monitor the video feed from his cell.

111. Defendants Ratigan, Medina, Holt, Jones, Scott-Williams, & John and Jane Does 1-10 acted with deliberate indifference and conscience-shocking indifference, as well as reckless disregard, to Brendon's serious medical needs, rights and safety by intentionally denying Brendon medical care consistent with the applicable standards of care, despite their awareness that he was suffering in his cell and his condition was deteriorating. Their actions consisted of willful and wanton conduct, and recklessness that evinces a conscious disregard for the safety of others.

112. The conduct by Defendants Ratigan, Medina, Holt, Jones, Scott-Williams, & John and Jane Does 1-10 constituted deliberate indifference and outrageous indifference on the part of Defendants to the known and foreseeable dangers and substantial risk of harm that Brendon was exposed to while in the custody and care of Defendants.

113. The conduct by Defendants Ratigan, Medina, Holt, Jones, Scott-Williams, & John and Jane Does 1-10 constituted deliberate indifference to Brendon's personal security, physical integrity, privacy and serious medical needs. Defendants' misconduct in fact created or exacerbated the danger to Brendon, because he was prevented from seeking medical care outside of the RSW Regional Jail due to his incarceration.

114. Defendants abused their authority by acting with deliberate indifference to, and with reckless, willful and callous disregard for, the known substantial risk of injury to Brendon, in deprivation of his constitutional rights, which is shocking to the conscience.

115. As a direct and proximate result of the foregoing deliberate indifference on the part

of Defendants Ratigan, Medina, Holt, Jones, Scott-Williams, & John and Jane Does 1-10 acting under color of the laws of the Commonwealth of Virginia, Brendon suffered serious physical and emotional injury, pain and suffering, consciousness of his own impending death, and death.

116. For the foregoing deprivations of Brendon's rights to personal security, physical integrity and privacy, Defendants are liable in their individual capacities for compensatory damages, including sorrow, mental anguish, and solace (which may include society, companionship, comfort, guidance, kindly offices and advice of the decedent), the reasonably expected loss of income of income of the decedent, and loss of services, protection, assistance and care provided by Brendon, reasonable funeral expenses, as well as for punitive damages and reasonable attorneys' fees and costs, as permitted under 42 U.S.C. §§ 1983 and 1988.

WHEREFORE, Plaintiff Joanie C. Sullins, Individually and as Personal Representative of the Estate of Brendon Garrett Sullins, requests that the Court enter judgment in her favor and against Defendants Ratigan, Medina, Holt, Jones, Scott-Williams, & John and Jane Does 1-10, jointly and severally, as follows: (1) for compensatory damages in the amount of $5,000,000.00, which amount shall be proven at trial; (2) for reasonable attorneys' fees and costs, as permitted under 42 U.S.C. § 1988; (3) pre- and post-judgment interest; (4) for punitive damages to the fullest extent permitted by law; and (5) for such other and further relief as this Court may deem just and proper.

COUNT II

Deprivation of Brendon Sullins' 14th Amendment Rights to Adequate Medical Care, Safe Conditions of Confinement, Personal Security, Physical Integrity and Privacy —*Supervisory Liability*
(Brought Under 42 U.S.C. § 1983 against Defendants William T. Wilson, in his individual and official capacity, and the RSW Regional Jail Authority)

117. The allegations in all prior paragraphs are incorporated by reference as though fully set forth herein.

118. This Count is brought against Defendants RSW Regional Jail Authority, and William

T. Wilson, the Superintendent of the RSW Regional Jail, in his individual and official capacity (together, "Supervisor Defendants").

119. As the highest-ranking officer at RSW Regional Jail, Wilson oversaw the creation and implementation of RSW Regional Jail's policies, procedures, and customs with regard to the provision of medical care. The Public Entity Defendants' acts and edicts constituted official policy.

120. This Count arises under 42 U.S.C. § 1983 and the Fourteenth Amendment of the U.S. Constitution.

121. In his capacity as the Superintendent of the RSW Regional Jail, Defendant Wilson had the ultimate responsibility and duty to properly hire, train, and supervise jail staff, including medical staff, so as to provide for Brendon's and similarly situated detainees' medical needs and safety.

122. The violations of Brendon's civil rights as well as the deliberate indifference and reckless disregard to Brendon's and similarly situated detainees' medical needs and safety, as set forth herein, were the direct and proximate results of the Supervisor Defendants' failure to properly hire, train, and supervise jail staff, including medical staff.

123. The Supervisor Defendants had actual or constructive knowledge that jail medical staff was engaged in conduct that posed a pervasive and unreasonable risk of constitutional injury to pretrial detainees like Brendon.

124. For example, the F&P Committee minutes for roughly a year prior to the incident recognized that there was a critical nursing shortage, causing the jail medical staff to struggle to get intake screens done, to fail to meet set standards, and to perform sick calls, on a timely basis.

125. Given the number of detainees at the RSW Regional Jail, these obvious shortcomings would inevitably lead to a pervasive, unreasonable risk that detainee's serious medical needs would be ignored, as Brendon's were.

126. On September 24, 2015, these minutes report Defendant Holt's statements that the RSW Regional Jail was in "crisis mode," with a "critical shortage of nursing staff," and that "Nursing hours have been cut due to a lack of staff and established guidelines by Mediko are not being met." Defendant Wilson was present at this, and other such meetings (described above).

127. However, when contracts were solicited to fill this need with either a less expensive Med Tech (not a nurse), or a marginally more expensive LPN (a nurse), the Supervisor Defendants opted to combat the nursing shortage by hiring a non-nurse Med Tech.

128. The Supervisor Defendants' response to their knowledge of the RSW Regional Jail's nursing shortage was thus so inadequate as to show deliberate indifference to Brendon's serious medical needs, and tacit authorization of the practices that violate the Constitution.

129. In spite of the Supervisor Defendants' knowledge of the critical nursing shortage, additional nurses were not hired due, in part, to the fact that the Supervisor Defendants' offered an uncompetitive salary to potential employees, and a contract LPN was considered too expensive.

130. The Supervisor Defendants' conduct, in failing to properly hire, train, and supervise jail medical staff showed deliberate indifference to Brendon's serious medical need and proximately caused Brendon's death.

131. The lack of nurses contributed to Brendon's death because there were not enough nurses at RSW Regional Jail to perform intakes, cover sick calls, and properly monitor and assess the ongoing physical condition of detainees like Brendon who were in a medical cell.

132. The Supervisor Defendants were aware of the deficiencies alleged in this Complaint, but failed to take effective measures to remedy such deficiencies.

133. For example, the Supervisor Defendants were present at the committee meetings where the critical nursing shortage was discussed, and Defendant Wilson actually provided updates on this nursing shortage, but failed to hire addition nurse or otherwise meet detainees' needs.

134. The Supervisor Defendants' acts and failures to act amount to deliberate indifference to the health and safety of Brendon and other of RSW Regional Jail's detainees, in violation of the rights, privileges, or immunities if those persons as secured or protected by the Constitution of the United States, including the Fourteenth Amendment thereto. Such deliberate indifference was the cause of the violations of Brendon's constitutional rights as set forth herein and the proximate cause of the injuries he suffered.

135. The Supervisor Defendants knew that inmates and detainees like Brendon, who was suffering from opiate withdrawals and in serious need of immediate medical attention and ongoing supervision for drug dependence and withdrawal, were not receiving mandated care and supervision. Because of these medical needs and his recent detention, Brendon faced a serious medical need, and the Supervisor Defendants' were obligated to take all reasonable measures under the circumstances to obtain prompt and/or immediate emergency medical treatment for Brendon's medical needs, including withdrawal treatment, hydration, medication and outside medical care.

136. The Supervisor Defendants knew that their actions and/or failures to act placed Brendon in substantial risk of severe pain, mental anguish, distress, serious physical injury, and death.

137. In so acting and/or failing to act, the Supervisor Defendants displayed deliberate indifference and deprived Brendon and similarly situated detainees of their clearly-established constitutional right to necessary medical care and treatment applicable to detainees (under the Fourteenth Amendments and the constitutional right to due process).

138. The Supervisor Defendants' actions and inactions constituted willful and wanton conduct, and recklessness that evinces a conscious disregard for the safety of others.

139. As a direct and proximate result of the Supervisor Defendants intentional, willful, and callous disregard of his serious need for necessary and competent medical treatment and

supervision, Brendon was subjected to severe pain, mental anguish, distress, serious physical injury, and death, which were a direct and proximate result of the Public Entity Defendants' customs, policies, and/or practices.

WHEREFORE, Plaintiff Joanie C. Sullins, Individually and as Personal Representative of the Estate of Brendon Garrett Sullins, requests that the Court enter judgment in her favor and against Defendants RSW Regional Jail Authority, and William T. Wilson, the Superintendent of the RSW Regional Jail, in his individual and official capacity, jointly and severally, as follows: (1) for compensatory damages in the amount of $5,000,000.00, which amount shall be proven at trial; (2) for reasonable attorneys' fees and costs, as permitted under 42 U.S.C. § 1988; (3) pre- and post-judgment interest; (4) for punitive damages to the fullest extent permitted by law; and (5) for such other and further relief as this Court may deem just and proper.

COUNT III

Deprivation of Brendon Sullins' 14th Amendment Rights to Adequate Medical Care, Safe Conditions of Confinement, Personal Security, Physical Integrity and Privacy —*Monell* Claim
(Brought Under 42 U.S.C. § 1983 against Defendants William T. Wilson in his individual and official capacity, and the RSW Regional Jail Authority)

140. The allegations in all prior paragraphs are incorporated by reference as though fully set forth herein.

141. This Count is brought against Defendants RSW Regional Jail Authority, and William T. Wilson, the Superintendent of the RSW Regional Jail, in his individual and official capacity (together, the "Public Entity Defendants").

142. As the highest-ranking officer at RSW Regional Jail, Wilson oversaw the creation and implementation of RSW Regional Jail's policies, procedures, and customs with regard to the provision of medical care. The Public Entity Defendants' acts and edicts constituted official policy.

143. This Count arises under 42 U.S.C. § 1983 and the Fourteenth Amendment of the U.S. Constitution.

144. The violations of Brendon's civil rights as well as the deliberate indifference and reckless disregard to Brendon's and similarly situated detainees' medical needs and safety, as set forth herein, were the direct and proximate results of the Public Entity Defendants' then-existing customs, policies, and practices. The Public Entity Defendants expressly or tacitly encouraged, ratified, and/or approved of the acts and/or omissions alleged herein, and knew or should have known that such conduct was unjustified and would results in violations of Constitutional rights.

145. These customs, policies, and practices constituted the Public Entity Defendants' standard operating procedures.

146. Such policies, customs, and/or practices constitute an ongoing pattern of deliberate indifference and reckless disregard to the health needs and safety of RSW Regional Jail detainees comprised of, *inter alia*; the failure to maintain healthcare staffing sufficient to provide for the health and safety needs of at-risk inmates and detainees, including the failure to provide adequate health care and treatment, the failure to take necessary steps to supply adequate health care; the failure to properly hire, train, or staff an adequate number of RSW Regional Jail medical professionals; the prioritization of finances over inmate medical care, the failure to properly train and/or supervise RSW Regional Jail medical and non-medical staff regarding the identification and treatment of severely ill, drug-addicted detainees; the failure to properly assess the health of severely ill, drug-addicted detainees, during their incarceration; the failure to comply with medical professionals' judgments and/or orders regarding tests, medications, and/or procedures for severely ill, drug-addicted detainees; the policy or custom of refusing to transport severely ill, drug-addicted detainees outside the RSW Regional Jail for hospital treatment; and the policy, custom, or practice of inadequately staffing the RSW Regional Jail locations severely ill, drug-addicted detainees are

permitted to be housed.

147. The Public Entity Defendants were aware of the deficiencies alleged in this Complaint, but failed to take effective measures to remedy such deficiencies.

148. The Public Entity Defendants knew that their inadequate medical care and treatment had resulted and would continue to result in potential and actual serious physical harm to inmates and detainees.

149. The Public Entity Defendants knew that inmates and detainees like Brendon, who was suffering from opiate withdrawals and in serious need of immediate medical attention and ongoing supervision for drug dependence and withdrawal, were not receiving mandated care and supervision. Because of these medical needs and his recent detention, Brendon faced a serious medical need, and the Public Entity Defendants were obligated to take all reasonable measures under the circumstances to obtain prompt and/or immediate emergency medical treatment for Brendon's medical needs, including withdrawal treatment and medication and outside medical care.

150. The Public Entity Defendants knew that their actions and/or failures to act placed Brendon in substantial risk of severe pain, mental anguish, distress, serious physical injury, and death.

151. In so acting and/or failing to act, the Public Entity Defendants displayed deliberate indifference to Brendon's serious medical need and deprived him and similarly situated detainees of their clearly-established constitutional right to necessary medical care and treatment applicable to detainees (under the Fourteenth Amendments and the constitutional right to due process).

152. The Public Entity Defendants actions and inactions consisted of willful and wanton conduct, and recklessness that evinces a conscious disregard for the safety of others.

153. As a direct and proximate result of the Public Entity Defendants intentional, willful, and callous disregard of his serious need for necessary and competent medical treatment and

supervision, Brendon was subjected to severe pain, mental anguish, distress, serious physical injury, and death, which were a direct and proximate result of the Public Entity Defendants' customs, policies, and/or practices.

WHEREFORE, Plaintiff Joanie C. Sullins, Individually and as Personal Representative of the Estate of Brendon Garrett Sullins, requests that the Court enter judgment in her favor and against Defendants RSW Regional Jail Authority and William T. Wilson, the Superintendent of the RSW Regional Jail, in his official capacity, jointly and severally, as follows: (1) for compensatory damages in the amount of $5,000,000.00, which amount shall be proven at trial; (2) for reasonable attorneys' fees and costs, as permitted under 42 U.S.C. § 1988; (3) pre- and post-judgment interest; (4) for punitive damages to the fullest extent permitted by law; and (5) for such other and further relief as this Court may deem just and proper.

COUNT IV

Gross Negligence—Wrongful Death (Va. Code § 8.01-50)
(Brought against All Defendants)

154. The allegations in all prior paragraphs are realleged and incorporated by reference as though fully set forth herein.

155. This claim is brought pursuant to Va. Code § 8.01-50, and is a wrongful death claim based on Defendants' gross negligence.

156. Defendants owed a manifest duty to Brendon Sullins to provide reasonable care, including medical care, to an inmate or detainee whose custody and care they had assumed. This special duty arose under constitutional law, statutory law, and Virginia common law.

157. Corrections Staff was grossly negligent and breached their duty of care by, *inter alia,* failing to monitor Brendon's medical condition and pass on information about his health where required, including but not limited to, information about his complaints of pain, his requests for assistance, the fact that he was not taking his medication, the fact that he was exhibiting diarrhea, and the fact that he was not holding down liquids.

158. Jail Medical Staff were grossly negligent and breached their duty of care by, *inter alia*: failing to monitor Brendon's condition, failing to assess his vital signs, failing to assess him in his cell (in person), failing to respond to his complaints, failing to provide medical care to Brendon, and failing to send him to a physician for evaluation.

159. Defendants breached their duty and, in so doing, acted with gross negligence and the utter disregard of caution amounting to a complete neglect of their duty to provide for Brendon's health, safety and security by failing to provide Brendon the medical care his condition demanded, including by confining him at all times to a solitary cell without providing adequate medical treatment or intervention, despite their awareness of the pain he was experiencing as a result of drug abuse withdrawal and physical illness in a detention facility that they knew was inadequately staffed and operated to provide inadequate medical care and supervision.

160. Defendants' actions and inactions amounted to a conscious or reckless disregard for human life—rights well-established by federal and state law as the standard of care for inmates and detainees in need of medical care. Defendants exerted no effort to avoid the known consequences of their failures to act in accordance with their known duties to prevent harm, acting as if such rights did not exist. Defendants' conduct was such that it shocks fairminded people.

161. Defendants' actions and inactions consisted of willful and wanton conduct, and recklessness that evinces a conscious disregard for the safety of others.

162. As a direct and proximate result of the foregoing gross negligence and reckless

disregard of Brendon's life and/or his rights on the part of Defendants, Brendon suffered serious physical injury, pain and suffering, loss of future income, consciousness of his own impending death, and death.

163. As a direct and proximate result of Defendants' tortious conduct and Brendon's death, Plaintiff suffered, continues to suffer, and will suffer in the future, and seeks compensatory damages, including sorrow, mental anguish, and solace (which may include society, companionship, comfort, guidance, kindly offices and advice of the decedent), the reasonably expected loss of income of income of the decedent, medical expenses, and loss of services, protection, assistance and care provided by Brendon, reasonable funeral expenses, as well as punitive damages.

WHEREFORE, Plaintiff Joanie C. Sullins, individually and as personal representative of the Estate of Brendon Sullins, demands judgment against Defendants as follows: (1) for compensatory damages in the amount of $5,000,000.00, which amount shall be proven at trial; (2) for punitive damages to the fullest extent permitted by law (3) for costs; and (4) such other and further relief as this Court may deem just and proper.

COUNT V
Negligence—Wrongful Death (Va. Code § 8.01-50)
(Brought against All Defendants)

164. The allegations in all prior realleged and incorporated by reference as though fully set forth herein.

165. This claim is brought pursuant to Va. Code § 8.01-50, and is a wrongful death claim based on Defendants' negligence.

166. Defendants owed a manifest duty to Brendon Sullins to provide reasonable care, including medical care, to an inmate or detainee whose custody and care they had assumed. This special duty arose under constitutional law, statutory law, and Virginia common law.

167. Corrections Staff was negligent and breached their duty of care by, *inter alia,* failing to monitor Brendon's medical condition and pass on information about his health where required, including but not limited to, information about his complaints of pain, his requests for assistance, the fact that he was not taking his medication, the fact that he was exhibiting diarrhea, and the fact that he was not holding down liquids.

168. Jail Medical Staff were negligent and breached their duty of care by, *inter alia*: failing to monitor Brendon's condition, failing to assess his vital signs, failing to assess him in his cell (in person), failing to respond to his complaints, failing to provide medical care to Brendon, and failing to send him to a physician for evaluation.

169. As a direct and proximate result of the foregoing negligence and indifference on the part of Defendants, Brendon suffered serious physical injury, pain and suffering, consciousness of his own impending death, and death.

170. As a direct and proximate result of Defendants' tortious conduct and Brendon's death, Plaintiff suffered, continues to suffer, and will suffer in the future, and seeks compensatory damages, including sorrow, mental anguish, and solace (which may include society, companionship, comfort, guidance, kindly offices and advice of the decedent), the reasonably expected loss of income of income of the decedent, medical expenses, and loss of services, protection, assistance and care provided by Brendon, and reasonable funeral expenses.

WHEREFORE, Plaintiff Joanie C. Sullins, individually and as personal representative of the Estate of Brendon Sullins, demands judgment against Defendants as follows: (1) for compensatory damages in the amount of $5,000,000.00, which amount shall be proven at trial; (2) for costs; and (3) such other and further relief as this Court may deem just and proper.

Dated: January 26, 2018

Respectfully submitted,

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JURY TRIAL DEMAND

Plaintiff demands a trial by jury with respect to each of the claims alleged herein.

/s Peter C. Grenier
Peter C. Grenier

/s Stan M. Doerrer
Stan M. Doerrer