IN THE UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF PENNSYLVANIA

CYNTHIA JEWETT WHITLOW, Administratrix Of the Estate of CLARENCE J. JEWETT, JR., Deceased,	)	No.
Plaintiffs,	)	**JURY TRIAL DEMANDED**
v.	)	
CORIZON, INC.; CORIZON HEALTH, INC.; ALLEGHENY COUNTY d/b/a ALLEGHENY COUNTY JAIL; ORLANDO HARPER; LATOYA WARREN;	)	

COMPLAINT IN CIVIL ACTION

AND NOW, come Plaintiffs, Cynthia Jewett Whitlow, Administratrix of the Estate of Clarence J. Jewett, Jr., deceased, by and through her attorney, STEVEN M. BARTH, ESQUIRE, and file the following COMPLAINT:

PARTIES

1. Plaintiff, Cynthia Jewett Whitlow, is an adult individual who has been appointed Administratrix of the Estate of Clarence J. Jewett, Jr., (hereinafter referred to as "Plaintiff Jewett"), deceased, by the Register of Wills of Allegheny County, Pennsylvania, case number 021506649. She has an address of 300 16th Street SW, Birmingham, Alabama 35211.

2. Plaintiff Jewett was born on November 19, 1952 and died on December 26, 2014.

3. Plaintiff, Cynthia Jewett Whitlow, as the Administrator and Administratrix of the Estate of the Estate of Clarence J. Jewett, Jr., deceased, bring this action on behalf of all persons entitled to recover damages for the wrongful death of Clarence J. Jewett, Jr., pursuant to 42 Pa. C.S.A. Section 8301. Plaintiffs also bring this action to recover damages on behalf of the Estate of Clarence J. Jewett, Jr., pursuant to 42 Pa. C.S.A. Section 8302.

4. The names and addresses of all persons entitled by law to recover damages for the death of Clarence J. Jewett, Jr., and their relationship to the Decedent Plaintiff are listed as follows:

(a) James Earl Jewett – Son
293 Abbey St.
NW Atlanta, Georgia 30314

(b) Cynthia Jewett Whitlow – Daughter
300 16th St.
SW Birmingham, Alabama 35211

(c) Ricky Eugene Jewett – Son
293 Abbey St.
NW Atlanta, Georgia 30314

(d) Felicia Jewett Todd – Daughter
1400 Chapelridge Dr. #144
Gardendale, Alabama 35071

5. During his lifetime, Clarence J. Jewett, JR., did not commence any action to recover damages for the injuries which caused his death and no other action has been filed to recover damages for the injuries and wrongful death of Clarence J. Jewett, Jr.

6. Defendant, Corizon Health, Inc., is a Delaware corporation or other business entity with the principal place of business located at 105 Westpark Drive, Suite 200, Brentwood, Tennessee 37027.

7. Defendant, Corizon, Inc., is a Missouri corporation or other business entity with a principal place of business located at 105 Westpark Drive, Suite 200, Brentwood, Tennessee 37027.

8. Defendants Corizon, Inc. and Corizon Health, Inc., (hereinafter referred to as "Corizon Defendants") are engaged in the business of providing health care and services on a contract basis to Allegheny County and Allegheny County Jail in December of 2014 and at all relevant times referenced later in this Complaint.

9. At all times relevant hereto, the CORIZON DEFENDANTS ensured the availability and provision of medical care at the Allegheny County Jail and accordingly, these Defendants acted as an agent, servant, employee and/or subordinate of local state agency Defendant, ALLEGHENY COUNTY.

10. At all times relevant hereto, the CORIZON DEFENDANTS were immediately and directly responsible for the availability and provision of medical services at the Allegheny County Jail and the maintenance of an infirmary as well as intake including 3 page reports within the jail. Accordingly, these Defendants, were immediately and directly responsible for the health and safety of inmates and the availability and provision of adequate medical treatment to inmates.

11. At all times relevant hereto, the CORIZON DEFENDANTS represented the legal authority and official policy of ALLEGHENY COUNTY in regards to the maintenance of the health and safety of inmates in regards to the provision and availability of adequate medical care. As such, these Defendants represented the legal authority of and acted under color of state law relative to the availability and provision of medical care.

12. At all times relevant hereto, Defendant ORLANDO HARPER (hereinafter "DEFENDANT HARPER") was the Warden of the Allegheny County Jail charged with the control and supervision of all guards and/or employees, independent contractors, and/or persons employed/working within the jail. As such, he was responsible for the training, supervision, direction, procedures and conduct of all guards, staff, personnel, independent contractors, and was responsible for the health and safety of inmates within the Allegheny County Jail.

13. At all times relevant hereto, Defendant HARPER was responsible for creating and executing policies to ensure the safety, health, and availability and provision of care, custody and control of all inmates within the Allegheny County Jail. Accordingly, Defendant HARPER was responsible for formulating and implementing jail guard procedures to protect the safety, health, availability and/or provision of adequate care and custody to inmates.

14. At all times relevant hereto, Defendant HARPER represented the legal authority and official policy of ALLEGHENY COUNTY pertaining to guard actions, duties, responsibilities, training, procedures, supervision regarding the safety, health, availability and/or provision of adequate care, custody and control of inmates. As such, Defendant HARPER acted under color of state law in those regards.

15. At all times relevant hereto, Defendant LATOYA WARREN, (hereinafter "WARREN") was the deputy warden of the Allegheny County Jail charged with the control and supervision of all guards employed within the jail. As such, she was responsible for the training, supervision, direction, procedures and conduct of all guards, and was responsible for the health, safety, custody and control of inmates within the Allegheny County Jail.

16. At all times relevant hereto, Defendant WARREN represented the legal authority and official policy of ALLEGHENY COUNTY pertaining to guard actions, duties, responsibilities, training, procedures, supervision regarding the safety, health, availability and/or provision of adequate care, custody and control of inmates. As such, Defendant WARREN acted under color of state law in those regards.

17. At all times relevant hereto, Defendant WARREN was responsible for creating and executing policies to ensure the safety, health, and availability and provision of adequate care, custody and control to all inmates within the Allegheny County Jail. Accordingly, Defendant WARREN was responsible for formulating and implementing jail guard procedures to protect the safety, health, availability and/or provision of adequate care, custody and control to inmates.

18. At all times relevant hereto, Defendants HARPER and WARREN were immediately and directly responsible for the availability and provision of training provided to correctional officers and other staff at the Allegheny County Jail and the maintenance of a fully trained staff within the jail. Accordingly, Defendants HARPER and WARREN were immediately and directly responsible for the health and safety of inmates and the availability and provision of adequate training to correctional officers and all staff.

19. At all times relevant hereto, Defendants HARPER and WARREN and their agents, servants, and/or employees were responsible for creating and implementing procedures, policies, guidelines, and practices for timely jail guard rounds, recognizing inmates under medical distress or in medical emergency and recognizing mental health inmates being at risk for medical emergencies and distress.

20. Defendants HARPER and WARREN represented the legal authority and official policy of ALLEGHENY COUNTY, and acted under color of state law.

21. At all times relevant hereto, Defendants HARPER and WARREN and their agents, servants and/or employees were responsible for creating and implementing procedures, policies, guidelines, and practices for timely rounds, investigations, referrals of inmates, and pod inspection when circumstances arose that warranted intervention in order to protect a mental health inmate from a medical emergencies.

22. Defendants HARPER and WARREN represented the legal authority and official policy of ALLEGHENY COUNTY and acted under color of state law.

23. At all times relevant hereto, the Defendant ALLEGHENY COUNTY was a local state agency organized and existing under the laws of the Commonwealth of Pennsylvania, authorized to and maintaining the Allegheny County Jail for the purposes of safely detaining, incarcerating and rehabilitating citizens and inhabitants of Allegheny County.

24. At all times relevant hereto, Defendants, HARPER, WARREN, CORIZON DEFENDANTS and ALLEGHENY COUNTY, and their agents, servants, and/or employees were responsible for creating and implementing procedures, policies, guidelines, and practices for timely jail guard and/or jail personnel referrals of inmates suffering from adverse medical conditions to the jail infirmary to protect the health and safety of inmates. In providing for this determination by jail guard and/or jail personnel, all Defendants represented the legal authority and official policy of ALLEGHENY COUNTY, and acted under color of state law.

25. At all times relevant hereto, all Defendants and their agents, servants and/or employees were responsible for creating and implementing procedures, policies, guidelines, and practices for timely referrals of inmates by infirmary personnel to outside medical providers which the medical facilities and personnel at the Allegheny County jail infirmary are inadequate to address an inmate's medical condition. In providing for this determination to be made by infirmary personnel, all Defendants represented the legal authority and official policy of ALLEGHENY COUNTY and acted under color of state law.

26. At all time relevant hereto, all Defendants were agents, servants, and/or employees of ALLEGHENY COUNTY.

27. At all times relevant hereto, Defendant ALLEGHENY COUNTY acted through its agents, servants, and employees.

28. By virtue of its conduct, through its agents, servants, and employees, in detaining, incarcerating, protecting and rehabilitating inmates at the Allegheny County Jail, Defendant, ALLEGHENY COUNTY, expressly assumed the duties of maintaining the health and safety of inmates in regards to the provision and availability of adequate medical care and maintenance of clean, healthful, and safe conditions at the Allegheny County Jail.

29. By virtue of its conduct, in the creation and through contract language, Defendant, ALLEGHENY COUNTY, expressly assumed the duties of maintaining the health and safety of inmates in regards to the provision and availability of adequate medical care and maintenance of clean, healthful, and safe conditions at the Allegheny County Jail.

30. The maintenance of clean, healthy, and safe conditions and the provision of adequate medical care to inmates within the Allegheny County Jail are operations and functions of the Defendant, ALLEGHENY COUNTY.

31. By virtue of its conduct, through its agents, servants, and employees, in detaining, incarcerating, protecting and rehabilitating inmates at the Allegheny County Jail, Defendant ALLEGHENY COUNTY expressly assumed the duties of maintaining the health and safety of inmates with the provision and availability of adequate care, custody and control as well maintenance of clean, healthful, and safe conditions at the Allegheny County Jail.

32. The maintenance of clean, healthy, and safe conditions and the provision of adequate care, custody and control to inmates within the Allegheny County Jail are operations and functions of the Defendant, ALLEGHENY COUNTY.

JURISDICTION AND VENUE

33. This action arises under 42 U.S.C. §1983. This Honorable Court has jurisdiction over this matter pursuant to 28 U.S.C. §1331 as this civil action arises under the Constitution and the laws of the United States.

34. Venue is proper in this District under 28 U.S.C. §1391(b) because all of the events, actions and omissions giving rise to the within claims occurred in this District.

FACTS

35. Each of the above paragraphs is incorporated herein by reference.

36. At all times relevant hereto, the CORIZON DEFENDANTS were doing business, including contracting for the provision of health services and providing health services to inmates of Allegheny County Jail, as agent of the Defendant ALLEGHENY COUNTY and were being paid by Defendant ALLEGHENY COUNTY.

37. At all times relevant hereto, all of the Defendants were required to adhere to and enforce the following policy and procedures:

a.) These Defendants must provide reasonable measures to prevent unfortunate death which can be caused by failing to obtain medical care for inmates that require such action and recognize this as one of the highest priorities of service within the correctional setting;

b.) These Defendants must work together to identify inmates at risk for medical issues;

c.) These Defendants will have an outlined program for responding to inmate medical issues;

d.) These Defendants must educate, train, enforce and/or adhere to the proper cell inspection when doing rounds in order to make sure that inmates are not in medical distress;

e.) These Defendants must learn about an inmates' high risk periods of experiencing medical distress due to mental health disabilities that make it difficult to communicate basic information;

f.) These Defendants must learn about the medical history of inmates housed on a pod in order to determine if any of the inmates are a medical threat to other inmates or in distress;

g.) These Defendants must make rounds upon the pod pursuant to policy and procedure in order to prevent inmate medical distress/death;

h.) These Defendants will review information of newly arriving inmates on a pod in this institution concerning issues related to being susceptible to medical conditions;

i.) These Defendants conducting the rounds on a pod will be continuously alert to medical emergencies;

j.) These Defendants will train their staff who work with inmates to recognize verbal and behavioral cues that indicate the potential for inmates suffering from acute injury, medical distress and the like;

k.) These Defendants who recognize an inmate as being potentially a medical emergency are to request immediate evaluation of the inmate through the nursing, medical or mental health staff;

l.) These Defendants' staff who recognize an inmate as being a potential medical emergency are to request immediate evaluation of the inmate through the nursing, medical and/or mental health staff on designated Pods;

m.) All assessments of potentially mentally ill inmates is to be conducted by qualified professionals, trained to determine an inmate's level of physical health, violence to other inmates, overall health and the like;

n.) Inmates who have been determined to be a medical emergency should be placed/housed according to institutional policy and procedures for the monitoring of such individuals within the correctional setting. Regular documented supervision should be maintained;

o.) Regular, documented supervision should be maintained of a pod by a correctional officer;

p.) Regular, documented round should be maintained of a pod by a correctional officer;

q.) Constant supervision by a staff member of the pod is required and if a situation arises which requires intervention, it must be investigated immediately and intervention is required if the safety of an inmate is at issue;

r.) The procedures for making rounds and how rounds are made as well as inspection of cells should be clearly outlined;

s.) Clear, current and accurate information regarding an inmate must be communicated between shifts and correctional personnel pursuant to the procedures of communication;

t.) The intervention plan on how to handle inmate medical emergencies that is in progress, including appropriate first aid measures, should be clearly outlined;

u.) Procedures for notifying correctional administrators, outside authorities and family members of potential, attempted or completed inmate medical emergencies will be in place;

v.) Procedures for documenting the identification and monitoring of potential or attempted inmate medical emergencies will be detailed, as well as procedures for reporting a completed inmate medical emergency;

w.) The intervention plan should specify the procedure for administrative review if an inmate medical emergency occurs;

x.) A formal procedure of collecting evidence and preserving evidence such as camera footage must be in place and clearly outlined;

y.) A formal procedure will be in place regarding assessing inmates with severe schizophrenia and the inability to communicate in order to determine their overall health;

z.) Taking a thorough physical and mental examination of mentally disabled/ill inmates in order to assess their overall health and care;

aa.) In having inmates see physicians in a timely manner when physician assistants order and/or refer an inmate to medical for a history and physical;

bb.) In recognizing that the Allegheny County Jail has taken on the role of housing mentally disabled and ill inmates and recognizing the necessary care that is required to provide the most basic of care and treatment;

cc.) In ordering baseline medical examines for recently acquired inmates;

dd.) In recognizing that follow through with obtaining medical referrals and the history and physical examination of inmates, intervention and treatment earlier in the course of an illness will have a positive outcome and cost the tax payers less in housing criminals;

ee.) In recognizing that peritonitis is a medical emergency;

ff.) In recognizing that a physical assessment can result in "objective findings" that would have shown that inmates may have suffered from treatable diseases and/or illnesses;

gg.) A plan is present for inmates that have poor nutrition and intake of fluids in order to assess for other illnesses, diseases or disorders;

hh.) In providing the therapeutic level of medication in order to have the desired effect of the medication which would control such mental health issues/diseases such as schizophrenia;

ii.) In recognizing that a person should go to a mental health facility instead of a jail setting when the appropriate guidelines and procedures are followed and met.

jj.) In implementing a policy and procedure to make inmates receive the proper medication;

kk.) In formulating a policy to handle and/or treat mental health inmates who are in full distress and/or catatonic and/or incompetent to make any health decisions in order to get a medical baseline and/or send them to a mental health facility;

ll.) In utilizing the various means to protect mentally ill inmates from themselves by implementing the mental health system.

38. On or about December 16, 2014, Plaintiff Jewett was arrested by the City of Pittsburgh Police Department and the arresting officer noted the following in his criminal complaint which is attached as Exhibit 1 to this Complaint:

On 12-16-14, at 1548 hrs, I was returning to the Zone 6 station after towing a suspicious vehicle on Banksville Road. While driving down Wabash into the West End. I came across a black male who was standing on the sidewalk, inches from the street. That male was screaming obscenities at someone down the street saying "Fuck you. Mother fucker", repeatedly. I pulled my car across the street into a parking lot, and exited my vehicle. As I got out of my car, the male, later identified as Clarence Jewett Jr, was still screaming obscenities at several civilians about thirty yards down the street.

As I crossed the street towards Jewett, I ordered him to stop screaming the obscenities, and that was when he looked at me and stated "Fuck you, motherfucker." I ordered Jewett to stop again, and to produce an Identification card or license. At that point I was going to cite Jewett for disorderly conduct, and Jewett again stated" Fuck you", and started up his steps into his apartment building. I caught up to Jewett, and again ordered him to stop. He told me to "Fuck off', and started to open the door to the inside of the apartment building. I requested backup immediately, and told Jewett again to stop, which he again replied "Fuck you" and continued to try and get in the apartment. After telling Jewett again to stop, he turned from the door and squared up facing me. Jewett leaned towards me in the foyer, and stated "I'm not fucking doing nothing." I grabbed Jewett's shirt, and attempted to pull him away from the door, but he did not budge and pushed my hand off his shirt sleeve. I heard sirens quickly approaching, so I took a step

back and waited for the next unit to arrive. Unit 3801 arrived, and Officers Duffola and DeGuffroy came up the steps into the small foyer area I was in. I ordered Jewett to face the wall and put his hands on the same wall, but he replied" I'm not doing fucking nothing." Officer Duffola grabbed Jewett's right arm, and I grabbed his left as we attempted to place Jewett against the wall. Jewett immediately resisted, and started attempts to pull his arm away. Myself and Officer Duffola managed to get a hold of each arm again, and started escorting Jewett out of the foyer to the porch area where there was more room. Jewett continued to resist us, and numerous more officers arrived on scene.

As we got Jewett outside, we were able to stand him against the porch and attempted to handcuff him. I held Jewett's left arm in place, while Detective Mates applied the cuff to the left wrist. Jewett continued to struggle, trying to get away from our grasp. I told Jewett to quit resisting, but he continued to struggle as we attempted to get the right cuff on his right wrist. Officer Spath finally got the cuff on Jewett's right wrist, and it took four officers to get Jewett into the 3601 wagon. While handcuffing Jewett, he screamed obscenities at all the officers there, calling us "racists", and "KK" repeatedly. Jewett refused to give me any of his personal information, but I was able to get his name and social security number off of his social security card. Once handcuffed, Jewett dropped himself to the ground in attempt to not be taken to the wagon. Detective Brock was able to catch him and prevent him from hitting the sidewalk face first. Detective Brock immediately stated he hurt his back, and later on followed up reporting that injury with the city. Jewett refused to cooperate and walk to the back of the wagon, and had to be carried by four officers to the rear of the wagon, where he was placed into back. Jewett was transported to the ACJ by 3601 and was checked in there. Once at the ACJ, Jewett refused to get out of the wagon, and was removed by jail staff and immediately placed into the restraint chair. Jewett was then accepted into custody at the jail.

Officers DeGuffroy and Duffola checked the back of the wagon at the beginning of the shift, and also before and after transporting Jewett to the ACJ. In addition. Both Officer Duffola and Officer DeGuffroy checked their weapons into the assigned lockers before Jewett was removed from their vehicle.

After Jewett was transported, I spoke with several neighbors who stated to me that they are afraid of Jewett, and that he has threatened them in the past on numerous occasions. These people did not want to be identified, but two females stated they are afraid to walk on the sidewalk if they see Jewett out.

39. Based upon this Criminal Complaint, Plaintiff Jewett was showing signs of mental illness at the time of his arrest as well as at the time he was taken into custody by the Allegheny County Jail.

40. Based on this Criminal Complaint, it appears that Plaintiff Jewett was either housed in the back of the transport for over 24 hours due to a policy and procedure of the Defendants.

41. Based on this Criminal Complaint, if the Plaintiff Jewett was not housed in the back of the transport then he was kept in the restraint chair from December 16, 2014 to December 18, 2014 pursuant to policy of the Defendants.

42. At all times relevant hereto, the Defendants did not have a policy to deal with mentally incompetent inmates and only advocated the policy of putting them out of sight.

43. The Defendants knew the following about Plaintiff Jewett when he was placed in their care, custody and control on December 16, 2014:

a.) Plaintiff Jewett was previously incarcerated at the Allegheny County Jail on January 24, 2006 to February 1, 2006 and August 13, 2013 to October 16, 2013;

b.) All of the Defendants knew that Plaintiff Jewett suffered from schizophrenia and psychosis;

c.) Plaintiff Jewett was previously taken to Mercy ER for not eating for 11 days on August 24, 2013;

d.) Plaintiff Jewett did not communicate with personnel of the Allegheny County Jail August 15, 2013 through August 24, 2013;

e.) Plaintiff Jewett was found to be dehydrated on August 13, 2013 when he was taken to the Allegheny County Jail and Allegheny Correctional Health Services, Inc., sent him to Mercy ER for treatment;

f.) When Plaintiff returned to the Allegheny County Jail after his August 15, 2013 visit to Mercy ER, he refused to eat, drink and communicate;

g.) During Plaintiff's August 2013 stay at the Allegheny County Jail he was exhibiting psychotic signs;

h.) Plaintiff was housed in 5C from August 13, 2013 to August 24, 2013;

i.) Plaintiff was physically examined by Mercy ER on August 13, 2013 and August 24-25, 2013;

j.) On August 28, 2013, an order was entered that the Plaintiff was thought to be incompetent to stand trial and was in need of a hearing and determination of competency;

k.) Plaintiff was put in the restraint chair when entering Allegheny County Jail in August of 2013.

44. At all times relevant hereto, the Defendant ALLEGHENY COUNTY knew that housing inmates in the appropriate housing promotes care, custody and control of the inmates.

45. At all times relevant hereto, Plaintiff Jewett was transported immediately to the Allegheny County Jail by the City of Pittsburgh Police on the date of his arrest on December 16, 2014. See Exhibit 1.

46. No records exist where Plaintiff Jewett was housed from December 16, 2014 through December 18, 2014, however, it is believed that Plaintiff Jewett was housed at the Allegheny County Jail as stated above.

47. When the Plaintiff Jewett was taken to the Allegheny County Jail, it is believed that the Plaintiff was unresponsive to correctional staff, refused to walk, refused to get out of the back of the transport wagon, sang excessively and was placed immediately in the restraint chair by all of the employees, agents, and/or servants of the Defendants. See Exhibit 1.

48. It is believed that it was a standard policy and procedure to deal with psychotic/mental health individuals to place them in the restraint chair or leave in the transport for unreasonable lengths of time by all Defendants.

49. At all times relevant hereto, no attempt was ever made to transfer the Plaintiff to a mental health facility by any Defendants.

50. On or about December 18, 2014, an agent, servant and/or employee of the CORIZON DEFENDANTS performed a Mental Health Evaluation which found the following:

a.) Plaintiff was non-responsive;
b.) Plaintiff was in the restraint chair;

c.) Plaintiff called the agent, servant and/or employee "Stupid" and continued to scream "You don't know who I is";

d.) CORIZON DEFENDANTS noted that the Plaintiff reportedly has not eaten anything in at least one day.

See MET dated December 18, 2014 which is marked as Exhibit 2.

51. Based on the Mental Health Evaluation, the Plaintiff was admitted to Pod 5C, the mental health pod of the Allegheny County Jail.

52. At all times relevant hereto, no physical was conducted on the Plaintiff at this time and no history was acquired.

53. On December 19, 2014, a Psychiatrist Initial Evaluation was conducted by an agent, servant and/or employee of the CORIZON DEFENDANTS which states the following:

a.) Prior October 2, 2013 evaluation was reviewed;

b.) Screaming was listed as present psychiatric illness;

c.) Refusal to answer questions are noted;

d.) Past psychiatric medication was listed;

e.) Refusal to answer history portion on 12/19, 12/20 of 2013;

f.) Referred to Medical for history and physical;

g.) Referred to Mental Health Clinician and Psychiatrist and labeled as routine.

See Psychiatrist Initial Evaluation dated December 19, 2014 which is marked as Exhibit 3.

54. The Plaintiff was never seen by anyone from Medical and no history or physical was performed at any time from December 19, 2014 through December 26, 2014 even though it was ordered by an employee, agent and/or servant of CORIZON DEFENDANTS. See Exhibit 3.

55. At all times relevant hereto, from December 16, 2014 through December 26, 2014, no medical professional attempted any physical exam upon the Plaintiff.

56. From December 16, 2014 through December 26, 2014, the Plaintiff Jewett experienced and exhibited the following while in the care, custody and control of the Defendants:

a.) It was clear upon admission that the Plaintiff was unable to clearly express himself regarding the reasons he was not eating or drinking;
b.) Plaintiff was referred to Medical for a history and physical on December 19, 2014;
c.) Plaintiff suffered from erosive esophagitis which is known to cause "secondary peritonitis";
d.) Plaintiff was never given a history or physical;
e.) A medical referral was given because the Plaintiff was non-communicative and it was unknown to the medical and jail personnel how long the Plaintiff was without food or water;
f.) No baseline medical examination was given of the Plaintiff;
g.) The Defendants knew from his prior incarceration in August of 2013 that he was taken to UPMC Mercy Hospital twice during an 11 day stay because he was severely dehydrated from not eating and drinking and required medical therapeutic intervention;
h.) Because of the lack of follow through on the medical referral, the Plaintiff's generalized peritonitis continued to advance along the expected course and he succumbed to the illness without any treatment;
i.) Peritonitis develops in several stages and the autopsy description of the Plaintiff peritoneal cavity indicated that he was clearly in the last stages of peritonitis;

j.) The Plaintiff's abdominal organs were bathed in pus and indicate the "spreading peritonitis" stage;

k.) A physical assessment would have resulted in objective findings that would have shown that the Plaintiff had acute peritonitis and that a medical emergency existed;

l.) No routine bloodwork was done even though the Plaintiff was not eating or drinking;

m.) The Defendants were aware during the Plaintiff's stay at ACJ that he had minimal fluid and food which was not consistent with maintaining optimal body functioning;

n.) The Plaintiff was never sent to the emergency room during this stay;

o.) The Plaintiff was ordered to be on Cogentin and Haldol to control his schizophrenia;

p.) The Plaintiff only received 6 doses of his ordered medication to control his schizophrenia when he should have received 16 doses;

q.) The Plaintiff needed his medication dispensed at therapeutic levels in order to have the desired effect of the medications which would control his schizophrenia;

r.) The Plaintiff's refusal to eat was a symptom of both his schizophrenia and his acute peritonitis;

s.) Nausea and vomiting of the Plaintiff are part of the symptoms related to acute generalized peritonitis;

t.) The Defendants knew that the Plaintiff was unresponsive to the personnel of the jail, yet no interventions or attempts to get the Plaintiff to respond;

u.) The Plaintiff vomited in his cell and coded;

v.) The Plaintiff was found lying face down in his cell on December 26, 2014;

w.) The Plaintiff died at the hospital on December 26, 2014.

57. According to the Inmate Timeline made by the CORIZON DEFENDANTS, the following was represented by them to other entities in the Mortality Review Form which is attached as Exhibit 4:

a.) 12-18-2014, Inmate Jewett was admitted to the Allegheny County Jail at 9:00AM was seen by the mental health specialist Michelle Kovalcik. Admitted to 5C gown only, close observation as per the mental health specialist with telephone orders from PAMundy;

b.) 12-19-2014, Inmate Jewett seen by PA Mundy, maintain close observation and begin Haldol - 5mg bid and Cogentin-lmg bid;

c.) 12-20/21-2014, Inmate Jewett seen by PA Mundy, maintain close observation.

d.) 12-22-2014, Inmate Jewett seen by Psychiatrist Wilkosz, stopped close observation and maintained on 50 continued Haldol and Cogentin;

e.) 12-23-2014, Inmate Jewett seen by NP Danielle Litzinger, possible hunger strike. Vital signs stable, patient encouraged to eat and drink;

f.) 12-24-2014, Inmate Jewett observed eating and drinking by Mental Health Aide Paul Veto;

g.) 12-25-2014, Inmate Jewett ate breakfast.

h.) 12-26-2014, 10:25PM; Inmate Jewett found face down in cell by CO Smart while making rounds and called for medical assistance. Nurses Rivi and Alicia Hollingsworth responded; inmate had faint heart rate, pulse 106, 29% 02 SAT, unable to obtain blood pressure. Medical emergency called- 911, AED applied, CPR initiated. Paramedics arrived and continued CPR, EPI X 3 by paramedics. Pulse obtained by paramedics, OX50% and pulse 118. Inmate transferred to Mercy hospital by paramedics.

i.) Inmate Jewett expired at hospital.

58. No reasons exists in the records why close observation was stopped on December 22, 2014 of the Plaintiff even though the Plaintiff still was not communicating and/or eating or drinking.

59. Close observation is a necessary tool which was purposefully discontinued on December 22, 2014 even though it was against the facts of this case.

60. At all times relevant hereto, the CORIZON DEFENDANTS and/other agents, servants and/or employees of the other Defendants recorded the following in the Medication Dispensed Report which is marked as Exhibit 5 and the Plaintiff was required to have medication twice a day:

a.) One dose of the medication required were given to the Plaintiff on 12/19/2014; 12/21/2014;

b.) Two doses of the medication were given to the Plaintiff on 12/22/2014; 12/25/2014;

c.) The Plaintiff was not given medication on 12/20/2014 (both doses)(Refused); 12/21/2014 (one dose)(Refused); 12/23/2014 (both doses)(One refused meds/other no reason given); 12/24/2014 (both doses)(Refused);

d.) This documentation said the Plaintiff refused the meds for 12/26 – 27/2014;

e.) In failing to implement a policy or procedure to help medicate the Plaintiff even when he was making decisions while medically incompetent and/or in a catatonic state.

61. The following Practitioner's Orders were given by CORIZON DEFENDANTS which is marked as Exhibit 6:

a.) 12/18/2014 (10:30 a.m.) Admit to 5C, close observation and gown only;

b.) 12/19/2014 (12 p.m.) Obtain 3 page, maintain close observation, begin medication;
c.) 12/20/2014 (12:35 p.m.) Maintain close observation;
d.) 12/21/2014 (2:15 p.m.) Maintain close observation;
e.) 12/22/2014 (9:20 a.m.) Stop close observation, maintain 5C and continue meds.

62. In failing to complete a 3 page report on the Plaintiff at any time during his incarceration.

63. At all times relevant hereto, partial vitals were only taken one time by the CORIZON DEFENDANTS which occurred on 12/23/2014 at 8 a.m. and only included a HR of 76, RR of 12, blood pressure of 140/90. See Vital Signs Flow Sheet marked as Exhibit 7.

64. At all times relevant hereto, a temperature was never taken nor weight. See Exhibit 7.

65. At all times relevant hereto, this Vital Signs Flow Sheet is not a history and physical which was ordered on December 19, 2014.

66. At all times relevant hereto, the Food Flow Sheet which is marked as Exhibit 8 only had entries for December 23, 24 and 25 of 2014.

67. The amount of food recorded in the Food Flow Sheet was a 16 oz. milk, 8 oz. coffee, 32 oz. Juice, one milk cake and 2 cookies. See Exhibit 8.

68. The Progress Notes of Plaintiff Jewett are attached and incorporated into this Complaint and are marked as Exhibit 9, and the following are contained in said notes but do not state all the information found in said notes:

a.) 12/18/2014 – Noted that Plaintiff is incoherent and singing, no intake info taken;

b.) 12/18/2014 – Plaintiff refuses full evaluation, has not eaten in 2 days;

c.) 12/19/2014 – Plaintiff refuses to engage staff;

d.) 12/20/2014 – Plaintiff refused tray and not eating;

e.) No entry for 12/21/2014;

f.) 12/22/2014 – Plaintiff claims to be doing well and getting direction from God;

g.) 12/23/2014 – Plaintiff would not lift arm for BP. Has not eaten in 3 days;

h.) 12/23/2014 – Plaintiff has not eaten since 12/19/2014. Soft normal abdomen noted;
i.) 12/24/2012 to 12/25/2014 – No progress notes;

j.) 12/26/2014 – Plaintiff transported to ER because found face down on floor.

69. On December 26, 2014, the Plaintiff was found face down in his cell in his own vomit.

70. CPR was performed but the AED was not used because it kept registering "No Shock Advised. all the Defendants recognized that inadequate staffing created a reckless risk of harm to inmates as well as correctional officers, medical staff and jail personnel.

71. On or about December 26, 2014, the Plaintiff was declared dead and the cause of death was "acute peritonitis" in his cell. See the autopsy which is marked as Exhibit 10.

72. Plaintiff suffered from chronic erosive esophagitis which is known to cause "secondary peritonitis".

73. Plaintiff suffered from severe schizophrenia which required him to receive medication dispensed at therapeutic levels.

74. During previous incarcerations, medical/intake screening was performed by the Defendants on the Plaintiff.

75. At all times relevant hereto, all of the Defendants knew or should have known the following about the Plaintiff:

a.) His prior medical conditions and medication needs from his prior incarcerations;

b.) That the Plaintiff was hospitalized previously in a prior incarceration in August of 2013 that he was taken to UPMC Mercy Hospital twice during an 11 day stay because he was severely dehydrated from not eating and drinking and required medical therapeutic intervention;

c.) That the Plaintiff had difficulty communicating when he was not given his proper medication;

d.) That the Defendants had actual knowledge that the Plaintiff suffered from chronic erosive esophagitis;

e.) That during the arrest of the Plaintiff, he exhibited various factors that he was experiencing a mental health break down;

f.) That the Plaintiff was held in the restraint chair when he was first taken to the jail on December 16, 2014 which indicated he was experiencing a medical mental health emergency;

g.) That the Plaintiff was not eating or hydrating while he was incarcerated at the jail from December 16, 2014 through December 26, 2014;

h.) That the Plaintiff never saw a doctor from December 16, 2014 through December 26, 2014;

i.) That the Plaintiff never saw a psychologist/psychiatrist from December 16, 2014 through December 26, 2014;

j.) That the Plaintiff never received any medical care or treatment/and/or minimal treatment from December 16, 2014 through December 26, 2014;

k.) That the Plaintiff never received any type of physical by any of the Defendants from December 16, 2014 through December 26, 2014;

l.) That none of the Defendants attempted to acquire any type of history from the Plaintiff and/or other sources from December 16, 2014 through December 26, 2014.

76. It is undisputed that the Plaintiff's physical, mental and/or overall health significantly decreased and/or worsened from December 16, 2014 through December 26, 2014, the date of his death.

77. It is undisputed that all of the Defendants knew that the Plaintiff's physical, mental and/or overall health significantly decreased and/or worsened from December 16, 2014 through December 26, 2014.

78. It is undisputed that the Plaintiff was never sent to any outside medical provider or treatment center or emergency room during his incarceration from December 16, 2014 through December 26, 2014.

79. As a result of the death of the Plaintiff, a County Report of Extraordinary Occurrence was completed by all Defendants which stated inaccurately that the Plaintiff did not give any signs of illness on admission and that the Plaintiff was examined by a physician after admission. See Said Report marked as Exhibit 11.

80. The Mortality Review Form submitted by the CORIZON DEFENDANTS stated that this was a category 3 meaning that they identified potentially preventable errors or omission/commission associated with opportunities for improvement in systems/processes that were unrelated to the event. See Exhibit 4.

81. All COUNTY Defendants and Defendant ALLEGHENY COUNTY agree that protocol and policy is in place at the jail in order to promote safety as well as for care, custody and control purposes.

82. All COUNTY Defendants and Defendant ALLEGHENY COUNTY recognize that violation of protocol and policy established at the jail more likely than not will result in injury to either inmates and/or other correctional staff.

83. At all times relevant hereto, the death of the Plaintiff was preventable Plaintiff.

84. Upon information and belief, the policy of all of the Defendants at the time of Plaintiff's incarceration was such that an inmate's prior medical history or record was not timely accessed or reviewed during the intake/screening process even with inmates who indicated or evidenced serious medical conditions such as Plaintiff Jewett.

85. Upon information and belief, it is believed that a contract was in place between the Defendants which promoted the policy and procedure to not send inmates out to outside medical providers even when it was to the detriment to the inmates, correctional staff and more specifically, the Plaintiff.

86. At all times relevant hereto, all the Defendants knew that the CORIZON DEFENDANTS had a history of providing substandard and grossly, recklessly indifferent medical care to inmates whose medical needs it was contracted to meet.

87. At all times relevant hereto, all of the Defendants knew that the CORIZON DEFENDANTS had a history of providing substandard and grossly, recklessly indifferent staffing to its medical services to inmate whose medical needs it was contracted to meet.

88. This history is detailed in excerpts from the "Examination report on Corizon Health, Inc.'s compliance with contract #153946 with Allegheny County for the period September 1, 2013 through February 28, 2014 as well as the February 10, 2014 correspondence from Controller of Allegheny County. See attached correspondence marked as Exhibit 12.

89. The Audit revealed numerous deficiencies in the care being provided by the CORIZON DEFENDANTS at the co-Defendants' Jail which included but is not limited to the following:

a.) Not maintaining the required staffing levels;
b.) Not complying with reporting requirements necessary for the ACJ to be accredited by the NCCHC;
c.) Not maintaining complete and accurate inmate medical records, including not implementing the required electronic medical records;
d.) Not conducting intake health assessments for newly-admitted jail inmates;
e.) Not providing inmates with required clinical care;
f.) Not complying with pharmacy management requirements;
g.) Not ensuring the readiness of emergency equipment and supplies;
h.) Not performing the necessary pre-placement health assessments and medical and mental health rounds for inmates in segregation;
i.) Not utilizing the appropriate triage process to prioritize inmate sick call requests;
j.) Not responding to inmate grievances in a timely manner;
k.) Engaging in unfair labor practices.

90. The correspondence dated February 10, 2014 from the Controller to the CEO of the CORIZON DEFENDANTS stated the following:

a.) Placement of formal notice to CORIZON DEFENDANTS of grave and serious concerns about healthcare provided to inmates at the jail;
b.) Description of the current situation as intolerable and outrageous;
c.) Failure noted by CORIZON DEFENDANTS to provide basic medical healthcare to inmates;
d.) Lack of proper staff to the detriment of the staff and inmates at ACJ;
e.) Refusing to treat inmates with certain mental illness.

See Exhibit 12.

91. At all times relevant hereto, the Defendants did knowingly disregard the objective and/or readily apparent signs and symptoms that the Plaintiff was in acute distress which posed an excessive risk to the life of the Plaintiff.

92. At all times relevant hereto, the COUNTY DEFENDANTS knew as well as the CORIZON DEFENDANTS that this recent history of the CORIZON DEFENDANTS reflects a systematic violation of the Constitutional rights committed by all Defendants, particularly violations of the Fourth, Eighth, and Fourteenth Amendments as further laid out in this Complaint.

93. As a direct and proximate result of the Defendants' conduct, Decedent Plaintiff suffered the following injuries:

a. Acute peritonitis and the entire autopsy is incorporated and attached Exhibit 12;

b. Death.

85. As a result of the death of their father – the Plaintiff JEWETT, the proper parties claim all appropriate damages under the Survivor Act, including but not limited to the following:

a.) Pain, suffering, and inconvenience;

b.) Anxiety, embarrassment and humiliation;

c.) Medical expenses;

d.) Funeral expenses; and

e.) Loss of earning capacity.

86. As a result of the death of Plaintiff, CLARENCE J. JEWETT, JR., his estate and heirs claim all appropriate damages under the Wrongful Death Act, including but not limited to the following:

a.) Estate administration expenses;

b.) Medical expenses;

c.) Loss of society, companionship and services; and

d.) Economic loss occasioned by the death of the Decedent Plaintiff.

COUNT I –PLAINTIFFS v. CORIZON DEFENDANTS PURSUANT TO 42 U.S.C. §1983

87. The Plaintiff incorporates by reference the above paragraphs of the within Complaint the same as though set forth herein and at length.

88. At all relevant times, these CORIZON Defendants were acting under color of law, the statutes, ordinances, regulations, customs and usages of policies and procedures and entered into a special relationship with Plaintiff Jewett, which imposed affirmative duties of care and protections to Plaintiff Jewett and obligated the CORIZON DEFENDANTS to not cause injury, death and/or harm while he was in the custody and control of the Defendants.

89. Defendants deprived the Plaintiff of the rights, privileges, and immunities secured to him by 42 U.S.C. §1983 and by the Fifth, Eighth, and Fourteenth Amendments to the United States Constitution, as well as the rights, privileges and immunities provided to Plaintiff by the Pennsylvania state constitution.

90. It was the duty of the CORIZON DEFENDANTS, while Plaintiff Jewett was within the care and custody of the co-Defendants, to provide for his safety and general well-being.

91. Plaintiff 's injuries and damages were the direct and proximate result of the Defendants' conduct, defective policies, procedures, practices, customs, directives, and/or administrative procedures of these Defendants as follows:

a. In failing to recognize that the Plaintiff was need of medical attention;

b. In failing to respond properly or adequately to the objective signs that the Plaintiff was in medical distress;

c. In failing to properly monitor the employees, servants and/or agents;

d. In failing to provide a safe environment that would have prevented the death of the Plaintiff while incarcerated at Allegheny County Jail;

e. In failing to review information concerning issues related to proper conduct of the CORIZON DEFENDANTS' agents, servants and/or employees and other staff of Allegheny County Jail;

f. In failing to outline the procedures for the proper handling of mentally ill patients and failing to outline the procedures for the proper handling of medication for mentally ill patients;

g. Deliberate indifference to the Constitutional rights of the citizens of this Commonwealth;

h. Deliberate indifference to the need to protect the citizens and inmates from poor and unreasonable medical care/assessment;

i. Deliberate indifference to their employees, agents, and/or servants failure to adhere to policies and procedures which were put in place to protect both inmates and correctional staff in monitoring, assessing, treating, supervising and watching inmates;

j. Deliberate indifference to the obvious need for training and supervision of their employees, agents, and/or servants;

k. In allowing a policy which permitted, encouraged or condoned the inadequate supervision of inmates with serious medical problems such as Plaintiff Jewett as set forth above;

l. Failing to properly supervise their employees, agents and/or servants so that protocol and policy for supervision of inmates with serious medical problems/emergencies would be adhered to and would not unnecessarily place inmates at risk for abuse and death;

m. In failing to train properly individual persons in safe methods of handling incarcerated persons with mental health issues or incompetent to make life and death decisions;

n. Fail to utilize the mental health system to assist the Plaintiff;

o. In failing to maintain close observation;

p. Incorporating all complaints stated in February 10, 2014 correspondence;

q. In failing to train properly individual agents, servants and/or employees in the monitoring of incarcerated persons under the care and custody of the Defendants;

r. In allowing a policy to be present which failed to require a timely and proper medical examination or care be given to an inmate when an inmate exhibits signs, symptoms, and/or conduct that suggests and/or makes difficult to assess a baseline of health;

s. In allowing a policy of failing to ensure necessary medications are accessible and given to inmates in a timely fashion;

t. In violating policy and procedures with deliberate indifference;

u. In failing to report to the proper authorities anything about inmates who were exhibiting severe mental health issues which made it difficult to communicate anything about their well-being;

v. In implementing policies and procedures that infringed on the rights of inmates;

w. In failing to properly research, check and investigate the prior work histories of its employees;

x. In failing to investigate any complaints of prisoner abuse/health;

y. In failing to adhere to their own policy and procedures regarding the conduct of its employees, agents and/or servants and staff and/or personnel when they would interact with inmates;

w. In failing to respond properly or adequately to the objective and/or excessive risk that failing to provide a baseline medical assessment such as a physical and a history of an inmate would cause in the care, custody and control of mentally ill inmates;

x. In failing to properly monitor the Plaintiff;

y. In failing to request intervention by experienced medical personnel and/or hospital on the Plaintiff's behalf;

z. In failing to properly observe the condition of the Plaintiff while in custody;

aa.) In failing to ensure procedures are in place to acquire medications immediately and/or AEDs in an emergency situation;

bb.) In allowing a policy to exist which failed to adequately train its agents, servants and/or employees to detect and properly address medical needs of inmates and inmates with mental health issues;

cc.) In failing to supervise its agents, servants and/or employees pertaining to the securing of medical care to inmates;

dd.) In failing to review information concerning inmates prior medical history;

ee.) In failing to conduct the rounds and other protocol governing the supervision of inmates on Pod 5C;

ff.) In failing to provide training;

gg.) In failing to train their staff members who work with inmates with mental health issues to recognize verbal and behavioral cues which indicate the potential for a medical emergency;

hh.) A policy of failing to require that an inmate's prior medical records be accessed at the time of intake, medical screening process, or when it is made known that an inmate may have an unmet medical need, including but not limited to a need for medication or emergency care;

ii.) A policy of understaffing physicians, nurses, medical staff, and other medical professionals at the jail;

jj.) A policy of failing to require that inmates receive medical care from competent medical professionals;

kk.) In failing to conduct the assessment of inmates by qualified professionals, trained to determine an inmate's level of health;

ll.) In failing to place the Plaintiff in the appropriate housing unit;

mm.) In failing to remove the Plaintiff to a mental health facility;

nn.) In failing to provide regular and documented supervision of Pod 5C;

oo.) In failing to take action when they received appropriate information that the Plaintiff was in medical distress;

pp.) In failing to follow the policies and procedures which govern pod 5C;

qq.) In failing to do rounds;

rr.) In failing to outline the procedures for referring potentially mentally ill inmates to other housing options at the jail and/or to sending them to hospitals for appropriate care;

ss.) In failing to provide procedures for communication between shifts, correctional officers, administrators and Allegheny County Jail correctional personnel regarding the status of mentally ill inmates;

tt.) In failing to outline an intervention plan on how to handle mentally ill inmates;

uu.) In failing to have procedures in place to notify the Allegheny County Jail administrators, outside authorities and family members of inmates with mental health issues that said inmates are in medical distress;

vv.) In failing to provide procedures of documenting the identification and monitoring of potential inmates who are in medical emergency;

ww.) In failing to monitor the CCTV and communicating and perceived risks;

xx.) A policy of failing to provided adequate training to its agents/employees and servants concerning the proper treatment of inmates with mental health issues and medical emergencies;

yy.) A policy of failing to be adequately staffed with the sufficient number of competent medical professionals, including doctors, to adequately meet and treat inmates' medical needs;

zz.) Other defective policies concerning the detention of inmates which may be determined in discovery;

aaa.) In failing to take reasonable measures to prevent Plaintiff's unfortunate death by failing to obtain medical care for him when he was initially incarcerated;

bbb.) In failing to have a procedure and/or policy in place to deal with mentally ill inmates who are unable to communicate/provide adequate information about how they feel and/or state what their current health status is and/or if they are in pain;

ccc.) In failing to recognize the symptoms and signs that the Plaintiff was in acute peritonitis;

ddd.) In failing to obtain any medical baseline of Plaintiff;

eee.) In failing to perform a history and physical even though it was ordered;

fff.) In failing to determine the real reason why the Plaintiff was not eating or drinking;

ggg.) In failing to act on the medical referral for a history and physical;

hhh.) In failing to perform a more thorough medical evaluation which would have resulted in a diagnosis of the Plaintiff's generalized severe peritonitis and thus initiated emergency medical management, both operative and non-operative;

iii.) In only performing only one abdomen exam, even if it was performed properly;

jjj.) In failing to perform a proper abdomen exam;

kkk.) In failing to recognize the prior history of the Plaintiff;

lll.) In failing to conform to past practice of ACHS;

mmm.) A lack of follow through with obtaining the medical referral and the history and physical examination early during the incarceration of the Plaintiff which caused the Plaintiff's severe generalized peritonitis to continue to advance along the expected course and he succumbed to the illness;

nnn.) In failing to recognized that intervention and treatment earlier in the course of the peritonitis would have had a positive outcome but with treatment was certain death;

ooo.) In failing to recognize and/or employ individuals who recognized that peritonitis develops in several stages;

ppp.) In failing to recognize or employ individuals who recognized and/or knew that peritonitis is a medical emergency and that an infection of a certain magnitude would result in sepsis;

qqq.) In failing to perform an adequate and/or no physical assessment in order to find "objective findings" that would have shown that the Plaintiff had acute peritonitis and that a medical emergency existed;

rrr.) In failing to look for a fever higher than 100.4 and chills;

sss.) In failing to look for a rapid heartrate, greater than 100/minute;

ttt.) In failing to take any temperature of the Plaintiff;

uuu.) In failing to perform a physical exam of the abdomen of the Plaintiff;

vvv.) In failing to look see if the Plaintiff avoided all motion and kept his hips flexed to relieve the abdominal wall tension;

www.) In failing to perform routine bloodwork;

xxx.) In having a policy to not send inmates to any outside hospitals/practices and/or minimize said activity because it would affect the profit of their contract and/or be penalized under the contract;

yyy.) The psychiatrist, physician assistant, the social worker and nurses failed to act in a way that is reasonable and expected in providing the necessary care an level of care for the Plaintiff over his days in incarceration;

zzz.) By not responding appropriately to the Plaintiff's continued not eating and drinking;

aaaa.) By not having the Plaintiff take his proper medication;

bbbb.) By letting the Plaintiff's medical condition progress to a point of no return.

92. The CORIZON DEFENDANTS did not recognize and respond to the objective symptoms of the illness of the Plaintiff.

93. The conduct of these Defendants stated above were reckless and/or deliberately indifferent to the safety, health and constitutional rights of the Plaintiff in the following particularly:

a.) Its failure to adequately train, supervise, and/or monitor agents and/or employees as set forth above;

b.) Its failure to correct (through training, discipline, monitoring, policy changes, etc…) its employees' conduct;

c.) Its failure to investigate and determine whether its agents/employees were complying with its policies, and/or customs, and/or violating inmates' Constitutional rights;

d.) Its failure to correct defective policies and/or training procedures, despite being put on notice to these defective policies and/or training procedures by recent occurrences similar to the one mentioned above;

e.) The intentional act of ignoring the stated communications regarding the Plaintiff's medical needs and its failure to access its own records when the said medical needs were communicated;

f.) See Exhibit 11.

94. Defendants, in depriving Plaintiff of his constitutional rights, were intentional, recklessly indifferent, willful, wanton, malicious, and outrageous.

95. The actions of the individuals as aforesaid resulted from and were taken pursuant to a policy, practice, and/or custom of the Defendants, which policy, practice and/or custom is implemented by individual agents/servants/employees.

96. Defendants had approved and condoned the procedures implemented by and enforced by the individual staff.

97. The Defendants' failures described above while in the care and custody of the Defendants caused the Plaintiff his injuries, death and previously described damages.

98. Plaintiffs also claim reasonable attorneys' fees and costs from Defendants as provided by 42 U.S.C. §1988.

WHEREFORE, the Plaintiffs demands judgment against the Defendants for damages, together with court costs, attorneys' fees, interest, and all other relief permitted by the Court. JURY TRIAL DEMANDED.

COUNT II –PLAINTIFFS v. CORIZON DEFENDANTS PROFESSIONAL NEGLIGENCE/SURVIVAL ACTION

99. The Plaintiff incorporates by reference the above paragraphs of the within Complaint the same as though set forth herein and at length.

100. Plaintiffs brings this survival action under 20 Pa.Cons.Stat. Ann. Section 3373 and 42 Pa. Cons.Stat.Ann. Section 8302.

101. Plaintiffs' injuries, death and damages were the direct and proximate result of the Defendants' negligent conduct, carelessness, defective policies, procedures, practices, customs, directives, and/or administrative procedures of these Defendants, acting by and through their agents, servants and/or employees, who were acting within the scope of the their employment, as follows:

a. In failing to respond properly or adequately to the objective signs that the Plaintiff was in medical distress;

b. Exhibit 11 is incorporated;

c. In failing to recognize that the Plaintiff was need of medical attention;

d. In failing to properly monitor the employees, servants and/or agents;

e. In failing to provide a safe environment that would have prevented the death of the Plaintiff while incarcerated at Allegheny County Jail;

f. In failing to review information concerning issues related to proper conduct of the CORIZON DEFENDANTS' agents, servants and/or employees and other staff of Allegheny County Jail;

g. In failing to outline the procedures for the proper handling of mentally ill patients and failing to outline the procedures for the proper handling of medication for mentally ill patients;

h. Deliberate indifference to the Constitutional rights of the citizens of this Commonwealth;

i. Deliberate indifference to the need to protect the citizens and inmates from poor and unreasonable medical care/assessment;

j. Deliberate indifference to their employees, agents, and/or servants failure to adhere to policies and procedures which were put in place to protect both inmates and correctional staff in monitoring, assessing, treating, supervising and watching inmates;

k. Deliberate indifference to the obvious need for training and supervision of their employees, agents, and/or servants;

l. In allowing a policy which permitted, encouraged or condoned the inadequate supervision of inmates with serious medical/mental health problems such as Plaintiff Jewett as set forth above;

m. Failing to properly supervise their employees, agents and/or servants so that protocol and policy for supervision of inmates with serious medical problems/emergencies would be adhered to and would not unnecessarily place inmates at risk for abuse and death;

n. In failing to train properly individual persons in safe methods of handling incarcerated persons;

o. In failing to train properly individual agents, servants and/or employees in the monitoring of incarcerated persons under the care and custody of the Defendants;

p. In allowing a policy to be present which failed to require a timely and proper medical examination or care be given to an inmate when an inmate exhibits signs, symptoms, and/or conduct that suggests and/or makes difficult to assess a baseline of health;

q. In allowing a policy of failing to ensure necessary medications are accessible and given to inmates in a timely fashion;

r. In violating policy and procedures with deliberate indifference;

s. In failing to report to the proper authorities anything about inmates who were exhibiting severe mental health issues which made it difficult to communicate anything about their well-being;

t. In implementing policies and procedures that infringed on the rights of inmates;

u. In failing to properly research, check and investigate the prior work histories of its employees;

v. In failing to investigate any complaints of prisoner abuse/health;

w. In failing to adhere to their own policy and procedures regarding the conduct of its employees, agents and/or servants and staff and/or personnel when they would interact with inmates;

w. In failing to respond properly or adequately to the objective and/or excessive risk that failing to provide a baseline medical assessment such as a physical and a history of an inmate would cause in the care, custody and control of mentally ill inmates;

x. In failing to properly monitor the Plaintiff;

y. In failing to request intervention by experienced medical personnel and/or hospital on the Plaintiff's behalf;

z. In failing to properly observe the condition of the Plaintiff while in custody;

cccc.) In failing to ensure procedures are in place to acquire medications immediately and/or AEDs in an emergency situation;

dddd.) In allowing a policy to exist which failed to adequately train its agents, servants and/or employees to detect and properly address medical needs of inmates and inmates with mental health issues;

eeee.) In failing to supervise its agents, servants and/or employees pertaining to the securing of medical care to inmates;

ffff.) In failing to review information concerning inmates prior medical history;

gggg.) In failing to conduct the rounds and other protocol governing the supervision of inmates on Pod 5C;

hhhh.) In failing to provide training;

iiii.) In failing to train their staff members who work with inmates with mental health issues to recognize verbal and behavioral cues which indicate the potential for a medical emergency;

jjjj.) A policy of failing to require that an inmate's prior medical records be accessed at the time of intake, medical screening process, or when it is made known that an inmate may have an unmet medical need, including but not limited to a need for medication or emergency care;

kkkk.) A policy of understaffing physicians, nurses, medical staff, and other medical professionals at the jail;

llll.) A policy of failing to require that inmates receive medical care from competent medical professionals;

mmmm.) In failing to conduct the assessment of inmates by qualified professionals, trained to determine an inmate's level of health;

nnnn.) In failing to place the Plaintiff in the appropriate housing unit;

oooo.) In failing to remove the Plaintiff to a mental health facility;

pppp.) In failing to provide regular and documented supervision of Pod 5C;

qqqq.) In failing to take action when they received appropriate information that the Plaintiff was in medical distress;

rrrr.) In failing to follow the policies and procedures which govern pod 5C;

ssss.) In failing to do rounds;

tttt.) In failing to outline the procedures for referring potentially mentally ill inmates to other housing options at the jail and/or to sending them to hospitals for appropriate care;

uuuu.) In failing to provide procedures for communication between shifts, correctional officers, administrators and Allegheny County Jail correctional personnel regarding the status of mentally ill inmates;

vvvv.) In failing to outline an intervention plan on how to handle mentally ill inmates;

wwww.) In failing to have procedures in place to notify the Allegheny County Jail administrators, outside authorities and family members of inmates with mental health issues that said inmates are in medical distress;

xxxx.) In failing to provide procedures of documenting the identification and monitoring of potential inmates who are in medical emergency;

yyyy.) In failing to monitor the CCTV and communicating and perceived risks;

zzzz.) A policy of failing to provided adequate training to its agents/employees and servants concerning the proper treatment of inmates with mental health issues and medical emergencies;

aaaaa.) A policy of failing to be adequately staffed with the sufficient number of competent medical professionals, including doctors, to adequately meet and treat inmates' medical needs;

bbbbb.) Other defective policies concerning the detention of inmates which may be determined in discovery;

ccccc.) In failing to take reasonable measures to prevent Plaintiff's unfortunate death by failing to obtain medical care for him when he was initially incarcerated;

ddddd.) In failing to have a procedure and/or policy in place to deal with mentally ill inmates who are unable to communicate/provide adequate information about how they feel and/or state what their current health status is and/or if they are in pain;

eeeee.) In failing to recognize the symptoms and signs that the Plaintiff was in acute peritonitis;

fffff.) In failing to obtain any medical baseline of Plaintiff;

ggggg.) In failing to perform a history and physical even though it was ordered;

hhhhh.) In failing to determine the real reason why the Plaintiff was not eating or drinking;

iiiii.) In failing to act on the medical referral for a history and physical;

jjjjj.) In failing to perform a more thorough medical evaluation which would have resulted in a diagnosis of the Plaintiff's generalized severe peritonitis and thus initiated emergency medical management, both operative and non-operative;

kkkkk.) In only performing only one abdomen exam, even if it was performed properly;

lllll.) In failing to perform a proper abdomen exam;

mmmmm.) In failing to recognize the prior history of the Plaintiff;

nnnnn.) In failing to conform to past practice of ACHS;

ooooo.) A lack of follow through with obtaining the medical referral and the history and physical examination early during the incarceration of the Plaintiff which caused the Plaintiff's severe generalized peritonitis to continue to advance along the expected course and he succumbed to the illness;

ppppp.) In failing to recognized that intervention and treatment earlier in the course of the peritonitis would have had a positive outcome but with treatment was certain death;

qqqqq.) In failing to recognize and/or employ individuals who recognized that peritonitis develops in several stages;

rrrrr.) In failing to recognize or employ individuals who recognized and/or knew that peritonitis is a medical emergency and that an infection of a certain magnitude would result in sepsis;

sssss.) In failing to perform an adequate and/or no physical assessment in order to find "objective findings" that would have shown that the Plaintiff had acute peritonitis and that a medical emergency existed;

ttttt.) In failing to look for a fever higher than 100.4 and chills;

uuuuu.) In failing to look for a rapid heartrate, greater than 100/minute;

vvvvv.) In failing to take any temperature of the Plaintiff;

wwwww.) In failing to perform a physical exam of the abdomen of the Plaintiff;

xxxxx.) In failing to look see if the Plaintiff avoided all motion and kept his hips flexed to relieve the abdominal wall tension;

yyyyy.) In failing to perform routine bloodwork;

zzzzz.) In having a policy to not send inmates to any outside hospitals/practices and/or minimize said activity because it would affect the profit of their contract and/or be penalized under the contract;

aaaaaa.)The psychiatrist, physician assistant, the social worker and nurses failed to act in a way that is reasonable and expected in providing the necessary care an level of care for the Plaintiff over his days in incarceration;

bbbbbb.) By not responding appropriately to the Plaintiff's continued not eating and drinking;

cccccc.)By not having the Plaintiff take his proper medication;

dddddd.) By letting the Plaintiff's medical condition progress to a point of no return.

eeeeee.) Failing to properly identify and consider the seriousness of the Plaintiff's medical conditions;

ffffff.) Failing to have the requisite level of medical knowledge to detect and properly address the medical needs of inmates and inmates with mental health issues.

102. The CORIZON DEFENDANTS did not recognize and respond to the objective symptoms of the illness of the Plaintiff.

103. Defendants, in depriving Plaintiff of his life, were intentional, recklessly indifferent, willful, wanton, malicious, and outrageous.

104. The actions of the individuals as aforesaid resulted from and were taken pursuant to a policy, practice, and/or custom of the Defendants, which policy, practice and/or custom is implemented by individual agents/servants/employees.

105. Defendants had approved and condoned the procedures implemented by and enforced by the individual staff.

106. The Defendants' failures described above while in the care and custody of the Defendants caused the Plaintiff his injuries, death and previously described damages.

WHEREFORE, the Plaintiffs demands judgment against the Defendants for damages, together with court costs, interest, and all other relief permitted by the Court. JURY TRIAL DEMANDED.

COUNT III –PLAINTIFFS v. CORIZON DEFENDANTS PROFESSIONAL NEGLIGENCE/WRONGFUL DEATH

107. The Plaintiff incorporates by reference the above paragraphs of the within Complaint the same as though set forth herein and at length.

108. Plaintiffs brings this Wrongful Death action under 42 Pa.Cons.Stat. Ann. Section 8301 and Pa.R.C.P. Section 2202(a).

109. The Plaintiff decedent did not bring an action for personal injuries during his lifetime and no other action for the death of the Decedent has been commenced against the Defendants.

110. Plaintiffs' injuries, death and damages were the direct and proximate result of the Defendants' negligent conduct, carelessness, defective policies, procedures, practices, customs, directives, and/or administrative procedures of these Defendants, acting by and through their agents, servants and/or employees, who were acting within the scope of the their employment, as follows:

a. In failing to recognize that the Plaintiff was need of medical attention;

b. In failing to respond properly or adequately to the objective signs that the Plaintiff was in medical distress;

c. In failing to properly monitor the employees, servants and/or agents;

d. In failing to provide a safe environment that would have prevented the death of the Plaintiff while incarcerated at Allegheny County Jail;

e. Incorporating in Exhibit 11;

f. In failing to review information concerning issues related to proper conduct of the CORIZON DEFENDANTS' agents, servants and/or employees and other staff of Allegheny County Jail;

g. In failing to outline the procedures for the proper handling of mentally ill patients and failing to outline the procedures for the proper handling of medication for mentally ill patients;

h. Deliberate indifference to the Constitutional rights of the citizens of this Commonwealth;

i. Deliberate indifference to the need to protect the citizens and inmates from poor and unreasonable medical care/assessment;

j. Deliberate indifference to their employees, agents, and/or servants failure to adhere to policies and procedures which were put in place to protect both inmates and correctional staff in monitoring, assessing, treating, supervising and watching inmates;

k. Deliberate indifference to the obvious need for training and supervision of their employees, agents, and/or servants;

l. In allowing a policy which permitted, encouraged or condoned the inadequate supervision of inmates with serious medical problems such as Plaintiff Jewett as set forth above;

m. Failing to properly supervise their employees, agents and/or servants so that protocol and policy for supervision of inmates with serious medical problems/emergencies would be adhered to and would not unnecessarily place inmates at risk for abuse and death;

n. In failing to train properly individual persons in safe methods of handling incarcerated persons;

o. In failing to train properly individual agents, servants and/or employees in the monitoring of incarcerated persons under the care and custody of the Defendants;

p. In allowing a policy to be present which failed to require a timely and proper medical examination or care be given to an inmate when an inmate exhibits signs, symptoms, and/or conduct that suggests and/or makes difficult to assess a baseline of health;

q. In allowing a policy of failing to ensure necessary medications are accessible and given to inmates in a timely fashion;

r. In violating policy and procedures with deliberate indifference;

s. In failing to report to the proper authorities anything about inmates who were exhibiting severe mental health issues which made it difficult to communicate anything about their well-being;

t. In implementing policies and procedures that infringed on the rights of inmates;

u. In failing to properly research, check and investigate the prior work histories of its employees;

v. In failing to investigate any complaints of prisoner abuse/health;

w. In failing to adhere to their own policy and procedures regarding the conduct of its employees, agents and/or servants and staff and/or personnel when they would interact with inmates;

w. In failing to respond properly or adequately to the objective and/or excessive risk that failing to provide a baseline medical assessment such as a physical and a history of an inmate would cause in the care, custody and control of mentally ill inmates;

x. In failing to properly monitor the Plaintiff;

y. In failing to request intervention by experienced medical personnel and/or hospital on the Plaintiff's behalf;

z. In failing to properly observe the condition of the Plaintiff while in custody;

aa.) In failing to ensure procedures are in place to acquire medications immediately and/or AEDs in an emergency situation;

bb.) In allowing a policy to exist which failed to adequately train its agents, servants and/or employees to detect and properly address medical needs of inmates and inmates with mental health issues;

cc.) In failing to supervise its agents, servants and/or employees pertaining to the securing of medical care to inmates;

dd.) In failing to review information concerning inmates prior medical history;

ee.) In failing to conduct the rounds and other protocol governing the supervision of inmates on Pod 5C;

ff.) In failing to provide training;

gg.) In failing to train their staff members who work with inmates with mental health issues to recognize verbal and behavioral cues which indicate the potential for a medical emergency;

hh.) A policy of failing to require that an inmate's prior medical records be accessed at the time of intake, medical screening process, or when it is made known that an inmate may have an unmet medical need, including but not limited to a need for medication or emergency care;

ii.) A policy of understaffing physicians, nurses, medical staff, and other medical professionals at the jail;

jj.) A policy of failing to require that inmates receive medical care from competent medical professionals;

kk.) In failing to conduct the assessment of inmates by qualified professionals, trained to determine an inmate's level of health;

ll.) In failing to place the Plaintiff in the appropriate housing unit;

mm.) In failing to remove the Plaintiff to a mental health facility;

nn.) In failing to provide regular and documented supervision of Pod 5C;

oo.) In failing to take action when they received appropriate information that the Plaintiff was in medical distress;

pp.) In failing to follow the policies and procedures which govern pod 5C;

qq.) In failing to do rounds;

rr.) In failing to outline the procedures for referring potentially mentally ill inmates to other housing options at the jail and/or to sending them to hospitals for appropriate care;

ss.) In failing to provide procedures for communication between shifts, correctional officers, administrators and Allegheny County Jail correctional personnel regarding the status of mentally ill inmates;

tt.) In failing to outline an intervention plan on how to handle mentally ill inmates;

uu.) In failing to have procedures in place to notify the Allegheny County Jail administrators, outside authorities and family members of inmates with mental health issues that said inmates are in medical distress;

vv.) In failing to provide procedures of documenting the identification and monitoring of potential inmates who are in medical emergency;

ww.) In failing to monitor the CCTV and communicating and perceived risks;

xx.) A policy of failing to provided adequate training to its agents/employees and servants concerning the proper treatment of inmates with mental health issues and medical emergencies;

yy.) A policy of failing to be adequately staffed with the sufficient number of competent medical professionals, including doctors, to adequately meet and treat inmates' medical needs;

zz.) Other defective policies concerning the detention of inmates which may be determined in discovery;

aaa.) In failing to take reasonable measures to prevent Plaintiff's unfortunate death by failing to obtain medical care for him when he was initially incarcerated;

bbb.) In failing to have a procedure and/or policy in place to deal with mentally ill inmates who are unable to communicate/provide adequate information about how they feel and/or state what their current health status is and/or if they are in pain;

ccc.) In failing to recognize the symptoms and signs that the Plaintiff was in acute peritonitis;

ddd.) In failing to obtain any medical baseline of Plaintiff;

eee.) In failing to perform a history and physical even though it was ordered;

fff.) In failing to determine the real reason why the Plaintiff was not eating or drinking;

ggg.) In failing to act on the medical referral for a history and physical;

hhh.) In failing to perform a more thorough medical evaluation which would have resulted in a diagnosis of the Plaintiff's generalized severe peritonitis and thus initiated emergency medical management, both operative and non-operative;

iii.) In only performing only one abdomen exam, even if it was performed properly;

jjj.) In failing to perform a proper abdomen exam;

kkk.) In failing to recognize the prior history of the Plaintiff;

lll.) In failing to conform to past practice of ACHS;

mmm.) A lack of follow through with obtaining the medical referral and the history and physical examination early during the incarceration of the Plaintiff which caused the Plaintiff's severe generalized peritonitis to continue to advance along the expected course and he succumbed to the illness;

nnn.) In failing to recognized that intervention and treatment earlier in the course of the peritonitis would have had a positive outcome but with treatment was certain death;

ooo.) In failing to recognize and/or employ individuals who recognized that peritonitis develops in several stages;

ppp.) In failing to recognize or employ individuals who recognized and/or knew that peritonitis is a medical emergency and that an infection of a certain magnitude would result in sepsis;

qqq.) In failing to perform an adequate and/or no physical assessment in order to find "objective findings" that would have shown that the Plaintiff had acute peritonitis and that a medical emergency existed;

rrr.) In failing to look for a fever higher than 100.4 and chills;

sss.) In failing to look for a rapid heartrate, greater than 100/minute;

ttt.) In failing to take any temperature of the Plaintiff;

uuu.) In failing to perform a physical exam of the abdomen of the Plaintiff;

vvv.) In failing to look see if the Plaintiff avoided all motion and kept his hips flexed to relieve the abdominal wall tension;

www.) In failing to perform routine bloodwork;

xxx.) In having a policy to not send inmates to any outside hospitals/practices and/or minimize said activity because it would affect the profit of their contract and/or be penalized under the contract;

yyy.) The psychiatrist, physician assistant, the social worker and nurses failed to act in a way that is reasonable and expected in providing the necessary care an level of care for the Plaintiff over his days in incarceration;

zzz.) By not responding appropriately to the Plaintiff's continued not eating and drinking;

aaaa.) By not having the Plaintiff take his proper medication;

bbbb.) By letting the Plaintiff's medical condition progress to a point of no return.

cccc.) Failing to properly identify and consider the seriousness of the Plaintiff's medical conditions;

dddd.) Failing to have the requisite level of medical knowledge to detect and properly address the medical needs of inmates and inmates with mental health issues.

111. The CORIZON DEFENDANTS did not recognize and respond to the objective symptoms of the illness of the Plaintiff.

112. Defendants, in depriving Plaintiff of his life, were intentional, recklessly indifferent, willful, wanton, malicious, and outrageous.

113. The actions of the individuals as aforesaid resulted from and were taken pursuant to a policy, practice, and/or custom of the Defendants, which policy, practice and/or custom is implemented by individual agents/servants/employees.

114. Defendants had approved and condoned the procedures implemented by and enforced by the individual staff.

115. The Defendants' failures described above while in the care and custody of the Defendants caused the Plaintiff his injuries, death and previously described damages.

WHEREFORE, the Plaintiffs demands judgment against the Defendants for damages, together with court costs, interest, and all other relief permitted by the Court. JURY TRIAL DEMANDED.

COUNT IV –PLAINTIFFS v. CORIZON DEFENDANTS CORPORATE NEGLIGENCE/SURVIVAL ACTION

116. The Plaintiff incorporates by reference the above paragraphs of the within Complaint the same as though set forth herein and at length.

117. The Defendants' employees were responsible for the care and treatment of the Plaintiff decedent and were duly appointed agents, ostensible agents, servants and/or employees of the CORIZON DEFENDANTS and they were acting within the scope and course of their agency and/or employment.

118. The Defendants had a duty under corporate negligence doctrine to ensure, among other duties described above, that all persons rendering medical care within the ACJ, who attended to the care and treatment of Plaintiff decedent comply with the prevailing standard of care and treatment of the Decedent, including the above described conduct.

119. The negligence, carelessness and/or other liability producing conduct on the part of the Defendants, their agents, servants and/or employees is more fully described in this Complaint.

120. Defendants, in depriving Plaintiff of his life, were intentional, recklessly indifferent, willful, wanton, malicious, and outrageous.

121. The actions of the individuals as aforesaid resulted from and were taken pursuant to a policy, practice, and/or custom of the Defendants, which policy, practice and/or custom is implemented by individual agents/servants/employees.

122. Defendants had approved and condoned the procedures implemented by and enforced by the individual staff.

123. The Defendants' failures described above while in the care and custody of the Defendants caused the Plaintiff his injuries, death and previously described damages.

WHEREFORE, the Plaintiffs demands judgment against the Defendants for damages, together with court costs, interest, and all other relief permitted by the Court. JURY TRIAL DEMANDED.

COUNT V –PLAINTIFFS v. CORIZON DEFENDANTS CORPORATE NEGLIGENCE/WRONGFUL DEATH

124. The Plaintiff incorporates by reference the above paragraphs of the within Complaint the same as though set forth herein and at length.

125. The Defendants' employees were responsible for the care and treatment of the Plaintiff decedent and were duly appointed agents, ostensible agents, servants and/or employees of the CORIZON DEFENDANTS and they were acting within the course and scope of their agency and/or employment.

126. The CORIZON DEFENDANTS had a duty under the corporate negligence doctrine to ensure, among other duties, that all persons rendering medical care within the ACJ, who attended to the care and treatment of the Plaintiff decedent comply with the prevailing standard of care and treatment of the Decedent, including the conduct described above.

127. The negligence, carelessness, and/or other liability producing conduct on the part of the Defendants, their agents, employees and/or servants is more fully described in this Complaint.

128. The actions of the individuals as aforesaid resulted from and were taken pursuant to a policy, practice, and/or custom of the Defendants, which policy, practice and/or custom is implemented by individual agents/servants/employees.

129. Defendants had approved and condoned the procedures implemented by and enforced by the individual staff.

130. The Defendants' failures described above while in the care and custody of the Defendants caused the Plaintiff his injuries, death and previously described damages.

WHEREFORE, the Plaintiffs demands judgment against the Defendants for damages, together with court costs, interest, and all other relief permitted by the Court. JURY TRIAL DEMANDED.

COUNT VI – PLAINTIFFS v. DEFENDANTS ALLGHENY COUNTY, ORLANDO HARPER, and LATOYA WARREN PURSUANT TO 42 U.S.C. §1983

131. The Plaintiffs incorporate by reference the above paragraph of the within Complaint the same as though set forth herein and at length.

132. At all relevant times, Defendants were acting under color of the statutes, ordinances, regulations, customs and usages of Defendant ALLEGHENY COUNTY and under the authority of their offices as law enforcement officers.

133. Defendants deprived Decedent Plaintiff of the rights, privileges, and immunities secured to him by 42 U.S.C. §1983 and by the Fifth, Eighth and Fourteenth Amendments to the United States Constitution, as well as the rights, privileges and immunities provided by Decedent Plaintiff by the Pennsylvania state constitution.

134. Decedent Plaintiff 's injuries and damages were the direct and proximate result of the Defendants' conduct as follows:

a.) In failing to recognize that the Decedent Plaintiff presented an objective and/or excessive risk of medical emergency;

b.) Incorporating Exhibit 11;

c.) In failing to respond properly or adequately to the objective and/or excessive risk of medical emergency posed by the Decedent Plaintiff ;

d.) In failing to properly monitor the Decedent Plaintiff ;

e.) In failing to request medical intervention by experienced medical personnel on the Decedent Plaintiff 's behalf;

f.) In failing to properly observe the condition of the Decedent Plaintiff while in custody;

g.) In deliberately and willfully placing Decedent Plaintiff under arrest without taking appropriate precautions to ensure his safety while in custody;

h.) In failing to provide a safe environment that would have prevented Decedent Plaintiff 's death;

i.) In failing to acquire medical assistance for Decedent Plaintiff in a timely manner;

j.) In failing to monitor the Decedent Plaintiff appropriately under the circumstances;

k.) In failing to review information concerning issues related to medical emergencies;

l.) In failing to conduct the health receiving screen in a manner which would continuously alert them to medical emergencies;

m.) In failing to provide training in suicide training in the training programs for both Allegheny County Jail correctional and health care staff;

n.) In failing to train their staff members who work with inmates to recognize verbal and behavioral cues which indicate the potential for medical emergencies;

o.) In failing to recognize that the Decedent Plaintiff as being potentially a medical emergency;

p.) In failing to request an immediate history and physical evaluation of the patient through the CORIZON DEFENDANTS;

q.) In allowing Decedent Plaintiff to be placed in the jail and not sending him to a mental health facility;

r.) In failing to conduct the assessment of potentially medical emergency inmates by qualified mental/medical health professionals, trained to determine an inmate's level of health;

s.) In failing to place the Decedent Plaintiff in the appropriate acute mental health facility;

t.) In failing to provide regular and documented supervision of Decedent Plaintiff ;

u.) In failing to outline the procedures for referring mentally ill inmates to mental health care facilities;

v.) In failing to provide procedures for communication between health care personnel and Allegheny County Jail correctional personnel regarding the status of the inmate in a clear, current and accurate fashion;

w.) In failing to outline an intervention plan on how to handle a uncommunicative mentally ill inmates;

x.) In failing to have procedures in place to notify the Allegheny County Jail administrators, outside authorities and family members of mentally ill inmates; who were not communicating their medical history or responding;

y.) In entering into a contract that frowned upon the intervention of outside medical treatment for inmates;

z.) In failing to provide procedures of documenting the identification and monitoring of potential mentally ill inmates who would not cooperate or communicate basic health information;

aa.) In utilizing the restraint chair for unreasonably and cruel periods of time on mentally ill inmates;

bb.) In failing to train;

cc.) In permitting a policy of encouraging and/or condoning inadequate supervision of inmates with serious medical problems and mental problems such as Plaintiff;

dd.) A policy of failing to require a timely and proper medical examination when an inmate is admitting to the jail;

ee.) A policy of failing to require a timely and proper medical examination when a mentally ill inmate is admitted to the jail;

ff.) A policy of failing to adequately train its Cos to detect and address medical needs of inmates and/or mentally ill inmates;

gg.) Incorporating all of the subparts of paragraph 91 (a) – (bbbb).

135. Defendants, in depriving Decedent Plaintiff of his constitutional rights, were intentional, negligent, recklessly indifferent, willful, wanton, malicious, and outrageous.

136. Defendants had approved and condoned the procedures implemented by and enforced by the individual staff.

137. The Defendants' failures described above while in the care and custody of the Defendants caused the Plaintiff his injuries, death and previously described damages.

138. Plaintiffs also claim reasonable attorneys' fees and costs from Defendants as provided by 42 U.S.C. §1988.

WHEREFORE, the Plaintiffs demand judgment against the Defendants for compensatory and punitive damages, together with court costs, attorneys' fees, interest, and all other relief permitted by the Court. JURY TRIAL DEMANDED.

COUNT VII – PLAINTIFFS v. DEFENDANTS ALLEGHENY COUNTY, ORLANDO HARPER, and LATOYA WARREN PURSUANT TO 42 U.S.C. §1983

139. The Plaintiffs incorporate by reference thereto the above paragraph of the within Complaint the same as though set forth herein and at length.

140. Decedent Plaintiff 's injuries, death, and damages were a direct and proximate result of the Defendants' conduct as follows:

a.) In failing to train properly individual corrections officers in safe methods of handling incarcerated persons;

b.) Incorporating all of Exhibit 11;

c.) In failing to train properly individual corrections officers in the monitoring of incarcerated persons under the care and custody of the Defendant ALLEGHENY COUNTY;

d.) In failing to properly train individual corrections officers to provide medical intervention to persons under the care and custody of the Defendant ALLEGHENY COUNTY;

e.) In failing to recognize that the Decedent Plaintiff 's mental breakdown during his arrest may have rendered him more susceptible to injury;

f.) In failing to supervise properly individual corrections officers;

g.) In failing to train properly corrections officers in the recognition of objective and/or medical emergencies of persons under the care and custody of the Defendant ALLEGHENY COUNTY;

h.) In failing to train properly corrections officers in handling mental health inmates under the care and custody of the Defendant ALLEGHENY COUNTY;

i.) In failing to train properly corrections officers in risk assessment of mentally ill inmates under the care and custody of the Defendant ALLEGHENY COUNTY;

j.) In failing to train properly corrections officers in responding to objective and/or excessive risk in mentally ill inmates under the care and custody of the Defendant ALLEGHENY COUNTY;

k.) In failing to review information concerning issues related to medical emergencies;

l.) In failing to conduct the health receiving screen in a manner which would continuously alert them to medical emergencies;

m.) In failing to provide training in suicide training in the training programs for both Allegheny County Jail correctional and health care staff;

n.) In failing to recognize that the Decedent Plaintiff presented an objective and/or excessive risk of medical emergency;

o.) In failing to respond properly or adequately to the objective and/or excessive risk of medical emergency posed by the Decedent Plaintiff;

p.) In failing to properly monitor the Decedent Plaintiff;

q.) In failing to request medical intervention by experienced medical personnel on the Decedent Plaintiff's behalf;

r.) In failing to properly observe the condition of the Decedent Plaintiff while in custody;

s.) In deliberately and willfully placing Decedent Plaintiff under arrest without taking appropriate precautions to ensure his safety while in custody;

t.) In failing to provide a safe environment that would have prevented Decedent Plaintiff's death;

u.) In failing to acquire medical assistance for Decedent Plaintiff in a timely manner;

v.) In failing to monitor the Decedent Plaintiff appropriately under the circumstances;

w.) In failing to review information concerning issues related to medical emergencies;

x.) In failing to conduct the health receiving screen in a manner which would continuously alert them to medical emergencies;

y.) In failing to provide training in suicide training in the training programs for both Allegheny County Jail correctional and health care staff;

z.) In failing to train their staff members who work with inmates to recognize verbal and behavioral cues which indicate the potential for medical emergencies;

aa.) In failing to recognize that the Decedent Plaintiff as being potentially a medical emergency;

bb.) In failing to request an immediate history and physical evaluation of the patient through the CORIZON DEFENDANTS;

cc.) In allowing Decedent Plaintiff to be placed in the jail and not sending him to a mental health facility;

dd.) In failing to conduct the assessment of potentially medical emergency inmates by qualified mental/medical health professionals, trained to determine an inmate's level of health;

ee.) In failing to place the Decedent Plaintiff in the appropriate acute mental health facility;

ff.) In failing to provide regular and documented supervision of Decedent Plaintiff ;

gg.) In failing to outline the procedures for referring mentally ill inmates to mental health care facilities;

hh.) In failing to provide procedures for communication between health care personnel and Allegheny County Jail correctional personnel regarding the status of the inmate in a clear, current and accurate fashion;

ii.) In failing to outline an intervention plan on how to handle a uncommunicative mentally ill inmates;

jj.) In failing to have procedures in place to notify the Allegheny County Jail administrators, outside authorities and family members of mentally ill inmates; who were not communicating their medical history or responding;

kk.) In entering into a contract that frowned upon the intervention of outside medical treatment for inmates;

ll.) In failing to provide procedures of documenting the identification and monitoring of potential mentally ill inmates who would not cooperate or communicate basic health information;

mm.) In utilizing the restraint chair for unreasonably and cruel periods of time on mentally ill inmates;

nn.) In failing to train;

oo.) In permitting a policy of encouraging and/or condoning inadequate supervision of inmates with serious medical problems and mental problems such as Plaintiff;

pp.) A policy of failing to require a timely and proper medical examination when an inmate is admitting to the jail;

qq.) A policy of failing to require a timely and proper medical examination when a mentally ill inmate is admitted to the jail;

rr.) A policy of failing to adequately train its Cos to detect and address medical needs of inmates and/or mentally ill inmates;

ss.) Incorporating all of the subparts of paragraph 91 (a) – (bbbb).

141. The actions of the individual corrections officers as aforesaid resulted from and were taken pursuant to a policy, practice, and/or custom of the Defendant ALLEGHENY COUNTY, which policy, practice and/or custom is implemented by individual corrections officers.

142. Defendant ALLEGHENY COUNTY had approved and condoned the procedures implemented by and enforced by the individual correctional officers.

143. The Defendants' failures described above while in the care and custody of the Defendants caused the Plaintiff his injuries, death and previously described damages.

144. Plaintiffs also claim reasonable attorneys' fees and costs from Defendants as provided for by 42 U.S.C. §1988.

WHEREFORE, the Plaintiffs demand judgment against the Defendants for compensatory and punitive damages, together with court costs, attorneys' fees, interest, and all other relief permitted by the Court. JURY TRIAL DEMANDED.

COUNT VIII – PLAINTIFFS v. ALL DEFENDANTS – WRONGFUL DEATH

145. The Plaintiffs incorporate by reference thereto the above paragraphs within Complaint the same as though set forth herein and at length.

146. The above described individuals are eligible to recover damages as a result of the Decedent Plaintiff 's death pursuant to Pa. C.S.A. §8301.

147. During his lifetime, Decedent Plaintiff did not commence any action for the injuries that caused his death and no other action has been filed to recover damages for the wrongful death of Decedent Plaintiff.

148. At all relevant times, Defendants conducted themselves in a careless, reckless, and negligent manner, and acted with reckless indifference to the rights of the Decedent Plaintiff, generally and in the above described particulars.

149. As the direct and proximate result of the Defendants' negligence, the plaintiffs and entitled persons have suffered the following damages:

a.) Funeral expenses of the Decedent Plaintiff ;

b.) Expenses of administration related to the Decedent Plaintiff 's injuries;

c.) The loss of contribution, support, consortium, comfort, counsel, aid, association, care and services of the Decedent Plaintiff ;

d.) Medical expenses incidental to treatment of the Decedent Plaintiff for his injuries and subsequent death;

e.) Such other damages as are permissible in the wrongful death action;

f.) Other losses and damages recoverable under 42 Pa. C.S.A. §8301.

150. As a direct and proximate result of the previously described outrageous, reckless, negligent, willful, wanton, and/or intentional conduct of the Defendants, plaintiffs seek punitive damages on behalf of the persons identified herein.

WHEREFORE, the Plaintiffs demand judgment against the Defendants for compensatory and punitive damages, together with court costs, attorneys' fees, interest, and all other relief permitted by the Court. JURY TRIAL DEMANDED.

COUNT IX – PLAINTIFFS v. ALL DEFENDANTS – SURVIVAL ACTION

151. The Plaintiffs incorporate by reference thereto the above paragraph of the within Complaint the same as though set forth herein and at length.

152. The Plaintiffs bring this survival action pursuant to 20 Pa.C.S.A. §3373 and 42 Pa.C.S.A. §8302.

153. As the direct and proximate result of the Defendants' negligence, the Defendants, and each of them, are liable for the following damages:

a.) Decedent Plaintiff 's pain and suffering between the time of the Defendants' negligence and time of the Decedent Plaintiff 's death;

b.) Decedent Plaintiff 's total estimated future earning power, less his estimate cost of personal maintenance;

c.) Decedent Plaintiff 's loss of retirement and Social Security income;

d.) Decedent Plaintiff 's other financial losses suffered as a result of his death;

e.) Decedent Plaintiff 's loss of the enjoyment of life.

WHEREFORE, the Plaintiffs demand judgment against the Defendants for compensatory and punitive damages, together with court costs, attorneys' fees, interest, and all other relief permitted by the Court. JURY TRIAL DEMANDED.

COUNT X – PLAINTIFFS v. ALL DEFENDANTS

154. The Plaintiffs incorporate by reference thereto the above paragraphs of the within Complaint the same as though set forth herein and at length.

155. Pursuant to 42 Pa. C.S.A. §8548, Defendant ALLEGHENY COUNTY is the indemnitor of its employees, the individual corrections officers, for the payment of any judgment for damages resulting from a judicial determination that an act of either or any of individual corrections officers was the cause and their actions were within the scope of their duties as corrections officers.

156. Plaintiffs are therefore entitled to recover payment from the Defendant ALLEGHENY COUNTY for any judgment against the individual Defendant corrections officers arising from the prior counts of this Complaint.

WHEREFORE, the Plaintiffs demand judgment against the Defendants for compensatory and punitive damages, together with court costs, attorneys' fees, interest, and all other relief permitted by the Court. JURY TRIAL DEMANDED.

JURY DEMAND

PLAINTIFF REQUESTS THAT ALL ISSUES THAT MAY BE DETERMINED BY A JURY BE TRIED BY A JURY.

Respectfully submitted,

BY: /s/ Steven M. Barth

Steven M. Barth, Esquire
Pa. I.D. #89395
P.O. Box 23627
Pittsburgh, PA 15222
(412) 779-3806
smbassociates@gmail.com
Attorney for the Plaintiffs