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

ESTATE OF JERAD M. TRAYLOR, by LISA M. PARRISH, as Personal Representative of the Estate, and on behalf of the Survivors,

Plaintiff,

v.

TAZEWELL COUNTY, TAZEWELL COUNTY SHERIFF ROBERT M. HUSTON, CORRECT CARE SOLUTIONS, LLC, JESSICA FLYNN, HANNAH WILLIAMSON, Dr. FATOKI, CHRIS BARNHILL, SARA VONDERHEIDE, and DAVID HARPER,

Defendants.

CASE NO. 18-CV-1309-JES-JEH

SECOND AMENDED COMPLAINT

Plaintiff sues Defendants and alleges:

Introduction

1. On August 26, 2017, Jerad M. Traylor died while isolated in a cell in the Special Housing Unit ("SHU") of the Tazewell County Jail. By the time the correctional officers and medical staff arrived on scene, Mr. Traylor showed no signs of life. Mr. Traylor was only 31 years old.

2. Prior to his death, fellow detainees in the SHU heard Mr. Traylor begging for help and yelling that he could not breathe and felt like he was dying.

3. Mr. Traylor found no help to his pleas. The lack of caring and the callousness displayed by the medical staff and correctional officers left Mr. Traylor without crucial medical treatment at a critical period in his short life.

4. Mr. Traylor had been in the SHU since he arrived at the Tazewell County Jail on August 22, 2017. According to reports, the cell that Mr. Traylor was in had a high ambient temperature. Mr. Traylor acted irrationally for days leading up to his untimely death, yet no one came to check on him.

5. In the hours leading up to Mr. Traylor's death, surveillance video from his cell showed Mr. Traylor laboring for breath and writhing in pain. Again, no one came into his cell to check on him.

Jurisdiction and Venue

6. This Court has jurisdiction over this matter under the following:

   a. 28 U.S.C. § 1331, as this is a civil action arising under the Constitution, laws, and/or treaties of the United States;

   b. 28 U.S.C. § 1337, as this is a civil action or proceeding arising under an Act of Congress regulating commerce and/or protecting trade and commerce against restraints and monopolies; and

   c. 28 U.S.C. § 1343, as this is a civil action seeking to redress the deprivation, under color of any State law, statute, ordinance, regulation, custom and/or usage, of a right, privilege or immunity secured by the Constitution of the United States and/or by an Act of Congress providing for equal rights of citizens or of all persons within the jurisdiction of the United States.

7. Plaintiff's claims for relief are predicated, in part, upon 42 U.S.C. § 1983, which authorizes actions to redress the deprivation, under color of state law, of rights, privileges, and immunities secured by the Constitution and laws of the United States, and upon 42 U.S.C. § 1988, which authorizes the award of attorneys' fees and costs to prevailing

plaintiffs in actions pursuant to 42 U.S.C. § 1983.

8. Plaintiff further invokes the supplemental jurisdiction of this Court, pursuant to 28 U.S.C. § 1367, to consider the state law claims alleged herein.

9. Venue is proper in this district pursuant to 28 U.S.C. § 1391(b) and § 1391(c), as Defendants do business in this judicial district and the events or omissions giving rise to the claims occurred in this judicial district.

Parties

10. Plaintiff LISA M. PARRISH is the duly appointed Personal Representative of the Estate of Jerad M. Traylor, having been appointed Personal Representative by the Probate Division of the Circuit Court Of The Tenth Judicial Circuit, Tazewell County, in Case No. 18-P-68. This action is brought by LISA M. PARRISH, mother of Jerad M. Traylor, in her capacity as Personal Representative of the Estate of Jerad M. Traylor, on behalf of the Estate of Jerad M. Traylor, and on behalf of Mr. Traylor's survivors, his three minor children.

11. At times material to this action, Jerad M. Traylor, Plaintiff's decedent, was a pre-trial detainee confined in Tazewell County Jail, Pekin, Illinois, a correctional facility maintained by Defendant ROBERT M. HUSTON ("Defendant HUSTON").

12. At all relevant times, Defendant HUSTON was the duly elected sheriff of Tazewell County and chief administrator of the Tazewell County Jail. At all relevant times, he was acting under color of law and in the course and scope of his employment as the agent, servant, and an official policy maker for Defendant TAZEWELL COUNTY on issues relating to care of prisoners in Tazewell County Jail and the policies, procedures, practices, and customs, as well as the acts and omissions, challenged by this suit, and as

the County's chief law enforcement officer. Defendant HUSTON was the commanding officer of all Tazewell County sheriff's deputies, correctional officers, and jail employees, and he was responsible for their training, supervision, and conduct. He is sued in his official capacity.

13. Defendant TAZEWELL COUNTY is joined in this action pursuant to *Carver v. Sheriff of LaSalle County*, 324 F.3d 947 (7th Cir. 2003).

14. At times material to this complaint, Defendant CORRECT CARE SOLUTIONS, INC. ("CCS"), was a Tennessee corporation doing business in Illinois that had a contract with Tazewell County to provide medical and mental health care to those detained in the Tazewell County Jail. Defendant CCS was responsible for providing all medical services to detainees, including but not limited to assessment of need for services; provision of care and treatment services for all health care needs and follow up; and for hiring, training, supervision and conduct of all health care providers at the Tazewell County Jail. At all relevant times, CCS, by and through its employees and agents, was acting under color of law, and its agents and employees were acting in the course and scope of their employment.

15. Defendant CCS was responsible for the establishment and implementation of the policies, procedures, practices, and customs, as well as the acts and omissions, challenged by this suit.

16. At times material to this complaint, Defendants, JESSICA FLYNN ("Defendant FLYNN") and HANNAH WILLIAMSON ("Defendant WILLIAMSON"), were nurses who was responsible for patient health care at The Tazewell County Jail. Defendants FLYNN and WILLIAMSON were responsible for carrying out the policies and

procedures for health care then in effect at the Tazewell County Jail and for the timely response to the medical care needs of detainees occurring and coming to their attention. At all times material to this action, Jerad M. Traylor was a detainee subject to the care and treatment of Defendants FLYNN and WILLIAMSON. Defendants FLYNN and WILLIAMSON are employees of Defendant CCS.

17. At times material to this complaint, Defendant Dr. FATOKI was a doctor who was responsible for patient health care at The Tazewell County Jail. Defendant Dr. FATOKI was responsible for carrying out the policies and procedures for health care then in effect at the Tazewell County Jail and for the timely response to the medical care needs of detainees occurring and coming to his attention. At all times material to this action, Jerad M. Traylor was a detainee subject to the care and treatment of Defendant Dr. FATOKI. Defendant Dr. FATOKI is an employee of Defendant CCS.

18. At times material to this complaint, Defendants CHRIS BARNHILL ("Defendant BARNHILL"), SARA VONDERHEIDE ("Defendant VONDERHEIDE") and DAVIS HARPER ("Defendant HARPER") were correctional officers in the Tazewell County Jail who were responsible for the well-being and safety of detainees, including doing cell checks on prisoners in the SHU and responding to requests for medical attention. At all times material to this action, Jerad M. Traylor was a detainee subjected to the care, custody and control of Defendants BARNHILL, VONDERHEIDE and HARPER while he was housed in the SHU. Defendants BARNHILL, VONDERHEIDE and HARPER are employed by Tazewell County.

Common Allegations of Fact

19. On or about August 22, 2017, Jerad M. Traylor was placed in the SHU at the Tazewell County Jail. He was 31 years of age.

20. Jerad M. Traylor was placed into the SHU by Defendant HARPER because he became "verbally demanding regarding his injuries" while he was in booking area. Jerad M. Traylor was complaining of trouble breathing and a pinching feeling in his left armpit area. Defendant HARPER did not send Mr. Traylor to the medical unit of the Tazewell County jail.

21. Prior to August 26, 2017, the day Jerad M. Traylor died, he had been requesting medical attention, complaining that he was having difficulty breathing and was sweating profusely.

22. Defendants BARNHILL and VONDERHEIDE, along with other Tazewell County Correctional Officers, walked past Mr. Traylor's cell and ignored his pleas for medical attention.

23. Mr. Traylor was also exhibiting bizarre behavior, including appearing to have conversation with imaginary people in his cell, but Defendant VONDERHEIDE did not summon medical attention for Mr. Traylor.

24. On August 25, 2017, at approximately 4:30 a.m., Defendant VONDERHEIDE, along with other Tazewell County Correctional Officers, went to Mr. Traylor's cell. According to a log entry made by Defendant VONDERHEIDE, Mr. Traylor was "still pretty out of it" and requested to go to the emergency room because he believed he had just drank alcohol. Defendant VONDERHEIDE also noted that Mr. Traylor had been throwing himself around his cell for two days. There is no indication that Defendant VONDERHEIDE contacted any medical staff to notify them of Mr. Traylor's condition or behavior.

25. Mr. Traylor pressed the call button in his cell requesting help. The Defendants that heard the requests ignored Mr. Traylor.

26. The cell that Mr. Traylor was in had a surveillance camera. Mr. Traylor could be observed acting bizarrely, kicking the door, and pressing the call button. No Defendant responded.

27. Defendants FLYNN and WILLIAMSON observed Mr. Traylor's bizarre behavior and elevated blood pressure yet failed to transport him to a hospital for proper evaluation of a serous medical need.

28. Defendants FLYNN and WILLIAMSON knew at the time they saw Jerad M. Traylor that he had serious medical needs, including elevated blood pressure.

29. Even after he was given medication for his blood pressure, Mr. Traylor's blood pressure continued to rise. On August 22, 2017 at 11:43 p.m., his blood pressure was 151/105. At that time he was given medication. On August 23, 2017 at 4:50 a.m., his blood pressure was 160/96. On August 24, 2017 at 6:30 a.m., his blood pressure was 171/113. After the reading on August 24, 2017, neither Defendants FLYNN nor WILLIAMSON took vital signs from Mr. Traylor to monitor his rising blood pressure.

30. According to the records, it does not appear that Defendant WILLIAMSON contacted Defendant Dr. FATOKI or any emergency medical provider after she took Mr. Traylor's vitals on August 24, 2017 at 6:30 a.m. when his blood pressure was 171/113.

31. Defendants FLYNN and WILLIAMSON knew at the time they saw Jerad M. Traylor that if they did not provide appropriate and effective care, Jerad M. Traylor's physical health could worsen.

32. On August 23, 2017, at approximately 10:30 a.m., Defendant FLYNN had a conversation with Defendant Dr. FATOKI regarding Mr. Traylor. They discussed Mr. Traylor's

complaints of the pain and pinching feeling he was having every time he took a breath. There was no treatment plan put into effect by either Defendant Dr. FATOKI or Defendant FLYNN.

33. Defendant Dr. FATOKI knew that if Jerad M. Traylor did not receive appropriate and effective care, Jerad M. Traylor's physical health could worsen.

34. On August 26, 2017 at approximately 7:00 a.m., Defendants BARNHILL and WILLIAMSON signed a refusal of treatment form for Mr. Traylor. They did not have Mr. Traylor sign the form. Defendants BARNHILL and WILLIAMSON did not come to Mr. Traylor's cell at 7:00 a.m. on August 26, 2017. At approximately 7:18 a.m. on August 26, 2017, the surveillance video shows that Defendants BARNHILL and WILLIAMSON were at Mr. Traylor's cell. At that time, Mr. Traylor was lying naked on the floor. Neither Defendants BARNHILL nor WILLIAMSON went into the cell to check on Mr. Traylor's condition.

35. At some point prior to 6:00 a.m. on August 26, 2017, Mr. Traylor stripped naked and was sluggish and lethargic. He had noticeable bruises on his extremities.

36. For approximately fours hours, Mr. Traylor flailed around his cell in obvious discomfort.

37. No Defendant ever came into the cell to check on Mr. Traylor's health until approximately 10:12 a.m. Mr. Traylor had already been dead for some time.

38. At approximately 10:12 a.m. on August 26, 2017, Defendants WILLIAMSON and BARNHILL, along with Commander Stanton, entered Mr. Traylor's cell. Defendant WILLIAMSON touched Mr. Traylor's shoulder and turned to Defendant BARNHILL and Commander Stanton and made a motion with her arms signifying that Mr. Traylor was dead. Contrary to a progress note made by Defendant WILLIAMSON, she never checked

Mr. Traylor for a pulse or attempted any life-saving measures.

39. Nobody ever called for emergency medical services.

40. All Defendants knew that Jerad M. Traylor, as a detainee in the Tazewell County Jail custody, had no other treatment options, and that if they (CCS and the Tazewell Defendants) failed to provide adequate treatment, he would get no other treatment.

41. It would have been obvious to anyone, including individuals with no medical training, that Mr. Traylor's serious medical needs were not being met by CCS and its personnel.

42. At times material hereto, Defendant HUSTON and TAZEWELL COUNTY's employees and agents acting on their behalf, acted within the scope of their employment and under color of state law.

43. At all times material hereto, Defendant HUSTON conducted regular audits and received reports on conditions at the Tazewell County Jail. Therefore, Defendant HUSTON was well aware that detainees, including Jerad M. Traylor, were not receiving minimally adequate medical care while incarcerated in the Tazewell County Jail.

44. Defendant HUSTON was aware there was not a sufficient medical staff at the Tazewell County Jail to address the health care needs of the detainees incarcerated at the jail.

45. Defendant HUSTON heavily participated in budget plans that left medical needs unmet for inmates like Jerad M. Traylor.

46. Defendant HUSTON was aware that correctional staff were untrained and prone to ignore medical problems, frequently causing harm to inmates in their care.

47. At all times material, Defendant HUSTON knew that the training given to correctional staff did not sufficiently provide the staff necessary information regarding the right of

detainees such as Plaintiff's decedent to be kept safe and provided with proper medical care.

48. The staff's training was inadequate and insufficient to properly provide appropriate guidelines and job standards for proper performance of their job in a manner sufficient to meet the needs of Plaintiff's decedent.

49. As a direct and proximate result of Defendants' acts and omissions, Jerad M. Traylor died in his cell on August 26, 2017.

50. Plaintiff has had to retain counsel and is entitled to reimbursement of a reasonable attorney's fees, pursuant to 42 USC §1988.

Causes of Action:

I. Claims under 42 U.S.C. 1983: Defendant HUSTON

51. Plaintiff re-alleges the Common Allegations of Fact as if fully set forth herein.

52. Plaintiff is entitled to relief against Defendant HUSTON under 42 U.S.C. § 1983, based on violations of the Fourteenth Amendment to the U.S. Constitution.

53. At all times material, Plaintiff's decedent, Jerad M. Traylor, had a constitutionally protected right under the Fourteenth Amendment to the U.S. Constitution to receive needed care while in the Tazewell County Jail, and to have his health issues timely and properly assessed and treated.

54. Defendant HUSTON deliberately disregarded the immediate and serious threats to the mental and medical health and well-being of persons in The Tazewell County Jail and exhibited deliberate and callous indifference to serious medical and mental health needs, by denying access to intensive and structured medical health care, treatment and observation

necessary to treat serious medical needs and prevent suffering and death.

55. Defendant HUSTON was well aware that there were detainees confined in the Tazewell County Jail who suffered from severe medical health needs and were at risk of injury and/or death. Despite this knowledge, Defendant HUSTON intentionally and knowingly failed to provide serious, ongoing case management and treatment for such inmates and failed to regularly monitor their medical health care needs.

56. Defendant HUSTON knew at all times material to this action that there was a substantial risk that detainees with serious medical issues, left substantially untreated, could die, that such deaths were reasonably foreseeable, and that the threat of this was imminent and immediate.

57. Defendant HUSTON deliberately disregarded the immediate and serious threat to detainees' medical health and well-being and exhibited deliberate indifference and callous indifference to their serious medical and psychological needs by denying and unreasonably delaying access to competent medical care to treat their serious medical needs, in that:

   a. with full knowledge of prior in-custody deaths, and that failing to provide adequate medical care to detainees with serious medical issues could die were reasonably foreseeable, Defendant HUSTON simply failed to provide needed care and attention;

   b. with full knowledge of detainees with histories of serious medical issues, Defendant HUSTON's actions in failing to provide close observation and adequate medical care by trained medical professionals was so grossly substandard, incompetent, and inadequate as to fairly be characterized as medical and mental health care so cursory as to amount to no medical and mental health care at all.

58. In light of the aforementioned, Jerad M. Traylor suffered from both an objectively and

subjectively substantial risk of serious harm while under the care and custody of Defendant HUSTON. Defendant HUSTON reacted to this risk in an objectively and subjectively unreasonable manner.

59. It is more likely than not that the failures of Defendant HUSTON as alleged above were the cause of Jerad M. Traylor's death.

60. As a result of Defendant HUSTON's disregard of and indifference to Plaintiff's decedent's constitutionally protected right to be provided with proper care, Plaintiff's decedent, Jerad M. Traylor's medical needs were ignored.

61. As a direct and proximate result of Defendant HUSTON's deliberate indifference to Jerad M. Traylor's serious medical health needs, Jerad M. Traylor died from complications of serious medical issues on August 26, 2017.

WHEREFORE, Plaintiff prays for judgment as noted below.

II. Claims under 42 U.S.C. 1983: Defendants FLYNN, WILLIAMSON, Dr. FATOKI, BARNHILL, VONDERHEIDE and HARPER

62. Plaintiff re-alleges the Common Allegations of Fact as if fully set forth herein.

63. Plaintiff is entitled to relief against Defendants FLYNN, WILLIAMSON, Dr. FATOKI, BARNHILL, VONDERHEIDE and HARPER under 42 U.S.C. § 1983, based on violation of the Fourteenth Amendment to the U.S. Constitution.

64. At all times material, Plaintiff's decedent, Jerad M. Traylor, had a constitutionally protected right under the Fourteenth Amendment to the U.S. Constitution to receive needed care while in the Tazewell County Jail, and to have his serious medical issues timely and properly assessed and treated.

65. Defendants FLYNN, WILLIAMSON, Dr. FATOKI, BARNHILL, VONDERHEIDE and

HARPER deliberately disregarded the immediate and serious threat to the health and well-being of persons in The Tazewell County Jail in need of medical treatment and exhibited deliberate and callous indifference to serious medical and mental health needs, by denying access to intensive and structured medical care, treatment and observation necessary to treat serious medical needs and prevent suffering and death.

66. Defendants FLYNN, WILLIAMSON, Dr. FATOKI, BARNHILL, VONDERHEIDE and HARPER were well aware of the facts that there were inmates who suffered from severe medical needs and were at risk of injury and/or death. Despite this knowledge, Defendants FLYNN, WILLIAMSON, Dr. FATOKI, BARNHILL, VONDERHEIDE and HARPER intentionally and knowingly failed to provide serious, ongoing case management and treatment for such inmates and failed to regularly monitor their medical health care needs.

67. Defendants FLYNN, WILLIAMSON, Dr. FATOKI, BARNHILL, VONDERHEIDE and HARPER knew at all times material to this action that there was a substantial risk that detainees with serious medical issues, left substantially untreated, could be seriously injured and/or die, that such injuries and/or deaths were reasonably foreseeable, that the threat injuries and/or death was imminent and immediate.

68. Defendants FLYNN, WILLIAMSON, Dr. FATOKI, BARNHILL, VONDERHEIDE and HARPER deliberately disregarded the immediate and serious threat to detainees' medical health and well-being and exhibited deliberate indifference and callous indifference to their serious medical needs by denying and unreasonably delaying access to competent medical care to treat their serious medical issues.

69. In light of the aforementioned, Jerad M. Traylor suffered from both an objectively and subjectively substantial risk of serious harm while under the care and custody of

Defendants FLYNN, WILLIAMSON, Dr. FATOKI, BARNHILL, VONDERHEIDE and HARPER. Defendants FLYNN, WILLIAMSON, Dr. FATOKI, BARNHILL, VONDERHEIDE and HARPER reacted to this risk in an objectively and subjectively unreasonable manner.

70. It is more likely than not that the failures of Defendants FLYNN, WILLIAMSON, Dr. FATOKI, BARNHILL, VONDERHEIDE and HARPER as alleged above were the cause of Jerad M. Traylor's death.

71. As a direct and proximate result of Defendants FLYNN, WILLIAMSON, Dr. FATOKI, BARNHILL, VONDERHEIDE and HARPER's deliberate indifference to Jerad M. Traylor's serious medical needs, Jerad M. Traylor died on August 26, 2017.

WHEREFORE, Plaintiff prays for judgment as noted below.

III. *Monell* Claim: CCS

72. The violations of Jerad M. Traylor's constitutional rights under the Fourteenth Amendment to the United States Constitution, his damages and the conduct of the individual defendants, were directly and proximately caused by the actions and/or inactions of CCS, which has, with deliberate indifference:

a) failed to establish and/or implement policies, practices and procedures to ensure that detainees at the Tazewell County Jail receive appropriate medical care for serious medical needs, and if necessary, health care services outside the jail. Specifically, it was a widespread practice and/or official policy at the Tazewell County Jail not to contact emergency medical services on behalf of an inmate experiencing an obvious medical emergency without the prior approval of CCS, even where such approval was wrongfully withheld or denied;

b) failed to establish and/or implement policies, practices and procedures to ensure that detainees at the Tazewell County Jail receive appropriate medical care for serious medical and mental health needs;

c) failed to adequately assess and provide adequate care and treatment for inmates exhibiting signs of bizarre behavior;

d) failed to adequately monitor the deteriorating mental and medical health conditions of inmates;

e) failed to ensure through training, supervision and discipline that medical staff at the Tazewell County Jail, in necessary circumstances, make a referral for health care services outside the jail;

f) failed to ensure through training, supervision and discipline that correctional and medical staff adequately communicate and document inmates' deteriorating mental and medical health conditions;

g) failed to ensure through training, supervision and discipline that correctional and medical staff properly respond to inmates' deteriorating mental and medial health conditions;

h) failed to contract for mental and medical health services in a manner that financial incentives would not interfere with referring inmates for health care services outside the jail;

i) possessed knowledge of deficiencies in the policies, practices, customs and procedures concerning inmates, and approved and/or deliberately turned a blind eye to these deficiencies.

WHEREFORE, Plaintiff prays for judgment as noted below.

IV. State Claim for Wrongful Death: HUSTON

73. Plaintiff re-alleges the Common Allegations of Fact as if fully set forth herein.

74. Jerad M. Traylor was and is survived by his mother Lisa M. Parris and his three minor children, whom constitute his heirs under Illinois law.

75. Jerad M. Traylor was officially pronounced dead on August 26, 2017.

76. The wrongful death of Jerad M. Traylor was proximately caused by the neglect, default, and/or willful and wanton conduct of the Defendants, as described above, in violation of 740 ILCS § 180/1.

77. Defendant TAZEWELL COUNTY and HUSTON's employees BARNHILL, VONDERHEIDE and HARPER failed to properly monitor and/or report the declining health and well-being of Jerad M. Traylor.

78. The wrongful conduct of Defendant TAZEWELL COUNTY and HUSTON's employees was the direct and proximate cause of injury and damage to Jerad M. Traylor and his estate.

79. As next of kin, the heirs of Jerad M. Traylor have lost and will continue to lose pecuniary support, consortium, society, companionship as well as the love and affection of their cherished son and father, and have incurred funeral and burial expenses as a proximate result of her wrongful death.

WHEREFORE, Plaintiff prays for judgment as noted below.

V. State Claim for Wrongful Death: CCS

80. Plaintiff re-alleges the Common Allegations of Fact as if fully set forth herein.

81. Jerad M. Traylor is survived by his mother LISA M. PARRISH and his three minor children, whom constitute his heirs under Illinois law.

82. Decedent Jerad M. Traylor was pronounced dead on February 27, 2014.

83. The CCS Defendants had a duty to Jerad M. Traylor 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 the community of the nursing community.

84. The CCS Defendants breached their duty to Jerad M. Traylor 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.

85. CCS Defendants FLYNN, WILLIAMSON and Dr. FATOKI had a duty to adequately evaluate and document Jerad M. Traylor's medical and mental health needs and to refer him for medical and psychiatric evaluation and treatment each time they observed that his needs were not otherwise being met, or were advised of his condition, and they failed to take action, such as requesting emergency medical services.

86. CCS Defendants FLYNN and WILLIAMSON saw Jerad M. Traylor on the dates of August 22, 24, and 26, and each time failed to adequately evaluate and document Mr. Traylor's medical needs.

87. CCS Defendant WILLIAMSON failed to physically examine Jerad M. Traylor on August 26, 2017, as his health was quickly deteriorating.

88. CCS Defendant Dr. FATOKI failed to send Jerad M. Traylor out for emergency medical services after he was made aware of Mr. Traylor's complaints of trouble breathing, pain in his left armpit area and elevated blood pressure.

89. On information and belief, CCS Defendants FLYNN and WILLIAMSON never sought supervision or guidance in this life-threatening situation.

90. CCS was negligent and deviated from the standard of care in one or more of the following respects:

a. Although Plaintiff objectively suffered from a serious medical issue, CCS employees failed to adequately intervene and determine that a health emergency existed;

b. CCS employees failed to properly diagnose and treat Mr. Traylor's serious medical issues; and

c. CCS failed to properly staff the facility.

91. The injuries and death suffered by Jerad M. Traylor were proximately caused by the negligence, breach of duty of the standard of care, neglect, default, and/or willful and wanton conduct of the CCS Defendants, as described above, in violation of 740 ILCS § 180/1.

92. The CCS Defendants' negligent and wrongful conduct was the direct and proximate cause of injury and damage to Jerad M. Traylor and his estate.

93. As next of kin, the heirs of Jerad M. Traylor have lost and will continue to lose consortium, society, companionship as well as the love and affection of their cherished son and father, and have incurred funeral and burial expenses as a proximate result of his wrongful death.

WHEREFORE, Plaintiff prays for judgment as noted below.

VI. Spoliation of Evidence/Denial of Access to Courts

94. Plaintiff re-alleges the Common Allegations of Fact as if fully set forth herein.

95. Defendants and their agents participated in the intentional destruction and spoliation of evidence central to this civil lawsuit, including but not limited to the following evidence:

    a. The original Progress Notes from Mr. Traylor's medical file.

96. Upon information and belief, the Illinois State Police obtained a copy of Mr. Traylor's medical file hours after his death in the Tazewell County Jail. The copy that the Illinois State Police obtained had two pages of Progress Notes. These notes were not copied double-sided and did not contain any notes of any treatment or observations of Mr. Traylor prior to the day of his death.

97. Upon information and belief, sometime after the Illinois State Police received their copy of the medical file and before July 2, 2019, the original Progress Notes were removed from Mr. Traylor's medical file. Plaintiff's counsel was unable to inspect the original Progress Notes to check for any doubled-sided entries.

98. Prior to removing and destroying these notes and other relevant evidence, such as any notes contained on the reverse side of the Progress Notes, the Defendants and their agents knew of the existence of a potential cause of action against them, and they intended in destroying this evidence to interfere with Plaintiff's ability to prove her lawsuit, causing further damages to her.

99. Removing the original Progress Notes has made Plaintiff's ability to prove her case against the Defendant more difficult.

100. The misconduct described in this Count was undertaken intentionally with malice and reckless indifference to the rights of others.

WHEREFORE, Plaintiff prays for judgment as noted below.

Damages

A. The Estate of Jerad M. Traylor has sustained the following damages:

1. funeral and burial expenses incurred as a result of decedent's death that have become a charge against his Estate or that were paid on his behalf;
2. loss of prospective net Estate accumulations;
3. decedent's conscious pain and suffering and the inherent value of life;
4. pre- and post-judgment interest; and
5. loss of earnings of Jerad M. Traylor from the date of his death, less lost support of his survivors excluding contributions in kind with interest.

B. L. T, as the daughter of Jerad M. Traylor, has sustained the following damages:

1. great mental pain, anguish, and suffering from the date of injury and continuing for the remainder of her life;
2. pre- and post-judgment interest.

C. J.T, as the son of Jerad M. Traylor, has sustained the following damages:

1. great mental pain, anguish, and suffering from the date of injury and continuing for the remainder of his life;
2. pre- and post-judgment interest.

D. L. T, as the daughter of Jerad M. Traylor, has sustained the following damages:

1. great mental pain, anguish, and suffering from the date of injury and continuing for the remainder of her life;
2. pre- and post-judgment interest.

Accordingly, Plaintiff respectfully requests that the Court award Plaintiff the aforementioned damages; any and all other compensatory damages suffered by Plaintiff; punitive damages; attorney's fees and costs pursuant to 42 U.S.C. § 1988; and such other and further relief as the Court deems just and equitable.

PRAYER FOR RELIEF

WHEREFORE, the Plaintiffs seek judgment as follows:

A. Compensatory damages against each of the defendants herein;

B. Punitive damages against defendants sued individually;

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

D. A trial by jury on all issues so triable;

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

Respectfully Submitted,

s/Louis J. Meyer
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IN THE UNITED STATES DISTRICT COURT
FOR THE CENTRAL DISTRICT OF ILLINOIS
PEORIA DIVISION

ESTATE OF JERAD M. TRAYLOR, by LISA M. PARRISH, as Personal Representative of the Estate, and on behalf of the Survivors	)	
Plaintiffs,	)	Case No.: 18-CV-1309
v.	)	Judge Shadid
TAZEWELL COUNTY, et al.,	)	Magistrate Judge Hawley
Defendants.	)	

AFFIDAVIT

Louis J. Meyer, pursuant to §735 ILCS 5/2-622, states the following under oath:

1. He has consulted and reviewed the facts of the case with Dr. Brian Stubitsch, a licensed physician that is board certified in Emergency Medicine.
2. He reasonably believes that Dr. Brian Stubitsch is Knowledgeable in the relevant issues involved in this particular action and has practiced within the last 5 years in the same area of health care that is at issue in this particular action.
3. He reasonably believes that Dr. Brian Stubitsch meets the expert witness standards set forth in paragraph (a) through (d) of Section 8-2501 [735 ILCS 5/8-2501]. His curriculum vitae is attached to his report.

4. Dr. Brian Stubitsch has determined in a written report, after a review of the assessable medical records, videos and other relevant material involved in this particular action that there is a reasonable and meritorious cause for the filing of such action as to Correct Care Solutions, LLC, Jessica Flynn, Hannah Williamson, and Dr. Fatoki. Dr. Stubitsch's written report and curriculum vitae are attached to this affidavit and labeled Exhibit A and B.

5. He has concluded on the basis of the reviewing health professional's review and consultation that there is a reasonable and meritorious cause for filing of such action as to Correct Care Solutions, LLC, Jessica Flynn, Hannah Williamson, and Dr. Fatoki.

6. Further affiant sayeth not.

Dated: December 31, 2018

Respectfully Submitted,

/s/ Louis J. Meyer
MEYER & KISS, LLC
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Peoria, Illinois 61614
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Clerk, U.S. District Court, ILCD

Louis J. Meyer
311 West Stratford Drive
Peoria, Illinois 61614

RE: Estate of Jerad M. Traylor v. Tazewell County, Tazewell County Sheriff, Correct Care Solutions, LLC , Jessica Flynn, Hannah Williamson, Dr. Fatoki, Chris Barnhill, Sara Vonderheide and David Harper

Mr. Meyer,

I am a licensed physician practicing medicine with all its benefits. I am board certified in Emergency Medicine. I am currently practicing in the specialty of Emergency Medicine and have practiced in this specialty for over 20 years. I am knowledgeable regarding the medical issues involved in this case.

I have reviewed the following materials that you provided, including:

- Court Complaint: The Estate of Jerad M. Traylor v. Tazewell County, Tazewell County Sheriff Robert M. Huston, Correct Care Solutions, LLC, Jessica Flynn, Hannah Williamson, Dr. Fatoki
- Jerad M. Traylor Report of Postmortem Examination, including Addendum and Amendment
- NNS Labs Toxicology Report, including Analysis Summary and Reporting Limits
- Tazewell County Jail Medical File
- Surveillance video of jail cell

Based upon my review of the above materials, and my background, training, and experience, I have concluded that there is reasonable and meritorious cause for filing a medical negligence claim against Correct Care Solutions, LLC, Jessica Flynn, Hannah Williamson, Dr. Fatoki, based upon their failure to cause Mr. Traylor to be sent to a hospital for emergency medical care. The need for which would have been apparent to a reasonably qualified healthcare worker.

The pertinent facts that form this conclusion include the following:

1. Mr. Traylor died of preventable causes. The CCS jail staff failed to perform a proper medical intake and have Mr. Traylor transported and evaluated at an Emergency Department due to his initial complaint of trouble breathing and lateral chest pain in his left axilla.
2. CCS staff did not perform appropriate vital signs nor take action and address abnormal vital signs such as the severely elevated blood pressure by contacting medical control or requesting transfer to an Emergency Department so Mr. Traylor could be evaluated by trained medical staff.

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3. CCS jail staff failed to recognize the fact that Mr. Traylor's mentation had changed and the staff did not seek medical help for his bizarre behavior, hallucinations, and violent behaviors by sending him to an Emergency Department for evaluation.
4. Per the coroner's findings Mr. Traylor had multiple contusions and abrasions to his body secondary to his violent behavior and flailing in his jail cell which also dictates his need for medical transport and evaluation in an Emergency Department.
5. Mr. Traylor's worsening condition was not recognized by CCS staff, while he continued to have increased difficulty in breathing and profuse diaphoresis, which necessitates an Emergency Department evaluation.
6. Mr. Traylor multiple times during his incarceration had been requesting medical attention and help from staff by asking to be transferred to an Emergency Department by pressing his call button and kicking his door. These requests and behavior should not have been ignored and should have put into action a medical evaluation at an Emergency Room.
7. Mr. Traylor's symptoms worsened still, he stripped his clothes and has a significant behavioral change by acting lethargic and sluggish the morning of his death. The CCS jail staff did not request transport for medical evaluation and care at an Emergency Department.
8. Mr. Traylor's jail cell did not have proper ventilation or air-conditioning causing a high temperature contributing to the patient's discomfort and symptoms.
9. Per the Coroners Summary of Findings which is also in the Prison Report, Mr. Traylor had nausea, vomiting, diarrhea, visual, auditory, and tactile hallucinations, restlessness, tremors, and diaphoresis. These multiple serious symptoms each by themselves would to most lay people cause them to seek emergency medical help.
10. CCS jail staff did not evaluate Mr. Traylor "hands-on" and instead observed him through a door, missing the opportunity to recognize that Mr. Traylor is seriously ill and in need of immediate emergency medical care.

It is my professional opinion that the CCS jail staff's failure to send Mr. Traylor to a hospital for emergency medical care was a proximate cause of Mr. Traylor's death and that Mr. Traylor's death could have been averted had he received prompt appropriate emergency medical attention.

/s/______________________

Brian Stubitsch, MD, FACEP, FAAEM

Reviewing Physician