IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLORADO

Civil Action No.: _____

THE ESTATE OF DANIEL JAMES MURRAY,
by and through its personal representative, David Murray;

Plaintiff,

v.

WELLPATH, LLC;
THE BOARD OF COUNTY COMMISSIONERS OF THE COUNTY OF EL PASO, COLORADO;
SHERIFF JOSEPH ROYBAL, in his official capacity;
DIANNE HAWTHRONE-CRUZ, individually;
WENDY MORRIS, individually;
GEORGE SANTINI, individually;
J. DYLAN COX, individually;
MICHELLE SILVA, individually;
MAGDALINA BEULTEMANN,
individually

Defendants.

AMENDED COMPLAINT AND JURY DEMAND

Plaintiff, by its attorneys of The Bagley Law Firm, LLC, submits the following Amended Complaint and Jury Demand against Defendants.

INTRODUCTION

1. This is a civil rights case about yet another painful, preventable inmate death at the El Paso County, Colorado Criminal Justice Center ("the Jail").

2. Daniel Murray died in the Jail on July 4, 2022, of untreated acute alcohol withdrawal, or delirium tremens ("DTs").

3. If not properly cared for, DTs is famously fatal. Before modern intensive care units and pharmacotherapies, DTs killed 35% of sufferers.

4. According to the Department of Justice Bureau of Justice Assistance, "a study of U.S. jails revealed that alcohol was involved in 76 percent of withdrawal-related deaths, confirming longstanding research findings on the lethality of alcohol withdrawal." Nonetheless, "deaths from withdrawal are preventable."

5. Those responsible for Daniel's Jail medical care ignored this.

6. Among the many examples of their recklessness and indifference: Insisting that Daniel was "refusing" medication, when instead, as Jail deputies witnessed, Daniel was hallucinating, a classic DTs symptom (the "delirium" in delirium tremens).

7. Jail medical staff had Daniel's life in their hands. That they ignored a critical and obvious symptom like hallucination reflects systemic, well-documented, nationwide issues in jails privatizing inmate medical care: It's cheaper for El Paso County, and more profitable for Wellpath, LLC ("Wellpath"), the Jail's medical provider, to let some sick inmates die than it is to provide a level of care adequate to save lives – a level of care commensurate with inmates' human dignity and constitutional rights.

ABOUT DANIEL MURRAY

8. Daniel James Murray was just 37 years old when he died.

9. He lived and worked in the Colorado Springs, Colorado area most of his life.

10. He was a beloved son, one of three brothers, and the father of five children, the youngest of whom is a three-year-old baby girl.

11. After Daniel's death, his father, David Murray, wrote "Love and miss you son, I know your mother [who died of cancer in March of 2022] has found you and taken you under her wing. Love and miss you both!"

12. Daniel's younger brother, Douglas Murray, wrote "I love my brother very much and

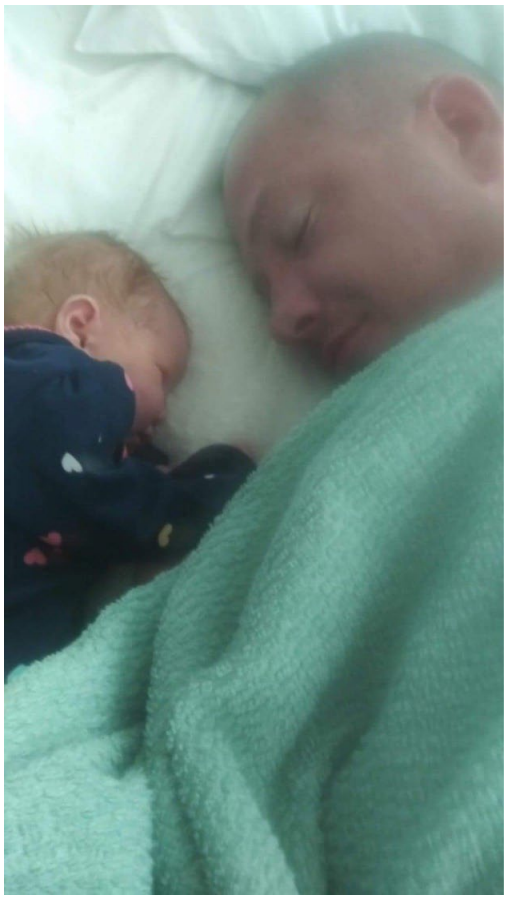
hurt every day knowing what happened to him. Knowing it was avoidable…"

13. Daniel's long-time partner and the mother of three of his children, Sharon Watt, wrote:

> Danny was and always will be the love of my life…Now my children and I have an empty hole in our hearts because the justice system has now failed us by not giving Danny the care every human being should have. He was treated inhumanely, and it will not go unnoticed for the rest of our lives and the many other lives he touched with his loving heart and undying loyalty.

14. Daniel's life mattered.

15. His death matters.



JURISDICTION AND VENUE

16. This case arises under 42 U.S.C. § 1983.

17. Plaintiff files this case in the District Court for the District of Colorado under 28 U.S.C. § 1391 as the judicial district where all relevant events and omissions occurred, and where Defendants have offices or reside.

PARTIES

18. At all relevant times, the decedent, Daniel Murray, was a Colorado resident and United States citizen.

19. At all relevant times, David Murray was a Colorado resident and United States citizen. David Murray is Daniel's father and the Personal Representative of Daniel's estate, which was opened in El Paso County, Colorado.

20. Defendant Board of County Commissioners of the County of El Paso, Colorado ("BOCC"), is a governmental entity chartered under the laws of the State of Colorado. Among other things, El Paso County, through the El Paso County Sheriff's Office ("Sheriff"), runs the Jail, located at 2739 E. Las Vegas St., Colorado Springs, Colorado 80906.

21. BOCC represents, oversees, and sets policy for El Paso County, Colorado. BOCC also contracted with Defendant Wellpath to provide health care to detainees and inmates at the Jail.

22. Defendant Joseph Roybal, in his official capacity, is the El Paso County Sheriff. Sheriff Roybal is the final policymaker for El Paso County regarding all matters concerning the Sheriff's Office and all of its divisions, including the Jail.

23. The El Paso County Sheriff and BOCC are collectively referred to herein as "El Paso County" or "County Defendants."

24. Wellpath, formerly known as Correct Care Solutions, LLC ("CCS"), is a private Delaware corporation doing business in Colorado with its headquarters located at 3340 Perimeter Hill Dr., Nashville, TN 37211. Wellpath's registered agent in Colorado, Corporate Creations Network, Inc., is located at 155 E. Boardwalk #490, Fort Collins, CO 80525.

25. County Defendants are properly sued under 42 U.S.C. § 1983 for their own deliberately indifferent policies regarding Jail inmate medical care and treatment. They are also properly sued for the deliberately indifferent policies and practices of Wellpath. Although El Paso County has sought to privatize health care services to inmates, it has a non-delegable duty to provide constitutionally adequate care, cannot contract away its constitutional obligations, and is legally liable for the challenged policies and practices as causing the deliberately indifferent medical care of people detained in the Jail, including Daniel Murray, by its contractors and their agents and employees.

26. Wellpath is properly sued under 42 U.S.C. § 1983 for its deliberately indifferent policies, practices, habits, customs, procedures, training, and supervision of staff with respect to the provision of medical care for Jail inmates. Since 2020, Wellpath has contracted with El Paso County to provide medical services to the Jail's detainees and inmates, and implements and supervises such care. Upon entering into contracts or subcontracts to provide medical services to Jail detainees and inmates, Wellpath

assumed public functions, acted under color of state law, and is legally responsible to comply with all requirements of the United States Constitution.

27. At all relevant times, Defendant Dr. George Santini, Defendant Nurse Magdalina Beultemann, and Defendant Licensed Practical Nurses ("LPN") Dianne Hawthrone-Cruz, Wendy Morris, J. Dylan Cox, and Michelle Silva were citizens of the United States and residents of Colorado. These Defendants were agents, employees, and/or subcontractors of Wellpath, responsible for providing medical care to Daniel Murray during his detention and acted under color of state law. Defendants Santini, Beultemann, Hawthrone-Cruz, Morris, Cox, and Silva are collectively referred to as the "Individual Wellpath Defendants."

FACTS

Arrest

28. On June 29, 2022, officers from the Colorado Springs Police Department arrested Daniel Murray on suspicion of misdemeanor violation of a protection order.

29. Daniel was never convicted of, and never pled guilty to, violation of a protection order, and died in the Jail as a pre-trial detainee.

30. The El Paso County Sheriff's Office booked Daniel into the Jail at 9:09 p.m. on the same day as his arrest.

31. Daniel was unable to bond out, and this inability would turn into a death sentence.

Delirium Tremens

32. Any reasonably trained health care worker knows that DTs is unquestionably a medical emergency requiring immediate hospitalization and intensive care treatment.

33. DTs is a severe form of alcohol withdrawal.

34. Alcohol is a depressant. It slows your brain and nervous system. When you suddenly stop drinking after a long period of alcohol use, your brain and nervous system can't adjust quickly. Your brain gets overstimulated.[1]

35. DTs is most common among white, younger, unmarried men, heavy, long-term drinkers, people with a history of seizures, and those who have gone through alcohol withdrawal before.

36. Daniel was 37 years old, white, and unmarried.

37. His Jail medical record, excerpted below, shows that for more than a year he was drinking over a pint of hard liquor every day.

2200007987	Receiving Screening	Alcohol	Yes	Hawthrone-Cruz, Dianne	06-30-2022 11:13 am
2200007987	Receiving Screening	Type:	LIQUOR	Hawthrone-Cruz, Dianne	06-30-2022 11:13 am
2200007987	Receiving Screening	Amount:	OVER 1 PINT	Hawthrone-Cruz, Dianne	06-30-2022 11:13 am
2200007987	Receiving Screening	Last Use:	06/29/2022	Hawthrone-Cruz, Dianne	06-30-2022 11:13 am
2200007987	Receiving Screening	Frequency:	daily	Hawthrone-Cruz, Dianne	06-30-2022 11:13 am
2200007987	Receiving Screening	Duration:	Greater than 1 year	Hawthrone-Cruz, Dianne	06-30-2022 11:13 am

38. This record also shows that Daniel had a history of seizures and tremors caused by alcohol withdrawal.

2200007987	Receiving Screening	Prior withdrawal: *If Tremors, Seizures, or DTs is marked, an Alert will automatically generate for Withdrawal History.	Tremors	Hawthrone-Cruz, Dianne	06-30-2022 11:13 am
2200007987	Receiving Screening	Prior withdrawal: *If Tremors, Seizures, or DTs is marked, an Alert will automatically generate for Withdrawal History.	Seizures	Hawthrone-Cruz, Dianne	06-30-2022 11:13 am

39. Without proper care, DTs has a 35% mortality rate.

40. With proper, modern care, that rate drops dramatically, to just 5%.[2]

[1] This paragraph and the next are quoted from webmd.com/mental-health/addiction/delirium-tremens

41. DTs symptoms typically develop two to four days after a sufferer's last drink, which is exactly the timeline on which Daniel developed symptoms and died.

42. In his incident report for Daniel's death, El Paso County Sheriff's Deputy Cody McCormick wrote:

> On July 3rd I started to notice an increased change in Murray…[H]e began to hallucinate. In the afternoon he began to rant that he had called his dad earlier (he had not), that his dad was outside his window and that he was down by the river and wanted to say goodbye to his dad before he moved away…I explained [to Daniel that] nobody was out there. He was begging me to let him out…On July 4th I came into shift…At approximately 0715 hours I conducted a check [on Daniel] and he had moved and was laying in the fetal position in the middle of the floor. [H]e expressed to me that he was "having a seizure…"

43. July 3, 2022, was exactly four days after Daniel's Jail intake medical screening on the morning of June 30, 2022.

44. Symptoms of DTs include tremors, sweating, excitability and hyperactivity, anxiety, rapid heartbeat (for example, pulse over 100), high blood pressure (for example, systolic blood pressure over 150), visual or auditory hallucinations, and death.[3]

45. Deputy McCormick's statement and Daniel's Jail medical record together show that Daniel had all of these symptoms.

2200007987	CIWA-Ar Score Sheet: Alcohol and/or Benzodiazepine Withdrawal	Systolic BP	156	Crofton, Katherine	07-01-2022 3:09 pm
2200007987	CIWA-Ar Score Sheet: Alcohol and/or Benzodiazepine Withdrawal	Diastolic BP	145	Crofton, Katherine	07-01-2022 3:09 pm
2200007987	CIWA-Ar Score Sheet: Alcohol and/or Benzodiazepine Withdrawal	Pulse	107	Crofton, Katherine	07-01-2022 3:09 pm

[2] Emedicine.medscape.com/article/166032-print.

[3] *Recognition and Management of Withdrawal Delirium (Delirium Tremens)*, Schuckit, Marc A., M.D., N Engl J Med 371;22.

2200007987	CIWA-Ar Score Sheet: Alcohol and/or Benzodiazepine Withdrawal	Pulse	115	Crofton, Katherine	07-02-2022 3:26 pm
2200007987	Receiving Screening	Appearance:	Sweating	Hawthrone-Cruz, Dianne	06-30-2022 11:13 am
2200007987	Receiving Screening	Behavior:	Appears under the influence/intoxicated/withdrawing from substance (SHAKING, UNABLE TO SIT STILL)	Hawthrone-Cruz, Dianne	06-30-2022 11:13 am
2200007987	Receiving Screening	Mood:	Anxious	Hawthrone-Cruz, Dianne	06-30-2022 11:13 am

46. Deaths from DTs are certainly avoidable if the condition is properly treated.

47. Preferred treatments include immediate inpatient hospitalization into an intensive care unit, intravenous benzodiazepines in sometimes prodigious amounts (for example, more than 2,000 milligrams of the benzodiazepine Diazepam in the first two days of treatment for some patients), administration of antipsychotic medication, and supportive care such as frequently monitoring vital signs in a quiet, well-lit room while reorienting the patient to time, place, and person.[4]

48. A given patient's dose of benzodiazepines administered for DTs must be closely and continuously monitored, as no one dose is always effective.

49. Ultimately, the severity of DTs symptoms requires hospitalization, and that care be directed by clinicians who are well trained in treating this severe disorder.[5]

[4] *Id.*
[5] *Id.*

Daniel's Time in the Jail

50. At 11:13 a.m. on June 30, 2022, Daniel completed a patient history and Jail intake medical screening with Wellpath LPN Dianne Hawthrone-Cruz.

51. During this screening, Daniel had visible tremors, and was sweating, anxious, and unable to sit still – all DTs symptoms.

52. LPN Hawthrone-Cruz recklessly did not take Daniel's vitals, including blood pressure, pulse, temperature, or oxygen saturation levels, even though these are all basic and essential tools of medical diagnosis and care, including diagnosis and care of DTs.

53. Daniel was candid with LPN Hawthrone-Cruz about his level of alcohol consumption and his history of withdrawal seizures and tremors, major risk factors for DTs.

54. LPN Hawthrone-Cruz contacted Wellpath doctor George Santini, MD, who, having never physically examined Daniel, and without any information concerning Daniel's vitals, ordered the following prescription at 11:22 a.m. on June 30, 2022:

> Long-acting Benzodiazepine taper…Chlordiazepoxide HCL (Librium) 50 mg by mouth every 8 hours for first 72 hours, then Chlordiazepoxide HCL (Librium) 50 mg by mouth [twice a day] for next 48 hours.

55. There is no indication that Dr. Santini has experience treating DTs.

56. At no point during Daniel's entire time in the Jail did any member of the Jail medical staff follow up to evaluate or alter this dosage for effectiveness.

57. Dr. Santini continued his indifference to Daniel's serious medical condition by failing to order the second part of the benzodiazepine taper. Nowhere in Daniel's medical records is there an entry or order for the actual "taper" part of the medication regimen.

58. Tragically, even as the dose automatically tapered down after 72 hours, Daniel's symptoms were becoming more severe. 72 hours after this prescription was entered

was 11:22 a.m. on July 3, 2022, almost exactly when Deputy McCormick witnessed Daniel's hallucinations.

59. Any reasonably trained health care provider knows that close and continual monitoring of benzodiazepines administered for DTs is critical to preventing DTs fatalities.

60. Instead, Jail medical staff took a "set-it-and-forget-it" approach to Daniel's Chlordiazepoxide, never once following up to check whether the prescribed dose was working.

61. Another result of the intake screening was that LPN Hawthrone-Cruz ordered CIWA-Ar assessments to be performed every eight hours for five days.

62. According to the American Addiction Centers, the Clinical Institute Withdrawal Assessment Alcohol Scale Revised, or "CIWA-Ar," is an instrument used by medical professionals to assess and diagnose the severity of alcohol withdrawal. The CIWA-Ar allows physicians to measure the severity of patients' alcohol withdrawal syndrome, and thus prevent further health complications and treat the withdrawal syndrome accordingly.

63. It didn't work; Daniel died.

64. There is no indication that LPN Hawthrone-Cruz consulted with a doctor, physician assistant, or nurse practitioner before ordering Daniel's CIWA-Ar assessments.

65. There is no indication that LPN Hawthrone-Cruz is qualified or has experience ordering CIWA-Ar assessments.

66. There is no indication that LPN Hawthrone Cruz has experience or is otherwise qualified to conduct care planning of any kind for patients with DTs.

67. LPN Hawthrone-Cruz did not ask any physician, physician assistant, or nurse

practitioner what a proper care plan for Daniel should be, whether Daniel should be sent to a hospital, or whether Daniel's care should be escalated in any way.

68. LPN Hawthrone-Cruz gives no reason for why she ordered CIWA-Ar assessments only every eight hours.

69. Given that Daniel died, every eight hours was not frequent enough. Indeed, simply ordering CIWA-Ar assessments is recklessly inadequate care planning for patients with DTs, who belong in an ICU. LPN Hawthrone-Cruz recklessly did not immediately get Daniel to a hospital, did not take his vitals, ignored Daniel's clear and serious signs of DTs, including agitation, sweating, and past withdrawal seizures and tremors, did not discuss Daniel's care plan with a more qualified provider, and did not follow up on the effectiveness of Daniel's DTs medication.

70. Wellpath LPN Katherine Crofton performed Daniel's first CIWA-Ar screening at 3:02 p.m. on June 30, 2022.

71. She notes that Daniel refused to have his vital signs taken.

72. LPN Crofton gives no reason for why Daniel refused to have his vitals taken.

73. LPN Crofton did not advise Daniel that vitals provide critical information for evaluating and treating DTs.

74. LPN Crofton did not report to any doctor, physician assistant, or nurse practitioner that Daniel refused to give his vitals.

75. LPN Crofton did nothing with Daniel's refusal but note it and move on.

76. Despite not having Daniel's vitals, LPN Crofton nonetheless assigned Daniel a two out of a total possible 67 on the CIWA-Ar risk scale, indicating low medical risk.

77. It did not occur to LPN Crofton that knowing Daniel's vitals was necessary for

accurately assessing his risk.

78. Wellpath Registered Nurse ("RN") Courtney Cray performed Daniel's second CIWA-Ar screening at 5:33 a.m. on July 1, 2022.

79. This was 14.5 hours after the first screening, almost twice as long as the eight-hour interval LPN Hawthrone-Cruz had ordered.

80. Inexplicably, at the end of her screening RN Cray did not assign Daniel a number on the CIWA-Ar risk scale, but instead left this blank, negating the purpose of a CIWA-Ar screening, which is to gauge risk.

81. This indifference and reckless lack of medical rigor characterized all of Daniel's CIWA-Ar screenings.

82. Over the next several assessments, performed between 10:10 a.m. on July 1, 2022, and 12:25 a.m. on July 3, 2022, Daniel's systolic blood pressure went as high as 156, his pulse went to 117, he reported being anxious, and he was seen agitated and sweating.

83. Jail medical staff ignored these warning signs. They performed no follow up and took no medical action whatsoever based on these indications, again simply recording the data – or not – and moving on.

84. Likewise, during several of these assessments no vitals were taken and no CIWA-Ar risk score was assigned, even for the assessments closest in time to when Jail deputies witnessed Daniel actively hallucinating.

July 3, 2022

85. On July 3, 2022 at 12:24am, LPN J. Dylan Cox cancelled Daniel's prescription for Librium. The reason given is "expired RX." The note goes on to say, "[s]tatus manually changed to Discontinued by J. Dylan Cox on 07/03/2022 at 12:24 am.

86. No explanation or charting note is included as to why LPN Cox cancelled Daniel's Librium. Further, there is no indication from the medical records that LPN Cox consulted with the on-call Health Care Provider before cancelling Daniel Murray's life-saving medication. LPN Cox unilaterally discontinued the prescription for Librium and Daniel Murray began to decompensate.

87. Daniel's Jail medical record shows that at 10:16 a.m. on July 3, 2022, he refused his dose of Chlordiazepoxide which is baffling since LPN Cox had manually cancelled Daniel's prescription earlier that day.

88. The Jail medical record gives no reason for Daniel's refusal, but he may already have been hallucinating.

89. Any reasonably trained health care provider – any person at all, in fact – knows that someone hallucinating lacks sufficient agency and wherewithal to "refuse" medication.

90. In response to Daniel's refusal, Wellpath LPN Wendy Morris completed a "Refusal of Treatment Form," attached to this Complaint as **Exhibit 1**.

91. On the form, LPN Morris checked the option for "Refused medication," and wrote, "Patient verbally refused chem-dep – would not come to cart."

92. The form has a section called "Reason For Refusal." LPN Morris left this blank.

93. The form has a section called "Potential Consequences Explained," where a health care provider can check options for "A. Worsening Of Medical Conditions; B. Death; C. Permanent Disability; D. Other,"

94. LPN Morris also left this blank.

95. As such, LPN Morris recklessly failed to advise or explain to Daniel that unmedicated

DTs is likely to lead to death, even though any reasonably trained health care provider knows this.

96. The form has a section for "Patient Signature."

97. This is blank, as Daniel had no role in completing this form.

98. The form has a section for "Witness Signature."

99. In LPN Morris's handwriting, this section is completed to say "Witness by Deputy."

100. No deputy's name or signature appears, making it entirely possible that, despite the form's requirements, no deputy or other Jail medical provider witnessed Daniel's refusal.

101. In fact, during his deposition, Deputy McCormick testified that sometimes he would sign refusal of medication forms that had not yet been filled out by medical staff.

102. At 1:18 p.m. on July 3, 2022, approximately 13 hours after his previous screening, LPN Morris completed Daniel's penultimate CIWA-Ar assessment.

103. This is very close in time to when Deputy McCormick witnessed Daniel hallucinating.

104. Daniel refused to give LPN Morris his vitals.

105. LPN Morris gives no reason for this refusal.

106. During this assessment, LPN Morris did not assign Daniel a number on the CIWA-Ar risk scale, even though Daniel was now off his meds, refusing to give his vitals, likely hallucinating, and would be dead less than 24 hours later.

107. LPN Morris could have saved Daniel's life by recognizing the emergency situation Daniel was now in, reporting it to her supervisors, and/or insisting that Daniel be taken to a hospital.

108. Instead, LPN Morris did nothing – the hallmark of indifference.

July 4, 2022, and Daniel's Death

109. 15 hours after LPN Morris's assessment, Wellpath LPN Michelle Silva completed Daniel's last CIWA-Ar screening at 4:12 a.m. on July 4, 2022, just four hours before EMTs would pronounce Daniel dead.

110. LPN Silva notes that Daniel refused to give vitals, but gives no reason for the refusal and takes no action based on the refusal.

111. LPN Silva notes that Daniel refused his meds, but gives no reason for the refusal and takes no action based on the refusal.

112. LPN Silva gives no number on the CIWA-Ar risk scale.

113. Despite Daniel's witnessed hallucinations the day before, LPN Silva makes no mention of the hallucinations, and inexplicably notes no agitation, no auditory or visual disturbances, and that Daniel appears oriented and at ease.

114. By contrast, Deputy McCormick's incident report observes that:

> On July 4th I came into shift and assumed duties…at approximately 0615 hours. I conducted my formal check and observed [Daniel] lying on his bunk sleeping. I was briefed he had been "in a mood" or combative. Over the next 30-45 minutes he would scream and yell, scaring other inmates in the ward. At approximately 0715 hours I conducted a check and he had moved and was laying in the fetal position in the middle of the floor…[H]e expressed to me that he was "having a seizure…" I…called medical and spoke to [Medical Staff Member] Monday C22187 about Mr. Murray.[6]

[6] MSM Monday refers to RN Beultemann ("Monday" is a nickname).

115. It is deeply concerning that Deputy McCormick's account and LPN Silva's account, just two hours apart, are so fundamentally different. Plaintiff wonders whether LPN Silva's CIWA-Ar screening was performed so cursorily and indifferently as to completely miss hallucinations, a seizure, and a level of agitation in Daniel sufficient to scare other inmates.

116. It is also exceedingly medically unlikely with DTs that Daniel was "at ease" at 4:12 a.m. and dead four hours later.

117. At best this was not a meaningful assessment, and, at worst, Michelle Silva did not perform an assessment at all.

118. In any event, at the time of LPN Silva's CIWA-Ar screening Daniel had been off his DTmeds since his last confirmed Chlordiazepoxide dose at 8:32 a.m. on July 2, 2022, had had hallucinations which were witnessed, he reported having a seizure, Jail medical staff had talked with Deputy McCormick, who witnessed the hallucinations and who Daniel told about his seizure, Daniel was so agitated that he was "scaring other inmates," he was seen having tremors and sweating, his pulse had gone to 117 and his systolic blood pressure had gone as high as 156, and still Wellpath Jail medical staff did nothing.

119. Deputy McCormick testified in his deposition that he called RN Beultemann to report that Daniel was having a seizure. *See* **Exhibit 2**, Deposition of Cody McCormick, p.56.

120. RN Beultemann knew that Daniel Murray was on chem dep protocol for alcohol withdrawal. RN Beultemann knew that medical did not have recent vitals for Daniel and, importantly, knew that he was not taking his life-saving medication. RN

Beultemann then received a report that Daniel was having a life-threatening seizure.

121. Daniel Murray's seizure was a medical emergency. RN Beultemann's response to this emergency was to wait for the next chem dep pass and "try" to get Daniel to provide vitals and take his medication. *See* **Exhibit 2**, p. 57. Daniel did not live to the next chem dep pass. Once again, Wellpath Jail medical staff did nothing.

122. Nothing at all. Daniel was simply left to die a painful, preventable death, alone in a jail cell.

123. Deputy McCormick's incident report relates the tragic, predictable outcome of the Wellpath Jail medical staff's deliberate indifference:

> At approximately 0730 [on July 4th]…I attempted to observe [Daniel] for breathing but was [not] noticing anything. I opened his food trap and squatted down to get a better look and did not notice anything. I called for assistance…due to Murray['s] erratic and violent behavior. I went to my desk and got a pair of gloves and by this time Deputy Scott and Deputy Ravenkamp were at the door…Inmate Murray was nonresponsive and slumped in the corner, I observed some drool coming out of the left side of his mouth onto his shirt. At approximately 0737 I called a Code Blue over my radio. I instructed Scott to straighten him out, Scott grabbed his ankles and pulled his body straight and at this point I observed his mouth and lips completely purple. We had rolled him to his side into the recovery position and I attempted a sternum rub to check for signs of life or reaction. I got [no] response, we checked him for a pulse in his wrist and neck, and it was very faint if it was there. I looked back to the ward door and observed medical staff entering the ward. I yelled out to them to bring an [Automated External Defibrillator]. At this time, we began our rotations of CPR…I began to do CPR when I was tapped out by medical and I began to cut his shirt off to apply the paddles for the AED, once the shirt was off the paddles were applied and CPR resumed. Medical called for a pause and me and Scott dragged inmate Murray into the ward, so we had more room. Once in the day room I did another 2 rounds of CPR until [Colorado Springs Fire Department] and [American Medical Response] arrived on scene. Medical was relieved and myself and Scott worked into the CPR rotation again with CSFD and AMR another 2 – 3 rounds approximately. At approximately 0910 hours I was asked to step out of the ward and relieved of my duties.

124. CSFD declared Daniel James Murray dead at 8:13 a.m. on July 4, 2022.

WELLPATH'S DELIBERATELY INDIFFERENT MEDICAL CARE

125. The following is a non-exhaustive list of ways that Wellpath Jail medical staff was indifferent to Daniel's DTs, a serious medical need – indeed, an emergency medical need. This indifference is even more shocking considering that, as related later in this complaint, Cassandra Ramirez died of untreated withdrawal in the Jail the day before Daniel's death.

Ignoring Serious and Obvious Warning Signs

126. Deputy McCormick witnessed Daniel hallucinating during "the afternoon" of July 3, 2022.

127. EMTs pronounced Daniel dead on July 4, 2022, at 8:13 a.m.

128. During this entire window – perhaps as much as 20 hours – Jail medical staff ignored Daniel's medical emergency and did not immediately get him to a hospital.

129. Even after Daniel told Deputy McCormick on the morning of July 4, 2022, that he was having a seizure, and Deputy McCormick informed RN Beultemann, Jail medical staff still did not get Daniel to a hospital.

130. Jail medical staff similarly ignored that Daniel was off his DTs meds, was so agitated that he was scaring other inmates, his high blood pressure and pulse rate, his sweating, anxiety, and tremors, his history of withdrawal seizures, and the fact that his age, race, and unmarried status put him at higher risk for DTs.

Medication

131. Dr. Santini prescribed Chlordiazepoxide without examining Daniel or knowing Daniel's vitals.

132. The initial amount of 50 milligrams by mouth every eight hours for the first 72 hours was likely a profound under-dosing.

133. No member of the Jail medical staff followed up to alter or evaluate this dose for effectiveness.

134. Dr. Santini failed to prescribe the second part of the benzodiazepine taper.

135. The medication was prescribed to be taken orally, rather than administered intravenously, which is medically preferred for DTs.

136. After Daniel refused this medication, he was not immediately taken to a hospital, even though any reasonably trained health care provider knows that unmedicated DTs has a high likelihood of becoming fatal.

137. No member of the Jail medical staff considered that Daniel refusing his medication indicated his worsening, emergency situation.

138. No member of the Jail medical staff advised Daniel of the risks of stopping his medication, namely that unmedicated DTs has a high likelihood of becoming fatal.

139. Daniel was never prescribed antipsychotics.

140. LPN J. Dylan Cox unilaterally cancelled Daniel's prescription for Librium. Nowhere in Daniel's medical records is there a note that LPN Cox consulted with a qualified medical provider regarding the change in life-saving medication.

Recklessly Incomplete Assessments, Lack of Hands-On Care, and Lack of Ongoing, Timely, and Medically Adequate Patient Observation

141. Daniel's Jail intake medical screening and several of his CIWA-Ar screenings were done without taking Daniel's vitals.

142. When Daniel refused to have his vitals taken, no follow up effort to obtain vitals,

such as getting Daniel to a hospital, was ever made, even though any reasonably trained health care provider knows that during DTs, information such as pulse, blood pressure, etc. are critical to assessing a patient's medical state and planning for and tailoring a patient's care.

143. Several of Daniel's CIWA-Ar screenings assigned no CIWA-Ar risk scale number, even as Daniel was off his DTs meds, hallucinating, having a seizure, and highly agitated.

144. Daniel's CIWA-Ar assessments were not done every eight hours as LPN Hawthrone-Cruz ordered. For example, 15 hours passed between the screening on July 3, 2022, at 1:18 p.m. and the screening on July 4, 2022, at 4:12 a.m. During this critical window Daniel was hallucinating.

145. The conclusions of several of the CIWA-Ar screenings are alarmingly different from the stark observations and reports of Jail deputies, indicating that the Jail medical staff was not observing Daniel in any sort of medically adequate way, if they were observing him at all.

146. There is no evidence that the final CIWA-Ar assessment, entered by LPN Michelle Silva, was a meaningful assessment.

147. Daniel never saw or spoke with a doctor.

148. Daniel received no supportive care. Rather than a quiet, well-lit hospital room in an ICU, he was left in a jail cell by himself.

149. No member of the Jail medical staff ever attempted to re-orient Daniel to time, place, and person.

150. For significant lengths of time, and as Daniel was developing critical DTs symptoms,

no Jail medical provider observed him in any way. He was simply ignored in his cell.

151. Even when Daniel was observed, Jail medical staff's observations were done so cursorily that they missed obvious and major DTs indicators that even medically untrained Jail deputies instantly saw and recognized as medically significant, such as seizures, hallucinations, and agitation sufficient to scare other inmates.

Unqualified Caregivers

152. Far from the recommended ICU setting with "clinicians who are well trained in the treatment of" DTs, licensed practical nurses performed Daniel's Jail medical intake screening and eight of his 10 CIWA-Ar screenings, including all screenings during the medically critical time period of July 3, and July 4, 2022.

153. According to the Colorado Department of Regulatory Agencies, becoming an LPN requires only nine months of medical training, LPNs are meant to focus on the care of patients with "predictable outcomes," and LPNs must practice under the supervision of registered nurses or doctors.

154. Daniel Murray had a medical emergency; not a routine medical issue with a predictable outcome. (Indeed, the only predictable thing about Daniel's DTs was that he was likely to die without proper care.) The Jail LPNs were not in any way equipped to diagnose or assess Daniel's condition, much less treat it.

155. LPN Hawthrone-Cruz was fundamentally unqualified to plan care for a patient, like Daniel, with DTs, and her plan of nothing more than CIWA-Ar screenings every eight hours was recklessly inadequate to address Daniel's serious and emergency medical needs.

Inappropriate Facilities

156. DTs needs to be treated in an ICU.

157. Jail medical staff never got Daniel to a hospital in any form, much less an ICU.

158. Daniel was never even placed in the Jail medical unit.

159. Instead, Daniel suffered and died from DTs alone in a jail cell, a grossly inappropriate setting for someone with this severe disorder.

WELLPATH'S PRACTICES, POLICIES, AND CUSTOMS, WERE MOVING FORCES IN THE UNCONSTITUTIONAL DEATH OF DANIEL MURRAY

160. At all relevant times, El Paso County contracted with Wellpath to provide Jail inmate medical care.

161. Wellpath maintains unconstitutional practices, policies, and customs that are deliberately indifferent to inmates' serious medical needs, which have left a trail of deaths and serious injuries at the Jail and throughout the country.

162. Specifically, Wellpath's practices, policies, and customs include:

- Recklessly using nurses to practice outside their scope of licensure;
- Recklessly failing to properly screen and plan care for medical needs on intake;
- Recklessly failing to timely respond to serious changes in patient medical condition, including related to withdrawal
- Recklessly failing to provide ongoing, timely, and medically appropriate observation and assessment (in other words, simply ignoring inmates with serious medical needs); and
- Recklessly failing to hospitalize inmates with obviously serious medical needs that cannot be met in the Jail.
- Recklessly failing to appropriately staff jail medical facilities.

163. These local and nationwide unconstitutional policies and practices, often implemented to maximize profits at the expense of care, have caused a host of abject neglect and abuse by Wellpath.

164. Former El Paso County Sheriff Bill Elder testified in 2021 that he absolutely had

concerns about Wellpath's care due to its "for-profit business model" having "systemic problems."

165. In August 2020, Denver's 5280 Magazine, in an article entitled "The Loneliest Place to Die," quoted then-Sheriff Elder about for-profit jail medical contractors like Wellpath as follows:

> They're in it for the money…They will do necessary operations, but if they can increase their net, they'll do it…What happens if a nursing job comes open and they don't fill it immediately, or ever? Those dollars go directly to the bottom line.

166. The article continues:

> The same goes for not providing prescription medications to inmates in a timely fashion, not calling a physician to see a very sick patient, or not dialing 911 for an ambulance to bring an inmate to the emergency room. Other common complaints include poorly trained medical staff, high staff turnover, nurses making medical decisions doctors should make, employees buying into the widespread idea that inmates are often faking their illnesses, [and] lax screening practices…

167. These unconstitutional practices caused Daniel Murray's death.

Daniel's Death was Preceded and Followed by Many Other Deaths and Serious Injuries at the Jail

168. Daniel's lack of medical care and preventable death were not an isolated incident.

169. Rather, Daniel's was the fourteenth death in the Jail since Wellpath took back over the contract in 2020, many from known serious medical conditions that were met with deliberate indifference.

170. On July 3, 2020, Shawn Meehan was found hanging in his cell. He had reported a history of mental health issues, but the Jail medical intake process was recklessly insufficient. On June 13, 2020, Mr. Meehan submitted a kite to Wellpath health care workers asking for help and saying he wanted to hurt himself, but as part of a continuing pattern of deliberate indifference, no alerts or precautions were started, and Mr. Meehan was not placed on suicide watch before he died.

171. Adison Reed was booked into the Jail on September 3, 2021. Wellpath staff were aware that Mr. Reed was diabetic based on a previous incarceration, but deprived him of necessary diabetic care and treatment. By September 8, Mr. Reed was in extreme diabetic ketoacidosis, a life-threatening condition that results from lack of insulin. He was finally transported to the hospital and died 19 days later on September 27, 2021. Wellpath was deliberately indifferent in Mr. Reed's intake screening and care planning. Staff then allowed his medical condition to devolve to the point of extreme diabetic ketoacidosis as part of their pattern of refusing to respond to obviously critical changes in medical condition until a person is dead.

172. On September 27, 2021, William Johnson suffered a fatal seizure in the Jail after spending a month pleading to receive the prescription medications that he brought to the Jail with his primary care physician's current orders and letters warning of the dangers of withdrawal if his medications were not provided. Wellpath staff conducted a cursory intake assessment and then abruptly discontinued four of Mr. Johnson's necessary mental health and anti-seizure prescriptions with no medical basis, and without consulting with Mr. Johnson's prescribing primary care physician. Without his medications, Mr. ohnson decompensated, became severely anxious, could not sleep, lost touch with reality, and suffered a complete mental breakdown. Instead of helping him, he was punitively placed in solitary confinement where he continued to not receive his medications, including those for seizure prevention. Although Mr. Johnson had a known, major change in mental status and was severely incapacitated, he was not sent to the hospital. He spent the last week of his life disoriented, alone, and begging for medications before dying of a seizure in solitary confinement.

173. On February 14, 2022, 32-year-old Sean Williams was in the Jail when deputies saw that he was "physically unwell." He was naked and emaciated, not responding to verbal commands, and there were feces scattered on the floor. He struggled to sit up and had to be helped into a wheelchair. Deputies decided that he needed to go to the medical unit immediately. Deputies told the Wellpath charge nurse that Mr. Williams hadn't eaten or drank much (if anything) for days. The charge nurse said that Mr. Williams was "experiencing an episode of psychosis," but did not evaluate him. Deputies decided to keep him in medical until he was actually evaluated. Over the next hours, deputies repeatedly found Mr. Williams still sitting in medical, ignored, and waiting to be evaluated. On one such occasion, a deputy noted that "[m]ultiple medical staff walked over Inmate Williams. He made sounds of distress while he laid on the floor." Deputies returned him to his wheelchair. When deputies asked medical staff about him, they said "just so you know, he's psychotic." Later that same day, deputies saw on the video feed of the medical unit that Mr. Williams was back on the floor with "medical staff standing at the charge desk approximately 6 feet from Inmate Williams" with "no one evaluating him." Mr. Williams became progressively worse while medical staff ignored him. Medical staff told deputies on multiple occasions that his medical crisis was not real, but instead "behavioral," meaning "a choice someone engages in" rather than an actual "medical condition." On one of the times, Mr. Williams slipped out of his wheelchair, too weak to hold himself up, and the charge nurse said "[h]e's fine. It's behavioral. Just leave him there. If anything, it's better than him sliding out of the wheelchair." Deputies returned to medical to help Mr. Williams, found him with mucus and spit all over his face, and demanded

that nurses take his vitals. EMT Patterson was not able to get vitals and left to get different equipment. His vital signs were unobtainable. Mr. Williams died on February 15, 2022, of lymphocytic encephalitis, only 22 days after being booked into the Jail on charges of trespass and shoplifting.

174. On March 16, 2022, Laura Gibbs told Jail deputies that she was not feeling well and was having panic attacks. Deputies told Jail medical staff, and the chemical dependency nurse said she would see Ms. Gibbs. Later that day, deputies again told Jail medical staff that Ms. Gibbs wasn't feeling well, but medical staff refused to come. Later on March 16, deputies called medical staff a third time and Ms. Gibbs was finally seen. Her problems continued into the morning of March 17. At approximately 9:00 a.m., when the nurses came to Ms. Gibbs's unit to pass out medications, deputies asked them to see Ms. Gibbs. She told medical staff that she was withdrawing from heroin and was experiencing nausea, diarrhea, the shakes, and was hot and cold. Medical staff merely responded that they would make note of her problems and would come back to see her. Medical did not come back or provide any medication to address Ms. Gibbs's worsening condition, even though all Jail staff know these withdrawal symptoms can be fatal in drug users if not treated. Predictably, later that day at 2:17 p.m. on March 17, Ms. Gibbs was found unresponsive and declared dead shortly thereafter. Like Daniel Murray, Ms. Gibbs died of ignored and untreated substance abuse withdrawal.

175. On April 24, 2022, Cristo Canett died from an untreated perforated duodenal ulcer, an emergency medical condition in which the rush of gastric juice and gas into the abdominal cavity causes infection of the abdominal lining and sepsis. Before ending

up in the Jail, Mr. Canett took himself to an ER for severe pain, but was arrested at the hospital without ever getting to see a doctor. At the Jail, Mr. Canett was in obvious agony – grimacing, crouching on the floor, leaning against walls, spitting up rubbing his abdomen, and repeatedly asking for help. Despite this, Jail medical staff ignored Mr. Canett other than eventually giving him a small amount of over-the- counter Tylenol. Even Jail deputies recognized Mr. Canett's urgent need for medical assistance and tried to get Jail medical staff to pay attention to him, all to no avail. Jail medical staff did not properly screen Mr. Canett, did not get him to a hospital, and indeed simply ignored him until he died in remarkable pain.

176. A little over two months before Mr. Canett died in the Jail, Wellpath failed to screen, care plan, and provide necessary medications and treatment to 32-year-old Princeton Jackson, who was paralyzed from a prior spinal cord injury with extremely limited use of his now-very-atrophied lower extremities. To urinate, Mr. Jackson requires a catheter and lubricant; to have a bowel movement, he requires an enema, all of which was well understood by Wellpath staff. Still, staff forced Mr. Jackson to ration catheters, leaving him without any means to relieve his bladder for extremely long periods of time. The limited catheter supply Mr. Jackson received was also the wrong size, causing him extreme pain every time he inserted or removed a too-big catheter, and also causing a discharge of chunks of tissue and blood. Wellpath staff also refused to allow Mr. Jackson access to cheap and readily available enema supplies. Instead, they forced him to digitally remove his own feces. Despite numerous requests for medical care and to be seen by a doctor, Mr. Jackson was effectively ignored. During his 72-day detention, Mr. Jackson often had to go hours without

being able to relieve himself, developing infections, constipation, diarrhea, and fecal impaction. He was also denied his prescription Gabapentin, which he needed to alleviate severe nerve pain, and Duloxetine for his depression and PTSD caused by his prior accident. Even one of the Wellpath medical staff was frustrated enough with Wellpath that he charted, in connection with Mr. Jackson's missed doses on March 6, 2022, that the "medication was not given due to critical staffing, only having one person to pass meds for the entire jail."

177. In June 2022, 18-year-old Dezeree Archuleta died from suicide after repeated worsening of her mental health condition was ignored and medical staff repeatedly refused to send her to a hospital. Ms. Archuleta had a well-documented history of mental health issues, including major depressive disorder and PTSD. Despite obvious and known signs of suicidality, staff took Ms. Archuleta off suicide watch. Over the course of her incarceration, Ms. Archuleta's condition spiraled. She talked of suicidal ideation, visual hallucinations, and self-harm, and asked for medications to help with her depression. Wellpath staff merely responded that she should try to take her mind off things. Even after Ms. Archuleta was found naked and punching herself in the face, she was not taken to a hospital or psychiatric care facility. Ms. Archuleta asked Wellpath staff to keep her on suicide watch as she was continuing to have self-harming thoughts. Nonetheless, on June 8 staff removed her from suicide watch. The only reason given for taking Ms. Archuleta off suicide watch was that she had been "bopping back and forth" between being on suicide watch and being off suicide watch. The next day, Ms. Archuleta had a blunted affect and again told staff she was suicidal, but still was not taken to a hospital. Instead, staff merely told Ms. Archuleta

to "use her coping skills." Ms. Archuleta was found dead hanging from a vent grate in her cell by a torn strip of clothing later that day.

178. The day before Daniel Murray's death, on July 3, 2022, Cassandra Ramirez died from drug-related issues in the Jail in yet another instance of untreated substance abuse withdrawal. That day, she had been "chem depping pretty aggressively throughout the day and she was needing a new jumpsuit and blankets," meaning her symptoms had caused her to urinate and defecate on herself. Later that day, she was acting erratically, humming at deputies and fluttering her eyes. Medical staff ignored these serious and obvious symptoms, leaving Ms. Ramirez to die near midnight. It is shocking that despite so many Jail deaths related to substance abuse withdrawal, including Daniel's death and Ms. Ramirez's death within just hours of one another, Wellpath and El Paso County have continued to treat these medical emergencies with deliberate indifference, simply ignoring inmates dying of withdrawal over and over again.

179. Felicia Hudson died at the Jail on October 15, 2022. She had a clinical history of chronic obstructive pulmonary disease and chronic respiratory failure requiring supplemental oxygen. During her intake screening on October 13, she reported to Wellpath staff that she was supposed to use an oxygen concentrator at night. She also reported that for the last three days, she had a cough and shortness of breath. Despite telling a nurse about her chronic conditions and serious symptoms, she was not given oxygen or taken to a hospital. Ms. Hudson was found dead in her cell just two days later.

180. On December 11, 2022, 24-year-old Savannah Poppell was found barely responsive

in her cell surrounded by large amounts of vomit that looked like coffee grounds – a sure sign of internal bleeding. The dark vomit was on the floor, the walls, her bed, and all over her face. Ms. Poppell was withdrawing from opiates, which reasonable medical providers know frequently involves significant vomiting and needs to be properly managed as it may be fatal. Ms. Poppell was also Type I diabetic and her insulin was totally unmanaged even in the very dangerous context of repeated vomiting of blood. Near the time of her death she was extremely hyperglycemic. The coroner concluded that Ms. Poppell experienced such violent and prolonged vomiting from substance abuse withdrawal that she tore her esophagus, suffered a fatal upper gastrointestinal hemorrhage and bled to death at the Jail.

THE JAIL DEATHS AND SERIOUS INJURIES ARE PART OF WELLPATH'S NATIONAL PATTERN OF UNCONSTITUTIONAL CARE

181. The tragic and preventable outcomes at the Jail are part of Wellpath's well-known pattern, practice, and custom of constitutionally inadequate care in jails across the country for many years.

182. These patterns and practices preceded the name Wellpath and were persistent problems in each of Wellpath's predecessor and subsidiary entities. These entities include Correct Care Solutions ("CCS"), Correctional Healthcare Companies ("CHC"), Correctional Healthcare Management ("CHM"), Correctional Medical Services ("CMS"), and Conmed Healthcare Management ("Conmed") (collective "predecessor companies").

183. Wellpath most recently operated under the name CCS, and, as Wellpath, has maintained the same leadership and consistent unconstitutional policies and practices. In submitting Wellpath's bid to take back over the medical care at the Jail, Wellpath

submitted a Qualification Statement for Inmate Medical Services signed by Wellpath President Kip Hallman. Wellpath was asked: "What other names has your company operated under" and answered: "Correct Care Solutions, LLC."

184. Wellpath and its predecessor companies have been the subject of many government investigations, the target of many watchdog organizations and press reports, and defendants in over a thousand lawsuits throughout the country. These investigations and reports all similarly reveal the company's deliberately indifferent practices of ignoring obvious medical emergencies, refusing to treat serious medical conditions, and failing to call a doctor or send someone to a hospital until far too late.

185. In November 2022 financial watchdog organization Private Equity Stakeholder Project issued a report focused on Wellpath entitled "Private Equity Firms Rebrand Prison Healthcare Companies but Care Issues Continue."

186. The report found that "recent investigations indicate that Wellpath facilities are characterized by poor intake and screening; difficulty accessing care; and inconsistent medication management practices."

187. The report concluded that "federal and state correctional authorities should not renew or seek new contracts with Wellpath."

188. In August 2021 the U.S. Department of Justice Civil Rights Division reported on its investigation into conditions of confinement at the San Luis Obispo County, California jail, including Wellpath's health care.

189. The DOJ decided to investigate after 16 inmate deaths between January 2012 and June 2020. By way of comparison, 14 people died at the El Paso County Jail in the much shorter space of time between 2020 and December 2022, mostly due to

Wellpath's deliberately indifferent medical care.

190. Among the DOJ's conclusions: "conditions at the San Luis Obispo County Jail violate the Eighth and Fourteenth Amendments to the United States Constitution…[through] failure to provide constitutionally adequate medical care to prisoners."

191. Specifically, the San Luis Obispo Jail "fails to provide adequate medical assessments, does not timely evaluate or treat prisoners who request medical attention…[and] has failed to deliver an acceptable quality of care in several areas…"

192. The DOJ further found that:

> Many of the [San Luis Obispo] Jail's prisoners…have substance use or co-occurring disorders. In January 2020 alone the [San Luis Obispo] Jail identified at least 103 prisoners actively withdrawing from the influence of drugs or alcohol….[Nonetheless,] when nursing staff learn through initial screenings that prisoners…are actively withdrawing from drugs, the [San Luis Obispo] Jail does not provide prompt evaluation and diagnosis by a medical provider[, defined as a physician, physician's assistant, or nurse practitioner.]

193. Likewise, after a comprehensive investigation, the DOJ reported in December 2018 on the Hampton Roads, Virginia Regional Jail, where Wellpath predecessor CCS provided medical care, that:

> The [Hampton Roads] Jail fails to provide constitutionally adequate medical care to prisoners. Many prisoners at the [Hampton Roads] Jail have serious medical needs requiring treatment, and these prisoners are placed at a substantial risk of serious harm when they do not receive adequate treatment. The [Hampton Roads] Jail fails to provide adequate intake, discharge planning, sick call, chronic care, and emergency care such that prisoners are subjected to an unacceptable risk of harm due to delays or lack of treatment…One of the primary deficiencies in the [Hampton Roads] Jail's medical care system is that it does not take prisoner requests for treatment seriously, and often ignores them.

194. In one illustrative example that closely parallels Daniel Murray's experience of simply being medically disregarded:

> DD, a 69-year-old prisoner, died in March 2016 of severe acute pancreatitis, which was caused by gall stones and coronary artery disease…He repeatedly sought emergency care for his abdominal pain and his chest pain, but there is no documented evidence that he received any medical assistance in the days prior to his death.

195. In June 2019, CNN published a scathing investigation into Wellpath, appropriately titled "Please Help Me Before It's Too Late," that reads like a trip through the dystopian looking glass and shows a crystal-clear nationwide pattern of exactly the same issues that killed Daniel Murray: profit obsession leading to wildly inadequate care or no care at all, practitioners who don't know what they're doing, preventable deaths, medical emergencies being ignored, etc.

196. As CNN put it, "Despite red flags, the same problems are repeated over and over – county to county, state to state and sometimes in the same facilities – in the worst cases leading to deaths that could have been prevented."

197. For example:

> Jeff Lillis, a 37-year-old father of five, was in the Arapahoe County[, Colorado] jail in December 2014 when he got sick and started running a fever. Then…he began coughing up blood and a nurse…called a doctor. Instead of ordering an X-ray of the man's chest, or requesting lab work to test for infection, the records show the doctor prescribed cough medicine. The next day, Lillis was found dead in a pool of blood and vomit. The autopsy report for Lillis showed how "severe" pneumonia had become deadly…The state medical board found that the doctor had acted "below the generally accepted standards of practice…" [T]he board stated that he failed to document any effort to advise the nurse on "concerning symptoms to watch for" and instructions for when Lillis should be sent out for further evaluation, even as he "rapidly deteriorated until his death."
>
> Denny Lovern entered the same Colorado jail in April 2017, more than two years after Lillis' death. Because of a serious heart condition…the 59-year-old told medical staff he had four stents. He was also taking a medication aimed at preventing heart attacks. During his first few days in the jail, Lovern didn't receive the medication because it wasn't in stock. On April 5, he complained of acid reflux and said he wanted to see a doctor. He sought assistance again on the evening of April 6, citing chest pain. He "was feeling as though he may be having a heart attack," a CCS nurse wrote in his chart. But

> instead of calling a doctor…the nurse gave him an antacid and put him in the medical unit for the night. Lovern received his first dose of heart medication the next day, but he was still not seen by a doctor. The morning of April 8, around five days after he was admitted to the jail, Lovern collapsed onto a toilet and died in his own blood and vomit – just like Lillis.

198. In September 2019, The Atlantic reported that "Wellpath's predecessor, [CCS], had been sued at least 1,395 times in federal courts over the past decade."

199. As such, it is impossible for this or any complaint to give more than the tip of the iceberg of cases illustrating Wellpath's patterns of unconstitutional care, but the following highlight Wellpath's repeated deliberate indifference to jail withdrawal, and bear clear similarities to Daniel's death.

200. On September 30, 2022, Prison Legal News reported on the $2.4 million settlement paid by Wellpath and Macomb County, Michigan for the in-custody withdrawal death of David Stojcevski:

> When Stojcevski was booked into the [county] jail on June 11, 2014, he was supposed to serve only 30 days on a failure-to-appear charge. Instead he got a death sentence. During the intake screening process, Stojcevski informed staff that he was being treated with prescriptions for methadone, benzodiazepines, and other opiate medication. His last methadone dose had been 24 hours before, he said. What no one said, but jail medical staff should have known, was that withdrawal from any one of these medications can lead to severe health problems or even death, and that withdrawing from all at once is a medical emergency.
>
> Nevertheless, jail staff made no effort to confirm or acquire Stojcevski's prescriptions…He was placed in a 'high observation' cell, a[n]…ironic name for the place where allegedly no effort was made to ensure that he received adequate nutrition or hydration over the next 16 days, as his uneaten meals piled up and he shed 44 pounds from his 195-pound weight.
>
> Instead, guards, nurses and doctors noted the detainee was behaving "bizarrely" and "refused to engage" with mental health workers. Locked in a suicide watch cell without toilet paper, he was "lying on the floor naked, with rapid eye movement," staff wrote, but they concluded he was "exaggerating his symptoms."

After Stojcevski began having seizures, CCS Dr. Lawrence Sherman noted the detainee's eyes were "fluttering" in what he opined was "certainly not a seizure, but…most likely his poor attempt to feign one." No vitals were taken, and no medical examination was made.

After multiple days on the floor, naked and starving, Stojcevski rolled into the middle of the cell and stopped moving. His breathing became shallow. Two guards reportedly watched on video surveillance as Stojcevski died, but they didn't attempt to get medical attention for him until he was no longer breathing. After they finally called for an ambulance, responding personnel pronounced the detainee dead on June 27, 2014.

201. In 2020, Teton County, Wyoming not only settled with the family of Scott Millward, but parted ways with CCS over Mr. Millward's in-custody death from withdrawal combined with hypertension.

202. According to the Jackson Hole News and Guide, Mr. Millward, 47, was arrested for DUI. He:

Agreed to a breath test when he was booked into the jail, which resulted in a .319 blood alcohol reading…[H]e then told jail staff about his hypertension and diabetes. A jail employee reportedly called a nurse at home to tell her about Millward's dangerously high breath test result.

The nurse ordered staff to take his blood pressure, which was 197 over 141…The nurse instructed a detention officer to give Millward a single dose of [the hypertension medication] Clonidine. Millward reportedly refused the medication, but the nurse wasn't notified.

[The next day] a nurse met with Millward, who would be dead less than 48 hours later…and noted he was experiencing severe tremors, agitation, and anxiety.

Millward appeared before [a] judge…for a preliminary hearing in his DUI. During the hearing [the judge] said Millward didn't look well and ordered an alcohol assessment…18 informal head counts were done improperly the night before and the morning of Millward's death…

203. Mr. Millward was found dead in his cell the next morning. Mr. Millward never saw a doctor, never received a withdrawal screening or withdrawal medication, and was left in his cell to die.

204. Wellpath predecessor, Correctional Healthcare Companies, was dismissed from a lawsuit after "a national healthcare company" that cannot be named because of the terms of the settlement paid $4.25 million for the withdrawal death of John Patrick Walter in the Fremont County, Colorado jail.

205. Jail staff confiscated Mr. Walter's prescription benzodiazepine without providing him a substitute, causing life-threatening withdrawal.

206. As Westword reported on November 30, 2018:

> The result was a horrific and escalating series of symptoms…[including] withdrawal psychosis…Walter went through this process in public. He was placed in an observation cell that allowed a slew of employees to witness his deterioration in slow motion. He was frequently naked and is believed to have lost between 30 and 50 pounds over a stretch that found him banging and kicking on walls, rolling on floors and yelling at people who existed only in his imagination. By the end, he was visibly bruised, swollen and had at least nine broken ribs…He was found lifeless in his cell on April 20, [2014].

207. In 2002 the ACLU settled a lawsuit against the El Paso County Jail and Wellpath predecessor company Correctional Medical Services ("CMS") for the withdrawal-related death of pre-trial detainee Andrew Spillane.

208. Mr. Spillane was showing classic DTs symptoms, including "hallucinating, bouncing off the walls, and becoming increasingly agitated and irrational. In addition, jail authorities were on notice that Spillane had a history of seizures during withdrawal."

209. Rather than CMS treating Mr. Spillane, Jail deputies viewed his symptoms as a behavioral problem, not a medical problem, and peppered sprayed him. They:

> Laid Spillane face-down on the concrete floor, handcuffed his hands behind his back, and shackled his legs. Spillane immediately had trouble breathing, and he died very shortly afterwards.

210. And so on. These are simply a small selection among literally hundreds of examples of horrifying deaths and refusals of care showing Wellpath's unconstitutional policies and practices, both under its previous names and continuing, and especially related to jail withdrawal.

COUNTY DEFENDANTS ARE LIABLE FOR THEIR POLICY DECISION TO RE-HIRE AND MAINTAIN WELLPATH AS THE MEDICAL COMPANY IN THE JAIL DESPITE KNOWN MISCONDUCT AND CONTINUING UNCONSTITUTIONAL CARE PRIOR TO MR. MURRAY'S DEATH

211. CCS, the immediate predecessor company to Wellpath, was the contracted medical provider in the El Paso County Jail until 2017.

212. Prior to Mr. Murray's death, the County Defendants knew that there was a widespread practice of deliberately indifferent medical care by Wellpath/CCS, both nationally and in the El Paso County Jail.

213. The County Defendants had previously *fired* CCS from the Jail because of CCS's recklessly substandard care, which played a significant role in the Jail being put on probation from its health care accrediting agency, the National Commission on Correctional Health Care.

214. Leading up to the 2017 termination of CCS/Wellpath, the County Defendants knew well that CCS/Wellpath's for-profit model was a major problem in the Jail, that over a thousand health care tasks and requests were not completed by the staff that CCS/Wellpath had in place, that inmate sick calls were going unanswered for a week or more, and that these factors nearly lost the County its accreditation.

215. The County hired Armor Correctional Health Services "(Armor") to replace CCS.

216. Roughly two years later, the County then terminated Armor and switched back to Wellpath because of dissatisfaction with Armor.

217. Armor's defense to the County's dissatisfaction was that Armor had inherited a system from CCS/Wellpath that was out of compliance with national standards and straining under a serious backlog of critical tasks – including more than 1,500 medical requests.

218. CCS's system-wide unconstitutional deficiencies were unlike anything Armor "had ever seen."

219. In an article about the decision to go back to Wellpath after having previously terminated CCS and the incredible backlog of medical care tasks that CCS left behind, then-El-Paso-County-Sheriff Elder said he was "'absolutely' concerned about similar problems if the County again hires Wellpath."

220. Despite Sheriff Elder's concerns, and despite the many, many lawsuits alleging deliberate indifference against Wellpath/CCS, El Paso County re-contracted with Wellpath/CCS to provide for-profit medical services in the Jail. Initially conceived as a stopgap measure while Sheriff Elder tried to persuade County stakeholders to create a community-based health care model for the Jail, the County's contract with Wellpath has been renewed every year since 2019.

221. In 2019 the County signed a one-year contract with Wellpath – valued at $8.7 million – despite having moved away from this very same for-profit correctional health care provider in the pursuit of better care. Sheriff Elder admitted to 5280 Magazine that

they were hiring Wellpath again "even though they're now the same people we had to get rid of two years ago."

222. When the County Defendants put the Jail medical care contract out for bid, the next nearest bid to Wellpath's was $15,000,000, "almost twice as much" as Wellpath bid, which likely reflects other companies' assessments of how much it costs to profitably run Jail medical care while also providing constitutionally adequate care.

223. Knowing that other companies looking at the Jail's health care needs thought it would cost twice as much as Wellpath bid was a red flag that Wellpath would continue underfunding and under-responding to inmates' serious medical needs – causing 14 deaths since Wellpath took back over the contract in 2020.

224. Knowing all of these problems, the County willingly, and with deliberate indifference, went back into a relationship with Wellpath.

225. This policy choice creates direct liability for the County Defendants, in addition to their liability for Wellpath's policies based on the County Defendants' non-delegable duties.

CLAIMS FOR RELIEF

First Claim for Relief
Violation of 42 U.S.C. § 1983) – 14th Amendment
Unconstitutional Policies
(Plaintiff Estate against Entity Defendants)

226. Paragraphs 1 through 226 are incorporated herein.

227. Daniel Murray was a pre-trial detainee.

228. As a pre-trial detainee, Daniel was protected from deliberate indifference to his known serious medical needs by the 14th Amendment.

229. The allegations in this Complaint show that Entity Defendants are liable under 42 U.S.C. § 1983 for maintaining deliberately indifferent policies which resulted in the violation of Daniel Murray's 14th Amendment right to adequate medical care and to humane conditions of confinement.

230. Defendant Wellpath knew that its policies, practices, and customs posed a risk of serious harm to pre-trial detainees like Daniel Murray, and it was obvious that such harm would occur and had occurred to other inmates.

231. Still, Wellpath failed to take steps to alleviate those risks of harm.

232. There is an affirmative causal link between the deliberate indifference of the individual health care workers toward Daniel Murray and the policies, practices, and customs described herein.

233. The El Paso County Defendants are directly liable for their own policy choices to hire and retain Wellpath.

234. The El Paso County Defendants also have non-delegable liability for the constitutional violations of Wellpath as the County Defendant's contractor.

235. As a direct and proximate result of Entity Defendants' unlawful conduct, Plaintiff Estate has suffered injuries and losses entitling it to recover its compensatory and special damages, including for death, loss of earnings, loss of enjoyment of life, loss of relationships, suffering, pain, and other special damages, all in amounts to be proven at trial.

236. Plaintiff is entitled to attorney fees under 42 U.S.C. § 1988, as well as interest and costs.

237. Plaintiff is also entitled to punitive damages against Wellpath, in that Wellpath's

actions were malicious, willful, or showed reckless or wanton disregard for Daniel Murray's constitutional rights.

Second Claim for Relief
Violation of 42 U.S.C. § 1983 – 14th Amendment
Unconstitutional Medical Care
(Plaintiff Estate against Defendants Dianne Hawthrone-Cruz, Wendy Morris, George Santini, J. Dylan Cox, Michelle Silva, and Magdalina Beultemann)

238. Paragraphs 1 through 238 are incorporated herein.

239. Daniel Murray was a pre-trial detainee.

240. As a pre-trial detainee, Daniel was protected from deliberate indifference to his known serious medical needs by the 14th Amendment.

241. At all relevant times, the Individual Wellpath Defendants acted under color of state law.

242. As a result of the allegations contained in this Complaint, Individual Wellpath Defendants are liable under 42 U.S.C. § 1983 for the violation of Daniel's rights under the 14th Amendment by acting with deliberate indifference to his serious, emergency medical needs and disregarding the excessive risks associated with Daniel's serious and life-threatening medical condition, despite being expressly aware of Daniel's known serious medical needs.

243. The Individual Wellpath Defendants personally participated in the constitutional deprivations described in this Complaint.

244. The acts and omissions of these Defendants were the legal and proximate cause of Daniel's injuries and his Estate's losses.

245. As a direct and proximate result of these Defendants' unlawful conduct, Plaintiff Estate has suffered injuries and losses entitling it to recover its compensatory and

special damages, including for death, loss of earnings, loss of enjoyment of life, loss of relationships, suffering, pain, and other special damages, all in amounts to be proven at trial.

246. Plaintiff is entitled to attorney fees under 42 U.S.C. § 1988, as well as interest and costs.

247. Plaintiff is also entitled to punitive damages against these Defendants, in that their actions were malicious, willful, or showed reckless or wanton disregard for Daniel Murray's constitutional rights.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff respectfully asks that the Court enters judgment against Defendants, and awards Plaintiff:

(a) All available compensatory damages, including, but not limited to, all available damages for pain and suffering, physical, mental, and emotional distress, lost past and future earnings, and all other economic and non-economic damages available under the law;

(b) Punitive damages on all claims as allowed by law, in an amount to be determined at trial against corporate defendant Wellpath and the Individual Wellpath Defendants.

(c) Costs and attorney fees

(d) Pre- and post-judgment interest as appropriate; and

(e) Any further relief at law or equity that this Court deems just and proper.

JURY DEMAND

Under Fed. R. Civ. P. 38(b), Plaintiff demands a jury trial on all issues so triable.

Dated: Originally filed June 28, 2024.
Approved for filing July 31, 2024.

s/ Scott Melin
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