E-FILED
Thursday, 16 July, 2020 04:02:26 PM
Clerk, U.S. District Court, ILCD

IN THE UNITED STATES DISTRICT COURT
FOR THE CENTRAL DISTRICT OF ILLINOIS
URBANA DIVISION

KELSEY JILL SMITH, as Administrator of the Estate of Dalynn Kee, and on behalf of her Next of Kin, Plaintiffs, COUNTY OF MACON, ANTONIO BROWN, Macon County Sheriff, KENNE LARGENT, MICHAEL WHITSEL, TOBY WALTER, DEREK FLAUGHER, JACOB WARRICK, and WENDY DIERICKS, Macon County Corrections Officers, COMMUNITY HEALTH IMPROVEMENT CENTER, INC. d/b/a CROSSING HEALTHCARE, DANA RAY, MD, DENNIS COSTERISAN, DO, LINDA FASICK, RN, KAM DOWDY, RN, AMANDA THOMPSON, RN, and CARETH JACOBY, LPN, Defendants.	)	No.
	)	**JURY DEMANDED**

COMPLAINT

I. PRELIMINARY STATEMENT

On October 7, 2019, Dalynn Kee, was arrested on an outstanding warrant and taken to the Macon County Jail (MCJ). Dalynn informed corrections staff and medical staff at the MCJ that she was participating in a medication-assisted treatment (MAT) program for her Opioid Use Disorder (OUD), taking a daily 208 mg dose of legally prescribed Methadone, and likely to experience serious withdrawal symptoms while detoxifying if her MAT was not

continued. As should have been expected, Dalynn experienced severe withdrawal symptoms while detoxifying, including agitation, insomnia, loss of appetite, and uncontrollable vomiting and diarrhea to the point that she was transferred from general population to a medical cell where she could be more closely monitored. The two medical cells are each equipped with a video camera to allow corrections staff and medical staff to monitor inmates from computer screens located at their stations. The two nurse's stations were located just a few feet away from Dalynn's medical cell.

During the 22 hours Dalynn was locked in a medical cell, video showed her become sicker and sicker. Corrections staff and medical staff did nothing to treat Dalynn's urgent medical condition or otherwise provide her access to qualified medical providers until she was found unresponsive in her medical cell. On October 17, 2019, – ten days after her admission to the Macon County Jail and 22 hours after being locked in a medical cell – Dalynn died naked and alone in her vomit covered cell. Dalynn's autopsy determined that she died of dehydration due to opioid withdrawal. She was just 21 years-old and left two small children surviving.

II. JURISDICTION & VENUE

1. The jurisdiction of the Court is invoked pursuant to the Constitution of the United States; the Civil Rights Act, 42 U.S.C. §1983; the Judicial Code, 28 U.S.C. §§ 1331, 1343(a), and supplementary jurisdiction, as codified in 28 U.S.C. §1367(a).

2. The violations of civil rights and other misconduct alleged herein occurred in

Decatur, Macon County, Illinois. Accordingly, this action properly lies in the United States District Court for the Central District of Illinois, Urbana Division, pursuant to 28 U.S.C. § 1391(b).

III. THE PARTIES

3. All relevant times, Dalynn Kee was a United States citizen and lived in Springfield, Sangamon County, Illinois. At the time of her death, Dalynn Kee was a pre-trial detainee confined in the MCJ. Dalynn was 21 years old, never married, and the mother of a 5-year-old son and a 1-year-old daughter, who survive her.

4. Plaintiff, Kelsey Jill Smith, is the adult sister of the decedent, Dalynn Kee, and was appointed Administrator of the of the Estate of Dalynn Kee by the Circuit Court of the Seventh Judicial Circuit in Sangamon County Case No. 2020-P-166. Plaintiff brings this action in her capacity as Administrator of the Estate of Dalynn Kee and for the benefit of Dalynn's next of kin.

A. Macon County, Sheriff, and Jailers (The Macon County Corrections Defendants)

5. At all relevant times, Defendant Antonio Brown (Sheriff Brown) was the duly elected Sheriff of Macon County and the warden and chief administrator of the MCJ. Sheriff Brown was the final policy maker for Defendant Macon County with respect to the care and custody of inmates in the MCJ. At all relevant times, Sheriff Brown acted under color of law. Sheriff Brown is sued in his official capacity.

6. Defendant Kenne Largent (Cpl. Largent) was employed by Macon County

and/or Sheriff Brown as a Corrections Corporal working in the MCJ during Dalynn's incarceration, including on the night she died. Cpl. Largent was the supervisor of the individually named jailers working in the MCJ during Dalynn's incarceration, including on the night she died. Cpl. Largent is sued in his official and individual capacity.

7. Defendant Wendy Diericks (CO Diericks) was employed by Macon County and/or Sheriff Brown as a Corrections Officer working in the MCJ during Dalynn's incarceration, including on the night she died. CO Diericks is sued in her individual capacity.

8. Defendant Derek Flaugher (CO Flaugher) was employed by Macon County and/or Sheriff Brown as a Corrections Officer working in the MCJ during Dalynn's incarceration, including on the night she died. CO Flaugher is sued in his individual capacity.

9. Defendant Michael Whitsel (CO Whitsel) was employed by Macon County and/or Sheriff Brown as a Corrections Officer working in the MCJ during Dalynn's incarceration, including on the night she died. CO Whitsel is sued in his individual capacity.

10. Defendant Jacob Warrick (CO Warrick) was employed by Macon County and/or Sheriff Brown as a Corrections Officer working in the MCJ during Dalynn's incarceration, including on the night she died. CO Warrick is sued in his individual capacity.

11. Defendant Toby Walter (CO Walter) was employed by Macon County and/or Sheriff Brown as a Corrections Officer working in the MCJ during Dalynn's incarceration,

including on the night she died. CO Walter is sued in his individual capacity.

12. At all relevant times, the individual jailer defendants identified above acted under color of law and in the course and scope of his or her employment as employees or agents of Macon County and/or Sheriff Brown.

13. Defendant Macon County is a governmental entity in the State of Illinois which funds and operates the MCJ and, while Sheriff Brown may be the actual employer of the individual jailers named herein, Macon County is a necessary party and is ultimately responsible for paying a judgment or settlement on behalf of the Sheriff or individual jailers and is joined in this action pursuant to *Carver v. Sheriff of LaSalle County,* 324 F.3d 947 (7th Cir. 2003).

B. Crossing Healthcare, Physicians and Nurses (The Crossing Healthcare Medical Defendants)

14. At all relevant times, Defendant Community Health Improvement Center, Inc. was an Illinois corporation d/b/a Crossing Healthcare (Crossing Healthcare) located in Decatur, Illinois, in the business of providing healthcare services to citizens of Macon County and its surrounding areas. At all relevant times, Crossing Healthcare provided healthcare to inmates in the MCJ pursuant to a contact with Macon County and Sheriff Brown. At all relevant times, Crossing Healthcare, by and through its employees and agents, was acting under color of law, and its employees and agents were acting in the course and scope of their employment or agency with Crossing Healthcare and/or Macon County and/or Sheriff Brown.

15. At all relevant times, Defendant Dana Ray, MD (CMO Dr. Ray) was a duly licensed physician employed by Crossing Healthcare as its Chief Medical Officer and was responsible for medical and psychiatric healthcare services at MCJ, including providing adequate physician, nurse practitioner or physician assistant staffing. CMO Dr. Ray was an official policy maker for Crossing Healthcare and Macon County and/or Sheriff Brown on all issues relating to the medical and psychiatric healthcare provided to inmates in MCJ. CMO Dr. Ray was acting under color of law and in the course and scope of her employment or agency with Crossing Healthcare and/or Macon County and/or Sheriff Brown. CMO Dr. Ray is sued in her official and individual capacities.

16. At all relevant times, Defendant Dennis Costerisan, DO (Dr. Costerisan) was a duly license physician employed by Crossing Healthcare and responsible for providing medical care to inmates of the MCJ. At all relevant times, Dr. Costerisan was acting under color of law and in the course and scope of his employment or agency with Crossing Healthcare and/or Macon County and/or the Sheriff Brown. Dr. Costerisan is sued in his individual capacity.

17. At all relevant times, Defendant Linda Fasick, RN (COO RN Fasick) was a registered nurse employed by Crossing Healthcare as its Chief Operations Officer and was responsible for providing nursing care to inmates of MCJ. COO RN Fasick was an official policy maker for Crossing Healthcare and/or Macon County and/or Sheriff Brown on all issues relating to providing nursing care to inmates of MCJ. COO RN Fasick was acting

under color of law and in the course and scope of her employment or agency with Crossing Healthcare and/or Macon County and/or Sheriff Brown. COO RN Fasick is sued in her official capacity.

18. At all relevant times, Defendant Amanda Thompson, RN (RN Thompson) was a registered nurse employed by Crossing Healthcare as a member of the medical staff and was responsible for providing medical care to inmates in the MCJ. At all relevant times, RN Thompson was acting under color of law and in the course and scope of her employment or agency with Crossing Healthcare and/or Macon County and/or Sheriff Brown. RN Thompson is sued in her individual capacity.

19. At all relevant times, Defendant Kam Dowdy, RN (RN Dowdy) was a registered nurse employed by Crossing Healthcare as a member of the medical staff and was responsible for providing medical care to inmates in the MCJ. At all relevant times, RN Dowdy was acting under color of law and in the course and scope of her employment or agency with Crossing Healthcare or Macon County or Sheriff Brown. RN Dowdy is sued in her individual capacity.

20. At all relevant times, Defendant Careth Jacoby, LPN (LPN Jacoby) was a licensed practical nurse employed by Crossing Healthcare as a member of the medical staff and was responsible for providing medical care to inmates in the MCJ. At all relevant times, LPN Jacoby was acting under color of law and in the course and scope of her employment or agency with Crossing Healthcare and/or Macon County and/or Sheriff Brown. LPN

Jacoby is sued in her individual capacity.

IV. COMMON ALLEGATIONS OF FACT

A. The Poor Quality of Medical Care Provided to Inmates in the MCJ was Well-known and Long-standing

21. On or about September 15, 2017, Tom Schneider unexpectedly retired as Macon County Sheriff and his undersheriff, Howard G. Buffett, was appointed to complete Sheriff Schneider's term. Howard Buffett manages or controls a charitable foundation called the Howard G. Buffett Foundation.

22. At the time Sheriff Buffet took office, the Macon County Sheriff's Department and Decatur Memorial Hospital, the entity contracted to provide medical care to MCJ inmates, were defendants in two pending federal civil rights lawsuits brought on behalf of inmates who died in the MCJ allegedly due to inadequate medical care and monitoring.

23. One suit was brought by the Estate and family of Michael Carter who died of diabetic ketoacidosis in 2015 five days after his arrest and detention in the MCJ. *See* case # 16-cv-02221 filed in the District Court for the Central District of Illinois, Urbana Division.

24. The other suit was brought by the Estate and family of Brandon Hopkins who died of suicide after an unsuccessful suicide attempt several days before. *See* case #17-cv-02048 filed in the District Court for the Central District of Illinois, Urbana Division.

25. After only two weeks in office, Sheriff Buffett became individually concerned about the quality of medical care inmates were receiving in the MCJ after personally investigating an incident where a MCJ inmate was sent to the hospital after a medication

error. As a result of his investigation, Sheriff Buffett demanded that the particular physician providing medical care to MCJ inmates be replaced.

26. Due to his concerns about the quality of medical care provided to MCJ inmates, Sheriff Buffett commissioned and, through the Howard G. Buffett Foundation, funded a study to assess various aspects of the MCJ, including its policies and mental and medical health protocols. The study cost approximately $236,000.

27. In a report titled "Report on Medical Services at the Macon County Jail, Decatur, Illinois," dated November 11, 2017, Jeffrey Keller, MD, FACCP, FACEP, who assessed the medical, dental and mental health services being provided to inmates incarcerated in the MCJ, found, in part, that:

a. the initial assessments and booking screens were poorly drafted and poorly performed by corrections staff and medical staff;

b. the jail had protocols that allowed nurses to make diagnoses and provide prescription medications without contacting a physician for an order in violation of the Nurse Practice Act;

c. the jail's deficient healthcare delivery system most likely arose as a response to inadequate staffing of an on-site physician at the facility;

d. the lack of a physician being on-site for a sufficient amount of time caused the physician to inappropriately delegate some of the practice of medicine to the nurses;

e. the on-site nurses had inadequate physician backup on call;

f. the on-call physician and nurse system was inadequate as neither on-call medical providers were compensated for being on call, which meant being available for telephone questions only, such that the corrections staff often had to make after hours medical decisions without the training to do so, such as whether a patient should be sent to the ER or could wait; and

g. the training required by the healthcare provider contract (i.e. that "All physicians and nursing staff provided by DMH shall be trained in accordance with NCCHC,) had likely never been done.

28. Macon County and/or Sheriff Buffett requested proposals from healthcare providers to provide medical services to inmates in the MCJ.

B. In its Proposal to Provide Medical Care to MCJ Inmates, Crossing Healthcare Agreed to Comply with NCCHC Standards for Health Services in Jail Specifically Noting the Serious Risks to Inmates Undergoing Withdrawal from Opiates and the Need for Medication Assisted Treatment.

29. Crossing Healthcare bid on the contract. In its Proposal to Provide Inmate Health Services to MCJ, Crossing Healthcare, wrote:

"**3. Regulatory Compliance**

> The provision of health service in a unique setting like a correctional facility requires a health care partner that is familiar with the standards for health services in jails as published by the National Commission on Correctional Health. A comprehensive understanding of these requirement[s] for proper management of a correctional health services delivery system supports a correctional facility and their partners to improve inmate health, increase

efficiencies of care delivery, and reduce the risk of an adverse patient outcome or legal judgement. For this reason, the leaders of Crossing Healthcare have taken the time to understand these standards and support policies and procedures for Healthcare delivery within the Macon County Jail that are in line with the intent of these standards.

Crossing Healthcare leadership has read and understands the County Jail Act, 730 ILCS 125/0.01 et seq. and the medical and mental health regulations set forth in 20 Illinois Administrative Code 701.90 and agrees to comply with these regulations. Further, the policies and procedures established by the Macon County Jail have been reviewed and are all written in accordance with current National Standards of Correctional Health. Crossing Healthcare will follow these policies and procedures and work in collaboration with Macon County Jail if selected to provide health services to routinely evaluate these policies and procedures for ongoing effectiveness."

30. In its Proposal to Provide Inmate Health Services to MCJ, Crossing Healthcare, wrote:

"**4. Staffing Plan**

As partner in the service delivery, Crossing Healthcare would work closely with the leaders of the Macon County Jail to ensure all staff selected for a role in the jail not only met background requirements, but fit well in the organization's culture. It is understood that the leaders of the Macon County Jail have the final approval of who is allowed to work by contract in the facility. With the goal of ensuring a qualified and capable staff to provide healthcare in the Macon County Jail, Crossing Healthcare, if selected as the provider of health services, would offer full time positions to all current nursing staff. Crossing will add nursing hours to reach 160 hours per week from our current staff if needed while nursing positions are posted and filled by Crossing. The nursing schedule that is currently being deployed can remain in place with adjustments to the hours nurses are on site being made to support goals of the team or in response to quality initiatives.

12 hours of on-site medical care will be provided by Nurse Practitioners and Physicians Assistants under the supervision of Dr. Dana Ray, the Chief Medical Officer of Crossing Healthcare. Administrative oversight of the medical program will be provided by Dr. Ray. Crossing Healthcare leaders

plan to have medical staff in the jail 5 days per week Monday thru Friday to ensure any concern identified by nursing staff can be addressed by the medical provider in a timely fashion. In order to ensure access to medical staff in the event of an emergency Crossing Healthcare will establish a subset of medical providers to remain on call for the jail. The Medical providers will be available by phone to discuss the circumstance or situation to provide Macon County Jail Staff with direction. In the event it is deemed the medical provider needs to present to the Jail in person, to assess an after hour emergency, they will be incentivized by Crossing Healthcare to do so within one hour of the call. Response to after hour calls is an item that should be measured and discussed monthly in quality meetings to ensure the needs of the jail are being addressed.

31. In its Proposal to Provide Inmate Health Services to MCJ, Crossing Healthcare, wrote:

"5. Daily Operations

Conditions that place an inmate at the highest risk for negative outcomes while incarcerated include withdrawal from alcohol and drugs, suicide and poorly controlled diabetes. For this reason special consideration to these conditions will be given to ensure inmates with a history of substance abuse disorder, suicide risk and diabetes are rapidly identified and medical and behavioral health interventions are put into place within 48 hours. Currently nursing staff provide coverage to the jail Monday thru Friday 6 AM to 10 PM with morning and weekend hours to cover medication administration. All inmates are screened at the time of booking with a tool that addresses medical, behavioral health, substance abuse and trauma history. Each day, Monday thru Friday, the screening of the previous 24 hours will be reviewed by nursing staff with weekend screenings reviewed by the weekend day nurse. Positive responses to the screening questionnaire will result in further review by the nurse or as appropriate, by the behavioral health staff member. Emphasis of nursing and medical staff time and daily procedures will be determined upon review of screening results and addressing identified needs of inmates within the first 48 hours. Crossing Healthcare is the largest primary medical care provider for the low income and Medicaid population in Macon County. Many inmates in the Macon County Jail receive medical care from Crossing Healthcare making the identification of significant medical and behavioral health needs easier for our team.

> A comprehensive assessment including all required components will be completed within 12 days of admission and reviewed by the medical staff within 14 days. The Crossing Healthcare Medical team will work closely with the Macon County Jail leaders to identify a tool to meet this requirement. As the jail transitions to a facility wide electronic record it will be important to evaluate any documentation tools that currently exist within the purchased system. If no documentation tool that meets the History and Physical Requirements outlined in the RFP exists Crossing Healthcare Medical team will develop such a tool for use by the medical staff.
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> Medication Assisted Treatment Services: As a result in the increase in opioid dependence in the jail population it is important that as part of the substance abuse assessment a detailed history of opioid use is obtained. When medically appropriate, Medication Assisted Treatment (MAT) treatment can be initiated or maintained in the jail with a medication known as buprenorphine. Crossing Healthcare has prescribers on staff that have sufficient Federal Data 2000 approval to provide this type of treatment (Attachment F)."

C. Crossing Healthcare Is Awarded the "Jail Contract" to Provide Medical Care for MCJ Inmates.

32. On May 1, 2018, Macon County, the Macon County Sheriff and Crossing Healthcare executed an "Agreement for Inmate Health Services at Macon County, Illinois." (the Jail Contract).

33. The Jail Contract required Crossing Healthcare to provide medical care to MCJ inmates, which included providing sufficient "staffing to effectively manage and operate a medicated assisted treatment program."

34. The Jail Contract required Macon County to pay Crossing Healthcare a fixed sum of approximately $635,000 per year.

35. The Jail Contract required that all medical and support staff provided by

Crossing Healthcare be trained in accordance with the National Commission on Correctional Healthcare (NCCHC).

36. The Jail Contract required Crossing Healthcare to establish a training program for the deputies and jailers employed by Macon County in accordance with the needs mutually established by Macon County and Crossing Healthcare.

37. The Jail Contract required Crossing Healthcare to bear the cost for on-call/after hours telephonic or on-site medical services rendered for medical emergencies.

38. The Jail Contract gave Crossing Healthcare's employees the authority to declare medical emergencies requiring off-site services such as transport by ambulance or hospitalization and required Macon County to pay the cost of associated ambulatory transport, emergency room visits and hospitalization.

39. In the years and months before Dalynn's October 2019 admission to the MCJ, the abuse of heroin and other opiate-based controlled substances increased dramatically throughout the nation, including Macon County and surrounding areas.

40. Reasonably trained corrections staff and medical staff responsible for coordinating access to and providing medical care to inmates housed in local jails were particularly attuned to patterns of heroin and opiate abuse due to the disproportionately high number of heroin and opiate abusers typically present in the correctional population.

41. Reasonably trained corrections staff and medical staff responsible for coordinating access to and providing medical care to inmates housed in local jails were,

likewise, aware of the significant medical issues presented in opiate addicted individuals detoxifying from opiates due to sudden termination of their usage upon admission to a correctional facility.

42. Inmates undergoing opioid detoxification have serious medical needs.

43. Opioid detoxification is known to have several harmful and potentially fatal medical consequences, which are particularly likely to be present in persons who are heavy users of opioids.

44. In the initial phase of opiate detoxification, a patient may experience the following unpleasant withdrawal symptoms: restlessness, agitation, anxiety, myalgia (muscle aches/pains), hyperlacrimation (increased tearing), insomnia, rhinorrhea (runny nose), diaphoresis (sweating), and yawning.

45. In the later phase of opiate detoxification, a patient may experience the following more menacing withdrawal symptoms: abdominal cramping, diarrhea, mydriasis (dilated pupils); horripilation (goose bumps); nausea; and vomiting.

46. The serious medical consequences present with opioid detoxification include: dehydration; electrolyte imbalance; neurological arrhythmia (seizures); or cardiac arrhythmias leading to cardiac arrest. The most serious medical consequence from opioid detoxification is death.

47. For these reasons, recognized standards of correctional healthcare require that persons who are admitted to correctional facilities with obvious signs of opiate abuse be

consistently monitored and assessed.

48. Such monitoring includes assessments multiple times per day of vital signs, including: pulse; respirations; blood pressure; and body temperature.

49. Such monitoring includes evaluation multiple times per day of symptoms which are consistent with serious health consequences of detoxification, including: abdominal cramping; diarrhea; mydriasis (dilated pupils); horripilation (goose bumps); nausea; vomiting; anxiety; insomnia; sweating; and restlessness.

50. Close monitoring, regular assessments and continued evaluations of this nature is necessary to ensure that an inmate experiencing opioid detoxification is not at risk of more serious medical consequences, including those outlined above.

51. Most opioid withdrawal protocols consist of the following measures:

a. daily clinic visits by a healthcare provider during the withdrawal period for vital sign assessments, clinical assessments and interviews to assess a patient's withdrawal severity utilizing the Clinical Opiate Withdrawal Scale (COWS), an objective assessment completed by a healthcare provider and the Subjective Opiate Withdrawal Scale (SOWS);

b. pharmacological intervention and support measures to assess, monitor and treat the patient's unpleasant and menacing symptoms of detoxification, including anxiety, insomnia, restlessness, agitation, nausea, vomiting, rhinorrhea, or myalgias.

c. to provide non-pharmacological intervention for signs of dehydration

resulting from diarrhea, vomiting and malnutrition; monitoring potential electrolyte imbalances and kidney function with chemical tests on a patient's blood sample; providing supplemental nourishment such as Ensure; and to provide intravenous fluids such as saline to maintain safe levels of hydration.

52. Macon County, as an entity that operates a correctional facility and is charged with the responsibility to provide medical care to an inmate population, was aware of the medical issues present in an inmate population and was thus aware of the need for monitoring, assessment and evaluation of persons admitted the correctional facilities with histories of opioid abuse.

53. Macon County was aware of the need to establish and follow specific policies, practices, and guidelines for its corrections staff and its medical contractors regarding care for inmates with histories of opiate abuse.

54. Macon County was, likewise, aware of the need to supervise, train and discipline its corrections staff and its medical contractors concerning compliance with established policies, practices and guidelines for its corrections staff and medical contractors, including those policies, practices and guidelines regarding regarding care for inmates with histories of opiate abuse.

55. The individual Macon County Corrections Defendants and the individual Crossing Healthcare Medical Defendants were each aware of the need to properly monitor, assess and evaluate persons admitted to MCJ with histories of opioid abuse and the need to

provide necessary medical intervention in the event of complications arising from opioid detoxification.

D. Dalynn Was Admitted to MCJ and Disclosed to Corrections and Medical Staff That She Suffered from Opioid Use Disorder and Had Previously Experienced Withdrawal Symptoms While Detoxifying from Methadone.

56. On October 7, 2019, Dalynn was arrested by the Springfield Police Department on an outstanding warrant from Macon County that was issued on July 18, 2019, for failing to appear in court. Dalynn was transported from Springfield to the MCJ.

57. On October 7, 2019, at approximately 2:45 p.m.[1], Corey Malone (CO Malone), a jailer, completed the intake/screening process to determine whether Dalynn had any condition requiring medical attention such as dependence on drugs or had any prescriptions that needed to be administered in the near future.

58. In completing the "Intake Acceptance Questionnaire Fitness to Confine" form and "Initial Medical Assessment Questionnaire" CO Malone learned that Dalynn was a recovering heroin addict, who received a daily dose of prescribed Methadone and had experienced withdrawal symptoms in the past when she stopped taking Methadone.

59. CO Malone designated that Dalynn be housed in the general female population of the MCJ in TROD 6, Pod-B, Cell 2 bottom bunk.

60. On October 7, 2019, at approximately 4:05 p.m., Dalynn told LPN Jacoby that

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[1] Dates with specific times alleged are those dates and times appearing in written records or on the date and time stamp appearing on video footage obtained from the Macon County Sheriff's Office.

she participated in a daily Methadone program through a clinic in Springfield and had not taken her prescribed Methadone in a couple of days.

61. Dalynn asked LPN Jacoby to continue her Methadone program at the MCJ. LPN Jacoby told Dalynn that was not possible because patients from another clinic could not be transferred to Macon County's Heritage Behavioral Health Center while incarcerated.

62. On October 8, 2019, at 8:03 a.m., RN Dowdy spoke to Barbara Wheatley, the clinical director of the Springfield Treatment Center, who confirmed that Dalynn's last used Methadone on October 5, 2019. Ms. Wheatley told RN Dowdy that Dalynn was on a daily dosage of 208 mg of Methadone.

63. On October 8, 2019, at 8:14 a.m., RN Dowdy relayed this information to CMO Dr. Ray. CMO Dr. Ray told RN Dowdy to start Dalynn on the opioid withdrawal protocol.

64. CMO Dr. Ray told RN Dowdy that Dalynn would need to be on the opioid withdrawal protocol for 7-10 days.

65. On October 8, 2019, at 8:15 a.m., RN Dowdy recorded an "Alert" for "Methadone Withdrawal" and "History of Drug Abuse/Addiction" in Dalynn's medical records.

66. Based upon the history presented, the Macon County Corrections Defendants and the Crossing Healthcare Medical Defendants knew that Dalynn had serious medical needs.

E. Dalynn Placed On MCJ's Opioid Withdrawal Protocol.

67. On October 8, 2019, at 8:15 a.m., RN Dowdy ordered medications to help control Dalynn's anticipated withdrawal symptoms: Clonidine (0.1 mg tablet by mouth TID, hold if systolic BO is less than 100); Hydroxyzine PAM (50 mg, 1 capsule by mouth TID); Ondanestron (4 mg, 1 tablet by mouth TID).

68. Neither CMO Dr. Ray nor any other physician, nurse practitioner, physician assistant or other qualified healthcare provider personally saw Dalynn in the MCJ prior to approving her for the opioid withdraw protocol or prior to prescribing medication for her.

69. Within twenty-four hours of Dalynn's admission to the MCJ, the Macon County Corrections Defendants and the Crossing Healthcare Medical Defendants were aware of her heroin addiction, her heavy methadone use, and her prior medical difficulties while undergoing Methadone withdrawal, and were each, therefore, aware that Dalynn had serious medical needs.

70. On October 8, 2019, Dalynn received two clinical assessments according to the Clinical Opioid Withdrawal Scale (COWS), and was administered Clonidine, Hyrdoxyzine, and Ondansetron. In her last assessment that day, RN Dowdy documented that Dalynn experienced nausea or a loose stool.

71. On October 9, 2019, Dalynn received three clinical assessments (COWS), and was administered Clonidine, Hyrdoxyzine, and Ondansetron. In her first two assessments that day, RN Dowdy documented that Dalynn experienced nausea or a loose stool. In her last

assessment, RN Thompson documented that Dalynn experienced nausea or a loose stool.

72. On October 10, 2019, Dalynn received three clinical assessments (COWS), and was administered Clonidine, Hyrdoxyzine, and Ondansetron. In her first two assessments that day, RN Dowdy documented Dalynn experienced nausea or a loose stool. In her last assessment, RN Thompson documented that Dalynn experienced vomiting or diarrhea.

73. On October 11, 2019, Dalynn received two clinical assessments (COWS), and only one of the three medications ordered for her. She received her Clonidine, but did not receive any Hyrdoxyzine or Ondansetron. In her last assessment that day, LPN Jacoby documented that Dalynn experienced stomach cramps

74. On October 12, 2019, Dalynn received two clinical assessments (COWS), and only one of the three medications ordered for her. She received her Clonidine, but did not receive any Hyrdoxyzine or Ondansetron. In each of her assessments that day, LPN Jacoby documented that Dalynn experienced nausea or a loose stool.

F. CMO Dr. Ray Refused to Adjust or Prolong Dalynn's Opioid Withdrawal Protocol Causing her Medical Condition to Decline.

75. On October 12, 2019, the records reflect that LPN Jacoby noted: "Per Dr. Ray protocol will not be adjusted or prolonged."

76. The records reflect that Dalynn's last clinical assessment (COWS) and last administration of Clonidine occurred on October 13, 2019.

77. On October 14, 2019, at 5:15 p.m., Dalynn's fellow inmates hit the alarm and told CO Michelle Stine (CO Stine) that cleaning supplies were needed because Dalynn was

vomiting into a garbage can and on the floor.

78. CO Stine provided the cleaning supplies to clean up the floor.

79. On October 14, 2019, at 7:20 p.m., Dalynn's fellow inmates hit the alarm again and notified CO Stine that Dalynn had vomited again. CO Stine obtained approval from her supervisors to move Dalynn from B-pod to E-pod. CO Stine also told Amanda Thompson, RN (RN Thompson) that Dalynn had vomited numerous times that evening.

80. Between October 15, 2019, and October 16, 2019, Dalynn continued to show more severe, obvious and alarming signs of medical distress. During this time, Dalynn vomited repeatedly and could not keep anything down, including her meals or fluids.

81. On October 16, 2019, at approximately 7:25 p.m., Dalynn pushed the E-pod's emergency button and alerted CO Wendy Dierecks (CO Diericks) that she could not keep anything down, and that she had been vomiting all day.

82. RN Thompson reviewed the video footage from E-pod for that day and confirmed that Dalynn had not eaten anything all day, and thereafter informed CO Diericks that Dalynn would be moved to a medical cell for observation.

G. On October 16, 2019, at 8:16 p.m., Dalynn is Transferred via Wheel Chair to a Video-monitored Medical Cell and a Nurse Notifies the on-call Physician of Dalynn's Serious Medical Needs.

83. On October 16, 2019, at approximately 8:00 p.m., Command Officer In Charge Elizabeth Tarczan (COIC Tarczan) approved Dalynn's transfer from general population to a medical cell.

84. Each medical cell in the MCJ is equipped with a video camera that transmits live video images to computers and monitors located throughout the MCJ, including the master control room and the two desks reserved for the nurses (nurse's stations).

85. Other video cameras are mounted at other location through the MCJ and provide live feeds of activities within each camera's view.

86 Each camera is identified by its location. For example, the video camera identified as "Medical Cell 2" shows and records activities in Medical Cell 2. The video camera identified as "Medical Staff 1" shows and records activities occurring near the nurse's stations.

87. Corrections staff and medical staff can switch to and from many different cameras from the desktop computers and can watch up to six different cameras simultaneously.

88. In addition to providing live feeds, the video system in the MCJ records and stores each camera's recordings.

89. The two nursing stations are a few feet away from the doors of Medical Cell 1 (MC1) and Medical Cell 2 (MC2).

90. On October 16, 2019, at approximately, 8:16 p.m., CO Jinks pushed Dalynn in a wheelchair into MC2.

91. MC2 is a single occupant cell with a single bunk, a toilet and a sink.

92. RN Thomson telephoned the on-call physician, Dr. Costerisan, and informed

him of Dalynn's medical condition and her move to a medical cell.

93. Dr. Costerisan ordered one 4 mg tablet of Ondansetron stat., which RN Thompson gave to Dalynn at approximately 8:16 p.m.

94. Dr. Costerisan was not on-site nor did he come to the MCJ to personally examine Dalynn or otherwise personally assess her medical condition.

95. Over the next 22 hours – October 16, 2019 at 8:16 p.m through October 17, at 6:01 p.m. – Dalynn was vomiting continuously and uncontrollably while locked in MC2.

96. Each time Dalynn vomited, a live video footage captured that event in real time and that video could have been transmitted live to any desktop workstation, including the two nurse's stations, if the MC2 camera was selected for monitoring.

97. On some of the numerous occasions that Dalynn vomited, stumbled or otherwise appeared in medical distress while locked in MC2, the nurses did not notice because the nurses did not have MC2 selected on the nurse's stations' monitors. At other times when MC2 was selected, the nurses ignored the respective monitors and played on their cell phones, ate snacks, talked with each other or corrections officers, or in LPN Jacoby's case, vaped.

98. Dalynn vomited 24 times after her transfer to MC2 on October 16, 2019, at 8:16 p.m. and 7:00 a.m. and October 17, 2019.

99. On October 17, 2019 at 7:06 a.m., a corrections officer unlocked Dalynn's cell and brought her breakfast in a Styrofoam container and a carton of milk, which she did not

eat or drink.

100. Dalynn vomited 5 more times between 7:10 a.m. and 7:30 a.m.

101. At 7:15 a.m., RN Dowdy arrived at work and at 7:36 a.m., a corrections officer unlocked Dalynn's cell and allowed RN Dowdy to give Dalynn a tablet, presumably of Odansetron.

102. LPN Jacoby arrived at work at approximately 8:37 a.m.

103. Between 7:36 a.m. and 9:52 a.m., Dalynn vomited 10 more times.

104. When Dalynn vomited at 9:45 a.m. and 9:52 a.m., she vomited on the floor of her cell and on her shirt and pants. Dalynn took off her soiled clothes and laid back down naked on her bunk.

105. At 10:00 a.m. a corrections officer unlocked Dalynn's cell and gave Dalynn clean clothes and a clean blanket. The corrections officer bagged up and removed Dalynn's vomit-soaked clothing and bedding. The corrections officer wheeled a bucket and mop into Dalynn's cell and watched while she mopped the floor.

106. Both RN Dowdy and LPN Jacoby were sitting at their respective desks just outside of Dalynn's medical cell as it was being cleaned.

107. Between 10:10 a.m. and 10:34 a.m., Dalynn vomited 6 more times.

108. At 10:39 a.m., a corrections officer unlocked Dalynn's cell door and allowed her to receive a plastic bottle of Sprite.

109. Between 10:40 a.m. and 11:01 a.m., Dalynn vomited 2 more times.

110. At 11:02 a.m., a corrections officer unlocked Dalynn's door and brought her lunch in a Styrofoam container and a Styrofoam cup of water. Dalynn sat up and vomited in the toilet as the corrections officer left her cell. Dalynn did not eat any of her lunch.

111. Between 11:03 a.m. and 11:40 a.m., Dalynn vomited 6 more times. The last three times, Dalynn could not make it to the toilet and vomited on the floor.

112. At 11:40 a.m., LPN Jacoby made Dr. Costerisan aware of Dalynn persistent vomiting. Dr Costerisan ordered that Dalynn receive an intramuscular injection of 4 mg of Ondansetron, and as needed every 6-8 hours thereafter.

113. Dr. Costerisan was not on-site nor did he come to the MCJ to personally examine Dalynn or otherwise personally assess her medical condition.

114. At 12:54 p.m., a corrections officer unlocked Dalynn's cell door, pushed in a bucket and mop and mopped Dalynn's vomit off the floor.

115. At 12:56 p.m., the same corrections officer and RN Dowdy entered Dalynn's cell and injected her with something. This was the last dosage of any medication Dalynn received.

116. Between 1:00 p.m. and 2:45 p.m., Dalynn vomited 2 more times.

117. At 2:48 p.m., a corrections officer unlocked Dalynn's cell and allowed RN Dowdy to give Dalynn a bag of items that appeared to be snacks, two plastic bottles of soft drinks (a red colored drink and a Mt. Dew) and a roll of toilet paper.

118. At 2:59 p.m., Dalynn took sips from the red-colored soft drink bottle and

immediately vomited 2 times.

119. At 3:07 p.m. Dalynn took off her shirt and laid down on her bunk.

120. At 4:11 p.m., Dalynn put her shirt back on, took a sip from the Mt. Dew bottle and laid back down.

121. At 4:14 p.m., Dalynn vomited in the bed and on herself.

122. At 4:27 p.m., Dalynn took several more sips of Mt. Dew, but immediately vomited 2 more times on the floor.

123. At 5:15 p.m., Dalynn stood up and walked to the sink to fill up her empty Sprite bottle at which time she leaned her forehead against the cinder block wall. Dalynn's knees buckled, and she stumbled around her cell. Dalynn then sat on the floor next to her toilet which was filled with vomit and feces. Dalynn's hands were visibly cramping as she rocked her head back and forth and before lying down on the concrete floor.

124. At 5:17 p.m., a corrections officer arrived and unlocked Dalynn's cell door and brought in her dinner in a Styrofoam container and a Styrofoam cup of water and placed them next to the two other Styrofoam containers which had Dalynn's untouched breakfast and lunch.

125. As the corrections officer exited Dalynn's cell, he and another corrections officer gathered at Dalynn's doorway and motioned and spoke to LPN Jacoby, who was sitting at her desk a few feet away. LPN Jacoby rolled her chair over to the cell door and all three watched Dalynn crawl on her knees back to her bunk and lay down. At that point,

Dalynn had been without any food for at least two days.

H. On October 17, 2019, at 5:41 p.m., Video Monitors Captured Dalynn Collapse and Strike her Head on the Concrete Vomit-stained Floor. Yet, No one Checked on her Welfare or Provided or Obtained Medical Assistance for Her.

126. At 5:41 p.m., Dalynn leaned over the side of her bunk and vomited on the floor.

127. In total, the video shows Dalynn vomited at least 62 times in the 22 hours she had spent locked in the medical cell.

128. After vomiting for the last time, Dalynn then sat up, walked to the sink to fill up a plastic bottle with water, and leaned her forehead against the cinder block wall. Then, Dalynn collapsed, fell over the toilet and struck the back of her head against the concrete floor. Dalynn laid on the vomit soaked floor for a few seconds and then crawled back to her bunk.

129. At 5:47 p.m., Dalynn fell off of her bunk and landed on the floor face down. After a few seconds, Dalynn struggled back to her bunk and laid down again.

130. At 5:54 p.m., Dalynn crawled to the floor, laid down in her own vomit, and then crawled back to her bunk, all the while her hands were visibly cramping.

131. At 5:55 p.m., Dalynn took off her vomit-soaked pants.

132. At 5:59 p.m., Dalynn struggled to breath.

133. At approximately 6:01 p.m., Dalynn's last movement was recorded.

134. At 6:12 p.m., CO Michael Whitsel (CO Whitsel) looked into Dalynn's cell and instructed her to cover herself up. Dalynn did not respond. CO Whitsel did nothing and

walked away.

135. At 6:19 p.m., CO Whitsel looked into Dalynn's cell again instructed her to cover up. Dalynn did not respond. CO Whitsel did nothing and walked away.

136. At 6:22 p.m. the Officer Activity Log recorded that CO Whitsell looked into Dalynn's cell. He was then relieved by CO Walter for his dinner break.

I. On October 17, 2019 at 6:35 p.m., Dalynn is Discovered Unresponsive in Her Cell.

137. On October 17, 2019, at approximately 6:35 p.m., LPN Jacoby observed Dalynn in her cell lying on her back, non-responsive, pale in color and not breathing.

138. LPN Jacoby called a 10-33 medical emergency and corrections staff responded and began CPR. The responders attempted to use the Automated External Defibrillator (AED) to resuscitate Dalynn, but it did not work.

139. Corrections staff called for an ambulance, and EMTs and members of the Decatur Fire Department responded. The EMTs arrived at MCJ and observed Dalynn naked, lying on her back on the floor of her medical cell, receiving CPR from corrections staff.

140. The EMTs noted that Dalynn's skin was pale, cool and clammy, and her pupils were fixed and dilated. The EMTs noted that both of Dalynn's arms were mottled and postured, and her body possibly had the beginning of rigor mortis.

141. The EMTs noted that Dalynn's cell floor was covered in urine and feces and the toilet in her medical cell was overflowing.

142. Dalynn was transported to Decatur Memorial Hospital where she was

pronounced dead at 7:10 p.m.

143. The video of the medical cell during the time Dalynn occupied it (October 16, 2019 at 8:16 p.m. thru October 17, 2019, at 6:01 p.m.), if the defendants had been watching it or otherwise monitoring her, would have shown Dalynn to be agitated, weak, confused, cramping and unable to sleep. Moreover, the video showed Dalynn vomiting at least 62 times in those 22 hours. It was obvious to anyone that Dalynn was in serious physical and mental distress.

J. The Macon County Corrections Defendants and Crossing Healthcare Medical Defendants Knew that Dalynn was in Medical Distress and Did Nothing to Save Her Life.

144. Corrections officers are required to conduct well-being checks of each inmate at the beginning and end of each shift to identify illness or other concerns. According to MCJ Policy:

> "Well-being checks are intended to verify the safety and health status of an inmate. Corrections officers should visually observe each inmate and make sure they see some part of the inmate's body, not just a pile of clothing or blankets. Pay attention to movements, breathing, etc. to make sure the inmate is okay. Security cameras may be used to assist routine monitoring of inmates but they are not a substitute for physical well-being checks.
>
> - For general housing areas, well-being checks will be conducted on all inmates at least once every **30 minutes** unless extenuating

circumstances delay it. You are encouraged to conduct checks more frequently when possible and late checks should be a rare occurrence.

- For inmates on suicide watch, in a restraint chair or who have been designated a medical, psychological or safety risk, well being checks will be conducted every **15 minutes**.

All checks should be recorded using the automated check logging system or through manual entry, if needed."

145. According to Crossing Healthcare's policies, the Chief Medical Officer, Defendant CMO Dr. Ray, is responsible for medical healthcare services at the MCJ, and assures quality, accessibility and timeliness of inmate care.

146. According to Crossing Healthcare's policies, the Chief Operating Officer, Defendant COO RN Fasick, is responsible for nursing care at the MCJ.

147. Crossing Healthcare's policies recognize that "the delivery of healthcare to detainees is a joint effort of custody and health care staff and is best achieved through trust, cooperation and open communication."

148. According to Crossing Healthcare's policies, Crossing Healthcare staff are required to refer detainees to other appropriate providers or services when a detainee's needs are beyond the scope of care provide by Crossing Healthcare staff.

149. According to Crossing Healthcare's policies, detainees with medical needs outside the scope of practice of Crossing Healthcare practitioners are to be referred to

specialists or other care providers as appropriate.

150. Defendant CO Diericks was on duty on October 16, 2019, and knew Dalynn was in medical distress and was involved in Dalynn's transfer from general population to a medical cell.

151. Defendant RN Thompson was on duty on October 16, 2019, and knew Dalynn was in medical distress and was involved in Dalynn's transfer from general population to a medical cell.

152. Defendant Dr. Costerisan was the on-call physician on October 16, 2019, and, at approximately 8:40 p.m., was informed by RN Thompson that Dalynn was in medical distress. Dr. Costerisan chose not come to the MCJ to assess Dalynn's medical condition; rather, he simply ordered that she be given anti-nausea medication.

153. The Macon County Corrections Defendants present on October 17, 2019, when Dalynn's condition became critical and/or when she died, included: Defendant Cpl. Largent; Defendant CO Whitsel; Defendant CO Walter; Defendant CO Flaugher; Defendant CO Warrick; and Defendant CO Diericks. Each of these Macon County corrections officers knew or should have known that Dalynn had serious medical needs and was in medical distress. None of these Macon County corrections officers did anything to get Dalynn the medical help she desperately needed to save her life.

154. The Crossing Healthcare Medical Defendants present on October 17, 2019, when Dalynn's condition became critical and resulted in her death were Defendant RN

Dowdy, whose shift began at 7:30 a.m. and ended at 4:00 p.m.; and Defendant LPN Jacoby, whose shift began at 8:30 a.m. and continued until Dalynn was discovered unresponsive in her medical cell. Each of these Crossing Healthcare medical staff members knew or should have known that Dalynn had serious medical needs and was in medical distress. Neither of these Crossing Healthcare medical staff members did anything to get Dalynn the medical help she desperately needed to save her life.

155. In the hours preceding her death, Dalynn's serious medical needs were objectively serious and her medical distress was objectively obvious.

V. CLAIMS FOR RELIEF

COUNT I
42 U.S.C. § 1983 - 14th Amendment - Denial of Medical Care - Individual Liability (Macon County Custodial Defendants and Crossing Healthcare Medical Defendants)

156. At all relevant times, Plaintiff's decedent, Dalynn Kee, had a constitutionally protected right under the Fourteenth Amendment to the United States Constitution to receive needed care while in the MCJ, and to have her health monitored and her medical issues timely and properly assessed and treated.

157. Defendants, CO Dierecks, CO Flaugher, CO Michael Whitsel, CO Warrick, CO Walter and CO Largent, acted under color of law.

158. Defendants, CMO Dr. Ray, Dr. Costerisan, COO RN Fasick, RN Thompson, RN Dowdy and LPN Jacoby, acted under color of state law. Each were private individuals acting under a contract with the County and/or Sheriff Brown to perform a traditional and

statutorily required governmental function.

159. These defendants were deliberately indifferent to Dalynn's serious medical needs and thereby deprived Dalynn of her constitutional right to due process of law guaranteed by the Fourteenth Amendment to the Unites States Constitution.

160. Dalynn suffered from both a objectively and subjectively substantial risk of serious harm while under the custody and care of these defendants, who responded to this risk in an objectively and subjectively unreasonable manner.

WHEREFORE, Plaintiff prays for judgment as noted below.

COUNT II
42 U.S.C. § 1983 - 14th Amendment - Denial of Medical Care – *Monell Claim*
(Macon County and/or Sheriff Brown)

161. The violation of Dalynn's rights under the Fourteenth Amendment to the United States Constitution, Plaintiff's damages, and the conduct of the Macon County Custodial Defendants and Crossing Healthcare Medical Defendants, were directly and proximately caused by the actions and/or inactions of the Defendant Macon County and/or Sheriff Brown, which, with deliberate indifference:

a. failed to ensure through proper training, supervision and discipline of corrections staff or termination of medical staff that corrections staff and medical staff complied with established policies, practices and procedures for addressing the serious medical needs of inmates at MCJ, such as Dalynn, who are undergoing detoxification from opioids,

including her lawfully prescribed methadone;

b. acquiesced in the widespread practice and/or office policy at MCJ for corrections officers or medical staff to not contact on call medical providers or call for emergency medical services on behalf of an inmate experiencing an obvious medical emergency;

c. failed to ensure through training, supervision and discipline of corrections staff or termination of medical staff that corrections staff and medical staff adequately communicate and document an inmate's deteriorating medical health conditions;

d. failed to ensure, through training supervision and discipline of corrections staff and termination of medical staff, that corrections staff and medical staff properly respond to an inmate's deteriorating medical health conditions;

e. failed to contract for healthcare services in a manner that financial incentives would not affect reasonable medical judgment, and deter medical corrections staff or medical staff from calling on-call healthcare providers, requesting on-call providers to return to the facility after hours for medical emergencies, or for calling outside non-contract emergency services; and

f. failed to provide or otherwise effectively manage a medication

assistance treatment program for inmates at MCJ, such as Dalynn, who are undergoing detoxification from opioids, including her lawfully prescribed methadone.

WHEREFORE, Plaintiff prays for judgment as noted below.

COUNT III
42 U.S.C. § 1983 - 14th Amendment - Denial of Medical Care – *Monell Claim*
(Crossing Healthcare)

162. The violation of Dalynn's rights under the Fourteenth Amendment to the United States Constitution, Plaintiff's damages, and the conduct of the individual Macon County Corrections Defendants and Individual Crossing Healthcare Medical Defendants was directly and proximately caused by the actions and/or inactions of the Defendant Crossing Healthcare, which, with deliberate indifference:

a. failed to ensure through proper training, supervision and discipline that the individual corrections staff and medical staff complied with established policies, practices and procedures for addressing the serious medical needs of inmates at MCJ, such as Dalynn, who are undergoing detoxification from opioids, including her lawfully prescribed methadone;

b. acquiesced in the widespread practice and/or office policy at MCJ for corrections officers or medical staff to not contact on call medical providers or call for emergency medical services on behalf of an inmate

experiencing an obvious medical emergency;

c. failed to adequately monitor the deteriorating medical health of inmates;

d. failed to ensure, through training supervision and discipline of corrections staff or termination of medical, that corrections staff and medical staff adequately communicate and document an inmate's deteriorating medical health conditions;

e. failed to ensure through training supervision and discipline of corrections staff or termination of medical staff, that corrections staff and medical staff properly respond to an inmate's deteriorating medical health conditions;

f. failed to contract for healthcare services in a manner that financial incentives would not affect reasonable medical judgment, and deter medical corrections staff or medical staff from calling on-call healthcare providers, requesting on-call providers to return to the facility after hours for medical emergencies, or for calling outside non-contract emergency services; and

g. failed to train corrections or medical staff or provide staff or otherwise effectively manage a medicated assistance treatment program for inmates at MCJ, such as Dalynn, who are undergoing detoxification from opioids, including Dalynn's lawfully prescribed methadone.

WHEREFORE, Plaintiff prays for judgment as noted below.

COUNT IV
State Law Claim – Survival – Wilful & Wanton Conduct
(Macon County/Sheriff Brown, Individual Macon County Custodial Defendants)

163. Plaintiff, Kelsey Jill Smith, is the Administrator or the Estate of Dalynn Kee, and brings this action pursuant to the Survival Act, 755 ILCS 5/27-6.

164. Defendants Macon County and/or Defendant Sheriff Brown, acting through its employees, including but not limited to: Defendant Cpl. Largent; Defendant CO Whitsel, Defendant CO Walter; Defendant CO Flaugher; Defendant CO Warrick; and Defendant CO Diericks; owed a duty to provide access to competent medical care to treat the serious medical needs of pre-trial detainees housed in the MCJ, including Dalynn.

165. The Macon County Custodial Defendants breached the aforesaid duty in the following manner:

a. wilfully and wantonly failed to monitor or assess Dalynn in order to address her withdrawal symptoms while detoxifying;

b. wilfully and wantonly failed to monitor Dalynn intake of nutrition and hydration while she was detoxifying;

c. wilfully and wantonly failed to communicate and document Dalynn's deteriorating medical condition and the severity of her withdrawal symptoms while detoxifying;

d. wilfully and wantonly failed to properly respond to Dalynn's

deteriorating medical condition in light of the increasing severity of her withdrawal symptoms while detoxifying;

e. wilfully and wantonly failed to properly communicate to on-site Crossing Healthcare medical providers or contact on-call, off-site Crossing Healthcare providers to report Dalynn's deteriorating medical condition and the increasing severity of her withdrawal symptoms while detoxifying;

f. wilfully and wantonly failed to recognize that the severity of Dalynn's withdrawal symptoms while detoxifying from opioids could not be properly be managed in the MCJ;

g. wilfully and wantonly failed to recognize that the severity of Dalynn's withdrawal symptoms while detoxifying from opioids should be managed in a hospital setting by a qualified medical provider; and

h. wilfully and wantonly failed to call emergency transport or transfer Dalynn to a hospital to receive timely and necessary treatment as she became critically ill while detoxifying from opioids.

166. As a direct and proximate result of one or more of the aforesaid wilfull or wanton acts or omissions, Dalynn died on October 17, 2019.

167. As a direct and proximate result of the aforesaid, Dalynn suffered injuries of a personal and pecuniary nature, including, but not limited to pain and suffering, and physical

and emotional trauma, all of which continued until her death and contributed to cause her death on October 17, 2019, and had she survived she would have been entitled to bring an action for the damages, and said action has survived her pursuant to the Illinois Survival Act.

WHEREFORE, Plaintiff prays for judgment as noted below.

COUNT V
State Law Claim – Wrongful Death – Wilful & Wanton Conduct
(Macon County/Sheriff Brown, Individual Macon County Custodial Defendants)

168. Plaintiff, Kelsey Jill Smith, is the Administrator or the Estate of Dalynn Kee, and brings this action on behalf of Dalynn Kee's next of kin pursuant to the Wrongful Death Act, 740 ILCS 180/1.

169. Defendants Macon County and/or Defendant Sheriff Brown, acting through its employees, including but not limited to: Defendant Cpl. Largent; Defendant CO Whitsel; Defendant CO Walter; Defendant CO Flaugher; Defendant CO Warrick; and Defendant CO Diericks, owed a duty to provide access to competent medical care to treat the serious medical needs of pre-trial detainees housed in the MCJ, including Dalynn.

170. The Macon County Custodial Defendants breached the aforesaid duty, in the following manner:

a. wilfully and wantonly failed to monitor or assess Dalynn in order to address her withdrawal symptoms while detoxifying;

b. wilfully and wantonly failed to monitor Dalynn intake of nutrition and hydration while she was detoxifying;

c. wilfully and wantonly failed to communicate and document Dalynn's deteriorating medical condition and the severity of her withdrawal symptoms while detoxifying;

d. wilfully and wantonly failed to properly respond to Dalynn's deteriorating medical condition in light of the increasing severity of her withdrawal symptoms while detoxifying;

e. wilfully and wantonly failed to properly communicate to on-site Crossing Healthcare medical providers or contact on-call, off-site Crossing Healthcare providers to report Dalynn's deteriorating medical condition and the increasing severity of her withdrawal symptoms while detoxifying;

f. wilfully and wantonly failed to recognize that the severity of Dalynn's withdrawal symptoms while detoxifying from opioids could not be properly be managed in the MCJ;

g. wilfully and wantonly failed to recognize that the severity of Dalynn's withdrawal symptoms while detoxifying from opioids should be managed in a hospital setting by a qualified medical provider; and

h. wilfully and wantonly failed to call emergency transport or transfer Dalynn to a hospital to receive timely and necessary treatment as she became critically ill while detoxifying from opioids.

171. As a direct and proximate result of one or more of the aforesaid wilful or wanton acts or omissions, Dalynn died on October 17, 2019.

172. As a direct and proximate result of Dalynn Kee's death, her next of kin have lost and will continue to lose a substantial pecuniary support, consortium, society companionship, and the love and affection of their mother, and are entitled to recovery under this Act.

WHEREFORE, Plaintiff prays for judgment as noted below.

COUNT VI
State Law Claim – Survival – Institutional Negligence
(Crossing Healthcare)

173. Plaintiff, Kelsey Jill Smith, is the Administrator or the Estate of Dalynn Kee, and brings this action pursuant to the Survival Act, 755 ILCS 5/27-6.

174. At all relevant times, Crossing Healthcare had an independent duty and/or voluntary and jointly assumed the non-delegable duty of the Macon County and the Macon County Sheriff to provide medical care to inmates of the MCJ, including:

a. a duty to manage and provide on-site and telemedicine healthcare services for the inmates/detainees at the MCJ;

b. a duty to provide sufficient staffing of qualified medical practitioners to effectively manage and operate a medicated assisted treatment program;

c. a duty to follow the medical policies and procedures set forth by Macon

County (which Crossing Healthcare determined to be written in accordance with current National Standards of Correctional Health); the standards set forth in the County Jail Act, 730 ILCS 125/0.01, et seq.; and the regulations set forth in 20 Ill. Admin. Code 701.90.

d. a duty to provide medical and support staff trained in accordance with NCCHC (National Commission on Correctional Healthcare).

175. At all relevant times, Crossing Healthcare had an independent duty and/or voluntary and jointly assumed the non-delegable duty of the Macon County and the Macon County Sheriff to provide administrative services to ensure proper medical care to inmates of MCJ, including:

a. a duty to provide quarterly reports to the Macon County Sheriff or his designee concerning the overall health care services program and the general health of the persons committed to the jail, including: the number of medical requests received; the number of medical visits; the number of unique inmates seen; the longest length of time between a request and a visit; the number of off-site visits to specialists; and the number of off-site emergency room visits;

b. a duty to meet quarterly with the Macon County Sheriff or his designee concerning procedures within the jail and any proposed changes in health-related procedures;

c. a duty to establish a training program for the Macon County jailers.

176. Defendant Crossing Healthcare breached one or more of the aforesaid duties in one or more of the following manners:

a. negligently and carelessly provided and managed the healthcare delivery system provided to the MCJ in that it incentivized nurses to act outside the scope of their qualifications;

b. negligently and carelessly managed the healthcare delivery system provided to the MCJ in that it disincentivized nursing staff from objectively communicating an inmate's condition to the on-call physicians or recommending that the on-call physician return to the MCJ to provide after-hours physician services;

c. negligently and carelessly managed the healthcare delivery system provided to the MCJ in that it disincentivized nursing staff from objectively communicating an inmate's medical condition to on-call physicians or recommending that the on-call physician return to the MCJ to provide after-hours physician services;

d. negligently and carelessly managed a medication assistance treatment program and failed to staff such a program with properly trained and qualified medical practitioners;

e. negligently failed to submit quarterly written healthcare reports or meet

with the Macon County Sheriff to evaluate or discuss improvements or changes in health-related procedures.

f. negligently and carelessly failed to establish a training program for the Macon County corrections officers.

177. The injuries and death suffered by Dalynn were proximately caused by the negligence, breach of duty of the standard of care, neglect, default, and /or wilful and wanton conduct of the Defendant Crossing Healthcare as described above.

178. As a direct and proximate result of the aforesaid, Dalynn suffered injuries of a personal and pecuniary nature, including, but not limited to pain and suffering, and physical and emotional trauma, all of which continued until her death and contributed to cause her death on October 17, 2019, and had she survived she would have been entitled to bring an action for the damages and said action has survived her pursuant to the Illinois Survival Act.

WHEREFORE, Plaintiff prays for judgment as noted below.

COUNT VII
State Law Claim – Wrongful Death – Institutional Negligence
(Crossing Healthcare)

179. Plaintiff, Kelsey Jill Smith, is the Administrator or the Estate of Dalynn Kee, and brings this action on behalf of Dalynn Kee's next of kin pursuant to the Wrongful Death Act, 740 ILCS 180/1.

180. Crossing Healthcare had an independent duty and/or voluntary and jointly assumed the non-delegable duty of the Macon County and the Macon County Sheriff to

provide medical care to inmates of the MCJ, including:

a. a duty to manage and provide on-site and telemedicine healthcare services for the inmates/detainees at the MCJ;

b. a duty to provide sufficient staffing of qualified medical practitioners to effectively manage and operate a medication assisted treatment program;

c. a duty to follow the medical policies and procedures set forth by Macon County (which Crossing Healthcare determined to be written in accordance with current National Standards of Correctional Health); the standards set forth in the County Jail Act, 730 ILCS 125/0.01, et seq.; and the regulations set forth in 20 Ill. Admin. Code 701.90; and

d. a duty to provide medical and support staff trained in accordance with NCCHC (National Commission on Correctional Healthcare).

181. At all relevant times, Crossing Healthcare had an independent duty and/or voluntary and jointly assumed the non-delegable duty of the Macon County and the Macon County Sheriff, to provide administrative services to ensure proper medical care to inmates of MCJ, including:

a. a duty to provide quarterly reports to the Macon County Sheriff or his designee concerning the overall health care services program and the general health of the persons committed to the jail, including: the

number of medical requests received; the number of medical visits; the number of unique inmates seen; the longest length of time between a request and a visit; the number of off-site visits to specialists; and the number of off-site emergency room visits;

b. a duty to meet quarterly with the Macon County Sheriff or his designee concerning procedures within the Jail and any proposed changes in health-related procedures;

c. a duty to establish a training program for the Macon County jailers.

182. Defendant Crossing Healthcare breached one or more of the aforesaid duties in one or more of the following manners:

a. negligently and carelessly provided and managed the healthcare delivery system provided to the MCJ in that it incentivized nurses to act outside the scope of their qualifications;

b. negligently and carelessly managed the healthcare delivery system provided to the MCJ in that it disincentivized nursing staff from objectively communicating an inmate's medical condition to on-call physicians;

c. negligently and carelessly managed the healthcare delivery system provided to the MCJ in that it disincentivized nursing staff from recommending or requesting that the on-call physician return to the

MCJ to provide after hour physician services;

d. negligently and carelessly managed the healthcare delivery system provided to the MCJ in that it disincentivized nursing staff from recommending or requesting that an inmate be sent to the emergency room;

e. negligently and carelessly managed a medication assistance treatment and failed to staff such program properly trained and qualified medical practitioners;

f. negligently failed to submit quarterly written healthcare reports or meet with the Macon County Sheriff to evaluate or discuss improvements or changes in health-related procedures; and

g. negligently and carelessly failed to establish a training program for the County Deputies and Jailers.

183. The injuries and death suffered by Dalynn were proximately caused by the negligence, breach of duty of the standard of care, neglect, default, and/or wilful and wanton conduct of the Defendants as described above.

184. As a direct and proximate result of Dalynn's death, her next of kin have lost and will continue to lose a substantial pecuniary support, consortium, society companionship, and the love and affection of their mother, and are entitled to recovery under this Act.

WHEREFORE, Plaintiff prays for judgment as noted below.

COUNT VIII
State Law Claim – Survival – Medical Malpractice
(Crossing Healthcare and the Individual Medical Defendants)

185. Plaintiff, Kelsey Jill Smith, is the Administrator or the Estate of Dalynn Kee, and brings this action pursuant to the Survival Act, 755 ILCS 5/27-6.

186. Plaintiff attaches hereto affidavits and medical reports in compliance with 735 ILCS 5/2-622 for Crossing Healthcare Medical Defendants; Defendant CMO Dr. Ray, Defendant Dr. Costerisan, Defendant RN Thompson, Defendant RN Dowdy, and Defendant LPN Jacoby.

187. Defendant Crossing Healthcare, acting through its employees, the Crossing Healthcare Defendants identified above, and Crossing Healthcare Medical Defendants, individually, owed a duty to exercise reasonable care according to the conditions known to them or that, through reasonable care should have been known to them, in accordance with standards of care in the community of physicians for CMO Dr. Ray and Dr. Costerisan, and in the community of nurses for COO RN Fasick, RN Thompson, RN Dowdy and LPN Jacoby.

188. The foregoing Crossing Healthcare Medical Defendants breached the aforesaid duty to Dalyn Kee to exercise reasonable care according to the conditions known to them or that, through reasonable care, should have been known to them, in accordance with the standards of are in their respective professional communities.

189. Defendant CMO Dr. Ray was negligent and deviated from the standard of care

in one or more of the following ways:

a. failed to adequately review Dalynn's intake assessment or medical history in order to properly assess the severity and duration of her withdrawal symptoms during her detoxification;

b. prematurely terminated Dalynn from the opioid withdrawal protocol;

c. failed to reinstate the previous opioid withdrawal protocol for Dalynn or provide an adequate alternative medication assisted treatment for her serious medical needs; and

d. failed to personally assess or provide for a personal assessment by a qualified physician after Dalynn's medical condition worsened.

190. Defendant Dr. Costerisan was negligent and deviated from the standard of care in one or more of the following ways:

a. failed to adequately review Dalynn's history in order to properly assess the severity and duration of her withdrawal symptoms during her detoxification;

b. prematurely terminated Dalynn from the opioid withdrawal protocol;

c. failed to reinstate the previous opioid withdrawal protocol for Dalynn or provide an adequate alternative medication assisted treatment for her serious medical needs;

d. failed to personally assess or provide for a personal assessment by a

qualified physician after Dalynn's medical condition worsened;

e. failed to return to the MCJ to personally assess Dalynn's medical condition after receiving notice of her serious medical needs;

f. failed to instruct the nursing staff on-site at the MCJ to seek emergency medical attention to treat Dalynn's serious medical needs; and

g. failed to instruct the nursing staff to transport Dalynn to the hospital.

191. Defendant RN Thompson was negligent and deviated from the standard of care in one or more of the following ways:

a. failed to adequately document in the medical records or otherwise communicate to on call physcians or oncoming on-site nursing staff the nature and extent of Dalynn's serious medical needs that required her to be transferred from general population to a medical cell; and

b. failed to adequately monitor or document Dalynn's medical condition after she was transferred to a medical cell, including monitoring her vital signs, loss of hydration due to vomiting and diarrhea, liquid intake, food intake, etc.

192. Defendant RN Dowdy was negligent and deviated from the standard of care in one or more of the following ways:

a. negligently and carelessly failed to properly screen Dalynn in order to anticipate the serious medical needs she would experience while

detoxifying from opioids;

b. negligently and carelessly failed to properly assess Dalynn to evaluate the severity of her withdrawal symptoms while detoxifying from opioids;

c. negligently and carelessly failed to monitor Dalynn in order to treat her withdrawal symptoms while detoxifying from opioids;

d. negligently and carelessly failed to monitor Dalynn's intake of nutrition and hydration while she was detoxifying from opioids;

e. negligently and carelessly failed to communicate and document Dalynn's deteriorating medical condition and the severity of her withdrawal symptoms while detoxifying from opioids;

f. negligently and carelessly failed to properly respond to Dalynn's deteriorating medical condition in light of the increasing severity of her withdrawal symptoms while detoxifying from opioids;

g. negligently and carelessly failed to properly communicate to on-site Crossing Healthcare medical providers or contact on-call, off-site Crossing Healthcare providers to report Dalynn's deteriorating medical condition and the increasing severity of her withdrawal symptoms while detoxifying from opioids;

h. negligently and carelessly failed to recognize that Dalynn's

deteriorating medical condition, as evidenced by the increasing severity of her withdrawal symptoms while detoxifying from opioids, could not be properly managed outside of a hospital; and

i. negligently and carelessly failed to properly call for emergency transport or obtain other emergency care for Dalynn in order for her to receive timely and necessary treatment as she became critically ill while detoxifying from opioids.

193. Defendant LPN Jacoby was negligent and deviated from the standard of care in one or more of the following ways:

a. negligently and carelessly failed to properly screen Dalynn in order to anticipate the serious medical needs she would experience while detoxifying from opioids;

b. negligently and carelessly failed to properly assess Dalynn to evaluate the severity of her withdrawal symptoms while detoxifying from opioids;

c. negligently and carelessly failed to monitor Dalynn in order to address her withdrawal symptoms while detoxifying from opioids;

d. negligently and carelessly failed to monitor Dalynn's intake of nutrition and hydration while she was detoxifying from opioids;

e. negligently and carelessly failed to communicate and document

Dalynn's deteriorating medical condition and the severity of her withdrawal symptoms while detoxifying from opioids;

f. negligently and carelessly failed to properly respond to Dalynn's deteriorating medical condition in light of the increasing severity of her withdrawal symptoms while detoxifying from opioids;

g. negligently and carelessly failed to properly communicate to on-site Crossing Healthcare medical providers or contact on-call, off-site Crossing Healthcare providers to report Dalynn's deteriorating medical condition and the increasing severity of her withdrawal symptoms while detoxifying from opioids;

h. negligently and carelessly failed to recognize that Dalynn's deteriorating medical condition, as evidenced by the increasing severity of her withdrawal symptoms while detoxifying from opioids, could not be properly managed outside of a hospital;

i. negligently and carelessly failed to properly call for emergency transport or obtain other emergency care for Dalynn in order to receive timely and necessary treatment as she became critically ill while detoxifying from opioids.

194. The injuries and death suffered by Dalynn were proximately caused by the negligence, breach of duty of the standard of care, neglect, default, and /or wilful and wanton

conduct of the Defendants as described above.

195. As a direct and proximate result of the aforesaid, Dalynn suffered injuries of a personal and pecuniary nature, including, but not limited to, pain and suffering, and physical and emotional trauma, all of which continued until her death and contributed to cause her death on October 17, 2019, and had she survived she would have been entitled to bring an action for the damages and said action has survived her pursuant to the Illinois Survival Act.

WHEREFORE, Plaintiff prays for judgment as noted below.

COUNT VIII
State Law Claim – Wrongful Death – Healing Art Malpractice
(Crossing Healthcare and the Individual Medical Defendants)

196. Plaintiff, Kelsey Jill Smith, is the Administrator or the Estate of Dalynn Kee, and brings this action on behalf of Dalynn Kee's next of kin pursuant to the Wrongful Death Act, 740 ILCS 180/1.

197. Plaintiff attaches hereto affidavits and medical reports in compliance with 735 ILCS 5/2-622 for Crossing Healthcare Individual Medical Defendants, CMO Dr. Ray, Dr. Costerisan, RN Thompson, RN Dowdy and LPN Jacoby.

198. Defendant Crossing Healthcare, acting through its employees, the Crossing Healthcare Defendants identified above, and Crossing Healthcare Medical Defendants, individually, owed a duty to exercise reasonable care according to the conditions known to them or that, through reasonable care should have been known to them, in accordance with

standards of care in the community of physicians for CMO Dr. Ray and Dr. Costerisan, and in the community of nurses for COO RN Fasick, RN Thompson, RN Dowdy and LPN Jacoby.

199. The foregoing Individual Medical Defendants breached the aforesaid duty to Dalynn Kee to exercise reasonable care according to the conditions known to them or that, through reasonable care, should have been known to them, in accordance with the standards of care in their respective professional communities.

200. Defendant CMO Dr. Ray was negligent and deviated from the standard of care in one or more of the following ways:

a. failed to adequately review Dalynn's history in order to properly assess the severity and duration of her withdrawal symptoms during her detoxification;

b. prematurely terminated Dalynn from the opioid withdrawal protocol;

c. failed to reinstate the opioid withdrawal protocol for Dalynn or provide an adequate alternative medication assisted treatment for her serious medical needs; and

d. failed to personally assess or provide for a personal assessment by a qualified physician after Dalynn's medical condition declined;

201. Defendant Dr. Costerisan was negligent and deviated from the standard of care in one or more of the following ways:

a. failed to adequately review Dalynn's history in order to properly assess the severity and duration of her withdrawal symptoms during her detoxification;

b. prematurely terminated Dalynn from the opioid withdrawal protocol;

c. failed to reinstate the previous opioid withdrawal protocol for Dalynn or provide an adequate alternative medication assisted treatment for her serious medical needs;

d. failed to personally assess or provide for a personal assessment by a qualified physician after Dalynn's medical condition declined.

e. failed to return to the MCJ to personally assess Dalynn's medical condition after receiving notice of her serious medical needs; and

f. failed to instruct the nursing staff on-site at the MCJ to seek emergency medical attention to treat Dalynn's serious medical needs.

202. Defendant RN Thompson was negligent and deviated from the standard of care in one or more of the following ways.

a. failed to adequately document in the medical records or otherwise communicate to on call physcians or oncoming on-site nursing staff the nature and extent of Dalynn's serious medical needs that required her to be transferred from general population to a medical cell; and

b. failed to adequately monitor or document Dalynn's medical condition

after she was transferred to a medical cell, including monitoring her vital signs, loss of hydration due to vomiting and diarrhea, liquid intake, food intake, etc.

203. Defendant RN Dowdy was negligent and deviated from the standard of care in one or more of the following ways:

a. negligently and carelessly failed to properly screen Dalynn in order to anticipate the serious medical needs she would experience while detoxifying from opioids;

b. negligently and carelessly failed to properly assess Dalynn to evaluate the severity of her withdrawal symptoms while detoxifying from opioids;

c. negligently and carelessly failed to monitor Dalynn in order to address her withdrawal symptoms while detoxifying from opioids;

d. negligently and carelessly failed to monitor Dalynn's intake of nutrition and hydration while she was detoxifying from opioids;

e. negligently and carelessly failed to communicate and document Dalynn's deteriorating medical condition and the severity of her withdrawal symptoms while detoxifying from opioids;

f. negligently and carelessly failed to properly respond to Dalynn's deteriorating medical condition in light of the increasing severity of her

withdrawal symptoms while detoxifying from opioids;

g. negligently and carelessly failed to properly communicate to on-site Crossing Healthcare medical providers or contact on-call, off-site Crossing Healthcare providers to report Dalynn's deteriorating medical condition and the increasing severity of her withdrawal symptoms while detoxifying from opioids; and

h. negligently and carelessly failed to recognize that Dalynn's deteriorating medical condition, as evidenced by the increasing severity of her withdrawal symptoms while detoxifying from opioids, could not be properly managed outside of a hospital; and

i. negligently and carelessly failed to properly call for emergency transport or obtain other emergency care in order for Dalynn to receive timely and necessary treatment as she became critically ill while detoxifying from opioids;

204. Defendant LPN Jacoby was negligent and deviated from the standard of care in one or more of the following ways:

a. negligently and carelessly failed to properly screen Dalynn in order to anticipate the serious medical needs she would experience while detoxifying from opioids;

b. negligently and carelessly failed to properly assess Dalynn to evaluate

the severity of her withdrawal symptoms while detoxifying from opioids;

c. negligently and carelessly failed to monitor Dalynn in order to address her withdrawal symptoms while detoxifying from opioids;

d. negligently and carelessly failed to monitor Dalynn's intake of nutrition and hydration while she was detoxifying from opioids;

e. negligently and carelessly failed to communicate and document Dalynn's deteriorating medical condition and the severity of her withdrawal symptoms while detoxifying from opioids;

f. negligently and carelessly failed to properly respond Dalynn's deteriorating medical condition in light of the increasing severity of her withdrawal symptoms while detoxifying from opioids;

g. negligently and carelessly failed to properly communicate to on-site Crossing Healthcare medical providers or contact on-call, off-site Crossing Healthcare providers to report Dalynn's deteriorating medical condition and the increasing severity of her withdrawal symptoms while detoxifying from opioids;

h. negligently and carelessly failed to recognize that Dalynn's deteriorating medical condition, as evidenced by the increasing severity of her withdrawal symptoms while detoxifying from opioids, could not

be properly managed outside of a hospital; and

i. negligently and carelessly failed to properly call for emergency transport or obtain other emergency care in order for Dalynn to receive timely and necessary treatment as she became critically ill while detoxifying from opioids;

205. The injuries and death suffered by Dalynn Kee were proximately caused by the negligence, breach of duty of the standard of care, neglect, default, and /or wilful and wanton conduct of the Defendants as described above.

206. As a direct and proximate result of Dalynn Kee's death, her next of kin, have lost and will continue to lose a substantial pecuniary support, consortium, society companionship, and the love and affection of their mother, and are entitled to recovery under this Act.

WHEREFORE, Plaintiff prays for judgment as noted below.

COUNT X
State Law Claim – Respondeat Superior -
(Macon County and/or Sheriff Brown)

207. The Macon County Corrections Defendants were employees and agents of Macon County and Sheriff Brown, were acting within the scope of his or her employment, and his or her acts or omissions are directly chargeable to his or her employer, the Defendant Macon County and/or Defendant Sheriff Brown under state law pursuant to *respondeat superior*.

208. The Crossing Healthcare Medical Defendants, CMO Dana Ray, Dr. Costerisan, COO RN Fasick, RN Thomspon, RN Dowdy, LPN Jacoby, were agents of Macon County and Sheriff Brown with respect to delivery of healthcare services to inmates of the MCJ, were acting within the scope of his or her agency with Macon County and Sheriff Brown, and his or her acts or omissions are directly chargeable to his or her principal, the Defendant Macon County and Defendant Sheriff Brown under state law pursuant to *respondeat superior*.

WHEREFORE, Plaintiff prays for judgment as noted below.

COUNT XI
State Law Claim – Respondeat Superior
(Crossing Healthcare)

209. The Crossing Healthcare Medical Defendants, CMO Dana Ray, Dr. Costerisan, COO RN Fasick, RN Thomspon, RN Dowdy, LPN Jacoby, were employees of Crossing Healthcare. Each of the individually named Crossing Healthcare Medical Defendant, was acting within the scope of his or her employment with Crossing Healthcare, and his or her acts or omissions are directly chargeable to his or her employer, the Defendant Crossing Healthcare under state law pursuant to *respondeat superior*.

WHEREFORE, Plaintiff prays for judgment as noted below.

COUNT XII
State Law Claim – Indemnification – 745 ILCS 10-9-102
(Macon County and/or Sheriff Brown)

210. Pursuant to §9-102 of the Local Government and Governmental Tort

Immunities Act (the Act), a local public entity is directed to pay any tort judgment or settlement for compensatory damages for which it or an employee acting within the scope of his employment is liable. 745 ILCS 10/9-102.

211. Defendant Macon County and Defendant Sheriff Brown are local public entities as defined by the Act. 745 ILCS 10/1-106

212. The Macon County Custodial Defendants at all relevant times were "employees" of the Macon County Sheriff as defined by the Act. 745 ILCS 10/1-102.

213. Certain conduct of the individually named Macon County Corrections Defendants, as described in the Complaint, was wilfull and wanton as defined in the Act. 745 ILCS 10-1-1-210.

214. The Macon County Custodial Defendants acted within the scope of their employment by Macon County and Sheriff Brown.

215. Pursuant to the Act, Macon County and/or Sheriff Brown are directly liable for the conduct of the individually named Macon County Corrections Defendants.

DAMAGES

216. The Estate of Dalynn Kee has sustained the following damages: funeral and burial expenses incurred as a result of decedent's death that have become a charge against her Estate or that were paid on her behalf; loss of prospective net estate accumulations; decedent's conscious pain and suffering and the inherent value of life; pre and post-judgment interest; and loss of earnings of

Dalynn Kee from the date of her death, less lost support of her survivors excluding contributions in kind with interest.

217. A.K., the minor son of Dalynn Kee, has sustained the following damages: great mental pain, anguish, and suffering from the date of Dalynn Kee's wrongful death and continuing for the remainder of his life; pre and post-judgment interest.

218. A.K., the minor daughter of Dalynn Kee, has sustained the following damages: great mental pain, anguish, and suffering from the date of Dalynn Kee's wrongful death and continuing for the remainder of her life; pre and post-judgment interest.

219. Plaintiff is entitled to attorneys fees and costs pursuant to 42 U.S.C. § 1988.

220. Plaintiff is entitled to punitive damages

PRAYER FOR RELIEF

WHEREFORE, the Plaintiff seeks judgment as follows:

A. Compensatory damages from each of the defendants herein.

B. Punitive damages against the individual defendants or Crossing Healthcare as an entity as allowed by law.

C. Attorney's fees pursuant to 42 U.S.C. U.S.C. § 1988, and costs of litigation;

D. Such further relief as the Court deems just and proper.

Respectfully submitted,

Kelsey Jill Smith, as Administrator of the Estate of Dalynn Kee, deceased, and for the benefit of her Next of Kin, Plaintiff,

By: \s\ Frederick J. Schlosser
One of Her Attorneys

Frederick J. Schlosser (6209954)
Todd M. Goebel (6275004)
GATES WISE SCHLOSSER & GOEBEL
1231 South Eighth Street
Springfield, IL 62703
(217) 522-9010

E-FILED
Thursday, 16 July, 2020 04:02:26 PM
Clerk, U.S. District Court, ILCD

IN THE UNITED STATES DISTRICT COURT
FOR THE CENTRAL DISTRICT OF ILLINOIS
URBANA DIVISION

KELSEY JILL SMITH, as Administrator of the Estate of Dalynn Kee, and on behalf of her Next of Kin, Plaintiffs, COUNTY OF MACON, ANTONIO BROWN, Macon County Sheriff, K. LARGENT, MICHAEL WHITSEL, TOBY WALTER, DEREK FLAUGHER, and JACOB WARRICK, Macon County Correctional Officers, COMMUNITY HEALTH IMPROVEMENT CENTER, INC.d/b/a CROSSING HEALTHCARE, DANA RAY, MD, DENNIS COSTERISAN, DO, LINDA FASICK, RN, KAM DOWDY, RN, AMANDA THOMPSON, RN,and CARETH JACOBY, LPN, Defendants.	)	No. **JURY DEMANDED**

AFFIDAVIT IN COMPLIANCE WITH 735 ILCS 5/2-622

I, Frederick J. Schlosser, having first been duly sworn on oath, state:

1. I have consulted and reviewed the facts of the case with a health care professional who I reasonably believe: (i) is knowledgeable in the relevant issues involved in this particular action; (ii) practices or has practiced within the last 6 years or teaches or has taught within the last 6 years in the same area of health care or medicine that is at issue in this particular action; and (iii) is qualified by experience or demonstrated competence in the subject of the case.

2. The reviewing healthcare professional has determined in a written report, after a review of the medical records and other relevant material involved in this particular action, that there is a reasonable and meritorious cause for filing such action as to Community Health Improvement Center, Inc.

d/b/a crossing healthcare Crossing Healthcare, and its agents or employees, Dana Ray, MD, Dennis Costerisan, DO, Linda Fasick, RN, Amanda Thompson, RN, Cam Dowdy, RN and Careth Jacoby, RN.

3. I have concluded on the basis of said healthcare professional's review and consultation that there is a reasonable and meritorious cause for filing this action against the medical professionals identified above.

4. A copy of said physician's written report is attached to this affidavit.

\s\ Frederick J. Schlosser

Subscribed and sworn to before me this 16th day of July, 2020.

\s\ Madison Hamilton
Notary Public, State of Illinois
My commission expires 09-05-2022

Certificate of Merit

July 7, 2020

Frederick J. Schlosser, Esq.
Gates Wise Schlosser & Goebel, Attorneys at Law
1231 South Eighth Street
Springfield, IL., 62703

In Re: Dalynn Kee

Dear Mr. Schlosser:

At your request, I have reviewed the medical records concerning Dalynn Kee.

I am a physician board certified in Internal medicine. I have 20 years of experience in emergency medicine and I am currently the facility medical director of the emergency department at Capital Region Medical Center. I have 13 years of experience in correctional medicine which includes jail and prison. I have owned a correctional medicine company and I was the medical director of the Boone County Jail for 12 years where I directed the medical and mental health departments. As jail director, I drafted and facilitated policies, protocols, and procedures for the Boone County jail.

I have reviewed the pertinent facts and circumstances associated with Miss Dalynn Kee's incarceration and subsequent death at Macon County Jail where she was incarcerated from October 7th until her death on October 17th of 2019. The following records reviewed were Decatur Ambulance report, St. Mary's Hospital records, incident reports of Macon County jailers, autopsy and toxicology report, cell video, contract between Macon County and Crossing Healthcare, and the policies and procedures of both Macon County and Crossing Healthcare available to me.

After reviewing the aforementioned material, it is my professional opinion that Community Health improvement Center, Inc., d/b/a Crossing Healthcare, Dr. Dana Ray, Dr. Dennis Costerisan, and nurses Linda Fasick, Kam Dowdy, Amanda Thompson, and Careth Jacoby all caused or contributed to cause the death of Daylnn Kee. I feel there is sufficient information based upon the material I have reviewed to conclude that there is a reasonable and meritorious cause for filing a medical negligence claim against Crosssing Healthcare and its employees.

Miss Kee was arrested on October 7, 2019. On her intake evaluation form, she notified the medical department that she was on Methadone as part of a Medication Assisted Treatment program for Opioid Use Disorder and she was concerned she would go through withdrawal without her methadone. During the time of her incarceration and until her subsequent death, Dalynn Kee had multiple bouts of vomiting and diarrhea so much so that she ultimately was placed in a supervised cell under medical segregation. During this time, she was never evaluated by a physician. She did not receive routine and appropriate monitoring of her vital signs and weight. There was never laboratory evaluation of her kidney function or electrolytes, and she never received IV fluids for appropriate hydration. She was observed on camera to fall, strike her head, and lose consciousness; yet, never received proper medical attention for this

incident and injury. She clearly was experiencing delirium due to her visibly being restless and the fact that she completely disrobed.

Crossing Healthcare and its employees failed to deliver standard of care. The facility did not follow their own established protocols nor those of the NCCHC guidelines which they promised to uphold. The National Commission on Correctional Healthcare (NCCHC) guidelines for opioid detoxification include screening of all inmates for potential withdrawal within 2 hours of entry into the facility and that all inmates who screen positive should have formal evaluation within 24 hours. (NCCHC, 2013). This was not accomplished. Also, all inmates with clinically significant withdrawal should be treated with effective medication. Miss Kee's symptoms continued unabated; therefore, she was not treated with effective medication; otherwise, her symptoms would have been controlled and she would have been properly hydrated. Because she did not have proper medical care for opioid withdrawal, Dalynn Kee died from dehydration secondary to persistent and uncontrolled vomiting and diarrhea as confirmed by a post-mortem examination.

Responsibility for the health and well-being of an inmate patient is a shared duty. Inmate patients are a at risk population with multiple comorbidities and risk factors. When they have their personal liberties removed and they are incarcerated, the county, jail, correctional staff, contracted medical companies and those who care for those patients assume responsibility for managing those risks. Therefore, in the case of Dalynn Kee, she underwent a withdrawal she did not agree to; in addition, she could not seek a second medical opinion or proper medical care while incarcerated. Keeping this in mind, Macon County and Macon County Jail also bear responsibility for lack of proper medical supervision of those under their employment and those who took care of Dalynn Kee, but those opinions are outside the scope of this certificate of merit.

Proper medical care and supervision was contracted to Crossing Healthcare who therefore bears responsibility for Dalynn Kee's death as the entity which was contracted for medical and mental health care at the jail. Crossing Healthcare employs the medical staff and is responsible for maintaining standards in accordance to the standards set forth by the NCCHC. The policies, protocols and procedures of the jail and maintaining proper jail standards is the responsibility of the facilities medical director. The responsible medical authority in this case was Dr. Dana Ray who then bears supervisory responsibility and was also contacted by nursing staff regarding Dalynn Kee. She should have personally examined the patient and ensured that proper vital signs, weight, hydration, and nutrition of the patient was routinely performed during the patient's opioid withdrawal. Also employed by Crossing Healthcare was Dr. Dennis Costerisan. He was notified by nursing staff regarding patient's persistent and uncontrolled symptoms. Since the patient had not been formally evaluated by a competent medical authority, and was not medically evaluated by Dr. Ray, Dr. Costerisan had the responsibility to present to the jail to evaluate the patient or request she be medically transported to the closest emergency room for further evaluation and treatment of her persistent and uncontrolled opioid withdrawal. The nursing staff are led and managed by a nurse manager who is responsible for maintaining proper nurse protocol, administration of medications, and coaching the nursing staff to advocate for the patient. She did not meet this standard and bears responsibility for Dalynn Kee's demise due to her supervisory role. The nursing staff has the duty to administer orders given verbally or written by the physicians, carry out guidelines and protocols accurately and safely, and to advocate for patient health and safety. Nurse Kam Dowdy, Amanda Thompson, and Careth Jacoby did not advocate for Miss Kee. The nursing staff did not perform routine vital signs, weigh the patient, or work diligently to control her symptoms. The nursing staff should have contacted the physicians and suggested more intense therapy when Miss Kee was not improving, and even unilaterally send the patient to the emergency department for evaluation and

treatment if they deemed necessary. They seemed to not have the clinical intuition or skills to understand just how dire Miss Kee's situation was as she continued to withdraw from methadone with her symptoms unabated. The patient even had a syncopal episode, falling and striking her head; yet, no nurse assessed the patient during this event.

To summarize, after review of the medical record, it is my professional opinion that Ms. Kee died of dehydration secondary to uncontrolled vomiting and diarrhea from opioid withdrawal. The cause of death was preventable and not properly treated, and her condition not properly assessed and managed. Crossing Healthcare and its employees (physicians and nurses identified above) were a proximate cause and their negligence contributed to Ms. Kee's demise.

I reserve the right to revise or update the letter insofar as I may receive additional or pertinent information and materials concerning this case.

*/s/*_____
Joel Blackburn, DO

References: National Commission on Correctional Healthcare. (2013, April 18). Opioid Detoxification Guideline. https://www.ncchc.org/opioid-detoxification-guideline