**IN THE SUPERIOR COURT OF COBB COUNTY**
**STATE OF GEORGIA**

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| **MONICA PELTIER as NEXT OF KIN and ADMINISTRATOR OF THE ESTATE OF REGINALD WILSON** | ) | |
| **Plaintiff,** | ) | |
| **vs.** | ) | **CIVIL ACTION FILE NO.:** |
| **SHERIFF NEIL WARREN, COBB COUNTY SHERIFF DEPUTIES DOE 1, 2, 3, COBB COUNTY COMMUNITY SERVICE BOARD, WELLSTAR HEALTH SYSTEM INC., OSAMA HINDASH, MD, LUIDA MERIUS, BRUCE ELLETT, PSY. D, LASHAWNDA WISE, ERICA HATNEY, TONETTA GARNER,** | ) | |
| **Defendants.** | ) | |

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## COMPLAINT

**COMES NOW**, the Plaintiff MONICA PELTIER ("Plaintiff" or "Peltier"), Next of Kin for Reginald Wilson ("Mr. Wilson") and Administrator of the ESTATE OF REGINALD WILSON (the "Estate"), and files this Complaint against Defendants Cobb County Sheriff Neil Warren ("Sheriff Warren"), Cobb County Sheriff Deputies Doe 1, 2, and 3 ("Doe Deputies"), Cobb County Community Service Board ("Service Board"), Wellstar Health System ("Wellstar"), Osama Hindash, MD ("Dr. Hindash"), Luida Merius, Nurse ("Nurse Merius"), Bruce Ellett, Psy. D. ("Dr. Ellett"), Lashawnda Wise, Nurse ("Nurse Wise"), Erica Hatney, Nurse ("Nurse Hatney"), and Tonetta Garner ("Garner") (collectively, "Defendants"). Plaintiff shows the Court as follows:

## NATURE OF CLAIM

1.

This is an action for wrongful death, pain and suffering, lost value of the life, punitive damages, attorney's fees, and all other damages suffered by the Plaintiff, the Estate, and Mr.

Wilson and proximately caused by the Defendants. Mr. Wilson died on December 29, 2018 of dehydration in the Cobb County Detention Center ("CCDC"), while lying in a room covered in feces and urine. He had been in an obvious psychotic episode due to bi-polar disorder and schizophrenia, since arriving at the jail on December 20, 2018, smearing his own feces and failing to eat or drink. The Defendants entirely failed to provide him with adequate supervision or care during this time. Instead, they merely documented his downward spiral until his death. This is an action to recover for these wrongful acts, as articulated below.

## JURISDICTION AND VENUE

2.

The Plaintiff is Monica Peltier, the Next of Kin of Mr. Wilson and Administrator of the Estate of Reginald Wilson. Ms. Peltier is a citizen of the State of Alabama.

3.

Cobb County Sheriff Neil Warren was the Cobb County Sheriff at the time of Mr. Wilson's incarceration and death. Sheriff Warren is in charge of the CCDC located at 1825 County Services Pkwy, Marietta, GA 30008, where Mr. Wilson died. Sheriff Warren bears ultimate responsibility to ensure that inmates, like Mr. Wilson, at the CCDC receive medical care. O.C.G.A. § 42-4-4; O.C.G.A. § 42-5-2. Sheriff Warren is liable for his and the Cobb County Sheriff Office's ("Sheriff Office") failure to provide any care to Mr. Wilson, as detailed below. Sheriff Warren may be served at 185 Roswell Street, Public Safety Building, Second Floor, Marietta, GA 30090. The Sheriff is, therefore, subject to the jurisdiction and venue of this Court.

4.

Cobb Community Service Board is a State Agency. The Service Board employed Dr. Hindash, Dr. Ellett, and Ms. Garner, whose tortious acts and omissions caused the death of Mr.

Wilson as detailed below. Accordingly, the Service Board is liable to Plaintiff pursuant to the doctrine of *respondeat superior*, agency, and others. These acts were committed within the course and scope of said employment. The Service Board must be served pursuant to O.C.G.A. § 50-21-35 as follows: (a) service of process on Foster Norman, Chief Executive Officer of the Service Board at 3830 South Cobb Drive, Suite 300, Smyrna, GA 30080, or another representative authorized to accept service on his behalf; and (b) service of process upon the Wade Damron, Director of Risk Management, Division of Administrative Services, at 200 Piedmont Avenue, Suite 1220, West Tower, Atlanta, Georgia 30334, or another representative authorized to accept service on his behalf. A copy will also be sent via statutory overnight delivery, return receipt requested, to the Georgia Attorney General, Chris Carr, Office of the Attorney General, 40 Capitol Square SW, Atlanta, GA 30334. The Service Board is, therefore, subject to the jurisdiction and venue of this Court.

5.

Defendant Wellstar Health Systems Inc. contracted with the Cobb County Sheriff's Office to provide medical care to inmates at the jail, including mental health services, during the relevant time period of Mr. Wilson's incarceration and death. [Ex. 1, Contract]. Upon information and belief, Nurse Merius, Nurse Wise, and Nurse Hatney were actual or apparent agents, employees, or servants of Defendant Wellstar, whose tortious acts and omissions caused the death of Mr. Wilson as detailed below. These acts were committed within the course and scope of said employment. Accordingly, Defendant Wellstar is liable to Plaintiff pursuant to the doctrine of *respondeat superior*, agency, and others. Defendant Wellstar maintains its principle place of business in Cobb County, and its registered agent is Leo E. Reichert, 793 Sawyer Road, Marietta, GA 30062, Cobb County, where it may be served with process. Defendant Wellstar is, thus, subject

to the jurisdiction of this Court.

6.

Defendant Osama Hindash, MD, resides in Cobb County, Georgia at 1308 Hatton Walk, Marietta, GA 30068, where he may be served with process. Defendant Hindash is, thus, subject to the jurisdiction of this Court.

7.

Defendant Bruce Ellett, Psy. D., resides in Gwinnett County, Georgia at 984 Hodges Way, Stone Mountain GA 30087, where he may be served with process. Defendant Ellett is, thus, subject to the jurisdiction of this Court.

8.

Defendant Luida Merius, a Registered Professional Nurse, resides in Paulding County, Georgia at 207 Derby Run, Dallas GA 30132, where she may be served with process. Defendant Merius is, thus, subject to the jurisdiction of this Court.

9.

Defendant Lawshawnda Wise, a Licensed Practical Nurse, resides in Bartow County at 57 Johnson Street, Kingston, GA 30145, where she may be served with process. Defendant Wise is, thus, subject to the jurisdiction of this Court.

10.

Defendant Erica Hatney, a Licensed Practical Nurse, resides in Cobb County, Georgia at 83 Queen Anne Drive, Mableton GA 30126, where she may be served with process. Defendant Wise is, thus, subject to the jurisdiction of this Court.

11.

Defendant Tonetta Garner, resides in Cobb County, Georgia resides in Paulding County,

Georgia at 59 Thornbrook Drive, Hiram GA 30141, where she may be served with process. Defendant Garner is, thus, subject to the jurisdiction of this Court.

12.

On information and belief, Defendant Doe Deputies worked at the CCDC during Mr. Wilson's incarceration and witnessed him in an obvious state of distress and needing immediate psychiatric attention. These Defendant Doe Deputies committed tortious acts and omissions as detailed below. On information and belief, Defendant Doe Deputies were employed by Defendant Sheriff and committed these acts within the course and scope of their employment.

13.

Sovereign immunity has been waived for these claims

14.

As for the § 1983 claims, sovereign immunity is inapplicable in claims asserted against state actors in their individual capacities. Hafer v. Melo, 502 U.S. 21, 23 (1991). As for the claims pursuant to the Georgia Tort Claims Act, sovereign immunity is waived. O.C.G.A. § 50-21-23. As for the claims against Wellstar for medical malpractice, there is no sovereign immunity for Wellstar. The remaining claims are for violations of ministerial duties for which there is no sovereign immunity. Ga. Const. Art. I, Sec. II, Para. IX(d).

15.

This Court has jurisdiction over this personal injury action. O.C.G.A. § 15-10-2.

16.

Venue is appropriate in Cobb County as one or more Defendants reside in said county. Ga. Const. Art. VI, Sec. II, Para. VI.

## FACTS

A. Proper Intake of Inmates

17.

Attached to this Complaint is the affidavit of Richard L. Frierson, M.D., a licensed psychiatrist, setting forth standard of care and the breach of the standard of care for treatment of an inmate under these same or similar circumstances. Dr. Frierson's affidavit is incorporated herein by reference as if the same was set forth herein verbatim. [Ex. 2, Affidavit of Dr. Frierson]

18.

Attached to this Complaint is the affidavit of Ioannis Ioannou, Psy D., a licensed psychologist, setting forth standard of care and the breach of the standard of care for treatment of an inmate under these same or similar circumstances. Dr. Ioannou's affidavit is incorporated herein by reference as if the same was set forth herein verbatim. [Ex. 3, Affidavit of Dr. Ioannou].

19.

Within the first 24 hours of their admission to a correctional facility, an inmate must undergo a thorough physical and mental health screening.

20.

When the screening reveals that the inmate displays severe psychiatric symptoms, the inmate requires immediate psychiatric attention, within a maximum of 24-48 hours.

21.

Severe psychiatric symptoms include psychosis due to bipolar disorder, schizophrenia or a related condition.

22.

A person who is psychotic is experiencing a break from reality. This person may talk

incoherently or display bizarre behaviors (for example, yell loudly, take their clothes off, act aggressively without provocation, and smear feces).

23.

When an inmate displays psychotic behaviors during the intake assessment, the medical professional conducting the assessment, including a nurse, must ensure that the psychiatrist in charge of inmates is aware of the admission of a psychotic inmate and the need for immediate assessment by a psychiatrist. Admission to close observation, without notifying the psychiatrist of this matter, is insufficient.

B. Proper Monitoring of Inmates.

24.

One of the most extreme symptoms of psychosis is when a person is smearing their own feces.

25.

A person smearing feces presents a health hazard to themselves and others.

26.

A jail staff member, deputy, mental health counselor, nurse or doctor is required to alert the psychiatrist when an inmate exhibits behaviors that demonstrate they are a danger to themselves.

27.

Upon witnessing an inmate who is psychotic to the point of being unable to care for themselves, a jail staff member, deputy, mental health counselor, nurse or doctor is required to alert the psychiatrist of the inmate's acute psychosis and the need for immediate psychiatric care.

28.

One symptom of psychosis is unprovoked aggression towards other persons.

29.

In the event that an inmate experiencing psychosis acts aggressively towards another person and is tased as a result, this inmate has displayed behavior indicating that he is a danger to others as well as himself. A jail staff member, deputy, mental health counselor, nurse or doctor who witnesses this behavior is required to alert the psychiatrist of the inmate's acute psychosis and the need for immediate psychiatric care.

C. Proper Psychologist Care of an Inmate

30.

When providing care to an inmate, a psychologist is required to conduct a full assessment.

31.

To conduct a full assessment, the clinical psychologist must perform a comprehensive medical examination which includes, at a minimum, a mental status exam, relevant history, diagnostic impressions, and a formal treatment plan.

32.

A full assessment must contain a formal treatment plan. A treatment plan is a formal plan to treat the inmate's mental health systems. A treatment plan cannot be limited to "hope" that symptoms spontaneously get better.

33.

When an inmate exhibits acute psychosis, such as when an inmate is smearing his own feces, this is a clear and obvious sign that the inmate is a danger to himself.

34.

When an inmate exhibits acute psychosis and acts violently towards staff member or the counselor, this is a clear and obvious sign that the inmate is a danger to others.

35.

If, during the assessment, the inmate exhibits signs of acute psychosis that endanger the health and safety of himself or others, the psychologist must alert the psychiatrist of the acute psychosis and need for immediate psychiatric care.

36.

Following the full assessment, the psychologist must follow up with the inmate to ensure that the treatment plan is followed and symptoms are responding to the treatment. If a psychologist sees that the inmate is decompensating, the psychologist must alter the psychiatrist of the acute psychosis and need for immediate psychiatric care.

D. Proper Psychiatric Care of an Inmate

37.

When a psychiatrist is alerted that an inmate requires antipsychotic medication, the psychiatrist must conduct an in-person interview and assessment before prescribing medication to the inmate. There is a limited exception to this standard when the psychiatrist has a prior doctor-patient relationship with the inmate and has previously treated the inmate with the specific medication prescribed with successful results. However, even when this limited exception is applicable, the psychiatrist must perform an in-person assessment within 24-48 hours of prescribing the medication.

E. Proper Administration of Medication by Nursing

38.

When a psychiatrist prescribes antipsychotic medication, the inmate may be unable to make a rational decision whether or not to take the medication.

39.

When an acutely psychotic inmate is a danger to themselves and fails to take medication, a nurse must notify the psychiatrist of the failure of the inmate to receive the medication and the need for the psychiatrist to conduct an immediate assessment for emergency forcible injection and/or hospitalization.

F. Results of Failure to Properly Treat Psychosis.

40.

Severe psychosis does not get better on its own.

41.

A severely psychotic person, such as one who is smearing feces, must receive immediate medical treatment in order to improve their health.

42.

With proper treatment, psychosis is treatable. However, failure to provide immediate medical attention may result in death of the psychotic person.

43.

A psychotic person may decompensate after multiple days and may exhibit lethargy, uncontrollable bowel movements, and moan incoherently.

44.

A psychotic person may be unable to make a rational decision to eat or drink a sufficient

amount of water to sustain human life.

45.

Dehydration may result from psychosis.

46.

Dehydration may result from untreated psychosis.

47.

Dehydration from psychosis is avoidable in a jail setting.

48.

An inmate should not die of dehydration.

G. Mr. Wilson's Incarceration.

49.

On December 20, 2018, Mr. Wilson was picked up by ambulance on Austell Road near Wellstar Cobb Hospital. [Ex. 2-A, p. 331].

50.

At the time, Mr. Wilson was rambling about angels, demons, and how the world goes round. Mr. Wilson stated his name was "Radio."

51.

The ambulance escorted Mr. Wilson to Wellstar Cobb Hospital.

52.

Mr. Wilson was discharged on December 20, 2018 to the care of the Sheriff's Office to be incarcerated at the CCDC.

H. Mr. Wilson's intake at the Jail.

53.

Luida Merius, a nurse at the CCDC, was assigned to Mr. Wilson's intake.

54.

At the time of his admission, the CCDC had an electronic health record system which labeled Mr. Wilson as SPMI, which stands for Serious Persistent Mental Illness. The electronic health system also would show his treatment including medication. Nurse Merius had access to this information at the time of intake. Accordingly, Nurse Merius knew that Mr. Wilson had a history of serious mental health disorders necessitating antipsychotic medications, at the time of his admission. [Ex. 4, Affidavit of Daphne Wacasey].

55.

In the intake form, Nurse Merius noted Mr. Wilson had bipolar, schizoaffective disorder. [Ex. 2-B, p. 468-472, 494-495]. This was an objectively serious medical need.

56.

Nurse Merius noted that Mr. Wilson demonstrated bizarre behavior and required close observation.

57.

Nurse Merius noted that he was internally preoccupied.

58.

Nurse Merius noted that Mr. Wilson was hearing voices or seeing visions, unusually loud with obnoxious behavior, and had an impaired level of consciousness.

59.

Nurse Merius had a duty to notify Dr. Hindash that Mr. Wilson was acutely psychotic and

in need of immediate psychiatric attention. There is no indication in the records that Nurse Merius notified Dr. Hindash, the jail psychiatrist, of Mr. Wilson's admission and the acute nature of his symptoms.

I. No care for Mr. Wilson while in the infirmary.

60.

Mr. Wilson was admitted to the infirmary on December 20, 2018. [Ex. 2-B, Detention 0481].

61.

The infirmary is staffed by Defendant Wellstar employees. This would include but not be limited to Nurse Merius, Nurse Wise, and Nurse Hatney.

62.

While in the infirmary, Mr. Wilson was clearly psychotic.

63.

Mr. Wilson was psychotically rambling. [Ex. 2-B, Detention 0481-0482].

64.

Mr. Wilson was staring at the staff members in an obviously psychotic state. Id.

65.

Mr. Wilson was smearing feces on the floor. Id.

66.

Mr. Wilson was clearly a danger to himself, as he was smearing his own feces in a psychotic state.

67.

Due to his psychosis, Mr. Wilson did not consume a sufficient amount of water to sustain

human life while in the infirmary.

68.

Mr. Wilson was clearly a danger to himself, as he was too psychotic to drink a sufficient amount of water.

69.

Multiple Wellstar employees, agents (apparent or actual), or servants observed Mr. Wilson in this state. This included but was not limited to Nurses Erica Hatney and Luida Merius. [Ex. 2-B, Detention 0560-0564].

70.

Despite their observation of Mr. Wilson in an obviously psychotic state and a danger to himself, no member of Wellstar notified the jail psychiatrist.

J. No care for Mr. Wilson while in the Intake Pad

71.

Mr. Wilson was moved from the infirmary to an intake pad on December 22, 2018. He remained under close observation.

72.

Mr. Wilson was clearly psychotic.

73.

On December 22, 2018, Defendant Garner noted that Mr. Wilson was "unstable," had "wide eyes," and was "smearing poo all over the floor today." Despite the fact that Mr. Wilson was clearly a danger to himself, Ms. Garner failed to inform the psychiatrist. [Ex. 2-B, Detention 0480-0481].

74.

Mr. Wilson was apparently tased on December 22, 2018, during the night shift, as there is an EKG ordered following the incident. [Ex 2-B, Detention 0576]. The Doe Deputy involved is unknown. However, the deputy did not inform the jail psychiatrist of the acute nature of Mr. Wilson's symptoms and the need for immediate psychiatric care.

75.

On December 22, 2018, due to his psychosis, Mr. Wilson did not consume a sufficient amount of water to sustain human life.

76.

On December 23, 2018, Dr. Ellett, the CCDC psychologist, noted that Mr. Wilson was "smearing feces all over [the] room, calling out/yelling periodically." Dr. Ellett noted that his "behavior [was] still out of control." Despite the fact that Mr. Wilson was clearly a danger to himself, Dr. Ellet failed to inform the psychiatrist. In addition, there is no evidence that Dr. Ellett formulated a proper diagnosis or treatment plan. [Ex. 2-B, Detention 0480-0481]. Instead, Dr. Ellet wrote that he would follow up "tomorrow with hope that he is better able to control himself." Id.

77.

On December 23, 2018, due to his psychosis, Mr. Wilson did not consume a sufficient amount of water to sustain human life.

78.

Mr. Wilson apparently received no care on December 24, 2018. There is no record that Dr. Ellett followed up on December 24, 2018, as he had indicated he would do in his prior note.

79.

On December 24, 2018, due to his psychosis, Mr. Wilson did not consume a sufficient

amount of water to sustain human life.

80.

On December 25, 2018, Dr. Ellet noted that Mr. Wilson was "very psychotic," "incoherent," "disoriented," "out of touch with reality," and his "behavior [was] unpredictable. [Ex. 2-B, Detention 0480]. Despite the fact that Mr. Wilson was clearly a danger to himself and others, Dr. Ellet failed to inform the psychiatrist. [Ex. 2-B, Detention 0480-0481].

81.

Instead, when Mr. Wilson reacted psychotically on December 25, 2018, he was tased by one of the Doe Deputies. No health care was provided to Mr. Wilson following the tasing. Neither Dr. Ellett nor this jail staff member informed the psychiatrist.

82.

On December 25, 2018, due to his psychosis, Mr. Wilson did not consume a sufficient amount of water to sustain human life.

83.

On December 26, 2018, Curt Morrison, a counselor at the CCDC, noted that Mr. Wilson "has been psychotic over past few days." Mr. Morrison indicated that he knew Mr. Wilson from prior time at the jail and Mr. Wilson "responds well to meds for bipolar [disorder], but [he is] not on meds yet." He indicated that he would consult with the doctor regarding starting medication. [Ex. 2-B, Detention 0480].

84.

That same day, in response to Mr. Morrison's request, Dr. Hindash (the jail psychiatrist) prescribed Zyprexa/Olanzapine every 4-6 hours and Visiatril every 4-6 hours. [Ex. 2-B, Detention 0561].

85.

Dr. Hindash never performed an in-person assessment of Mr. Wilson, either before or after prescribing the medication.

86.

Mr. Wilson was provided no Zyprexa/Olanzapine medication on December 26, 2018.

87.

Mr. Wilson was never provided Visatril throughout his incarceration at the jail.

88.

On December 27, 2018, Nurses Wise and Hatney apparently did not administer the medication because Mr. Wilson was "not present." There is no indication that Nurse Wise or Nurse Hatney informed Dr. Hindash, the jail psychiatrist, of Mr. Wilson's failure to receive the prescribed medication and the need for immediate psychiatric care.

89.

On December 28, 2018, Mr. Wilson took one Zyprexa tablet. Nurse Hatney offered Mr. Wilson a second Zyprexa which he apparently "refused." There is no indication that Nurse Hatney informed the jail psychiatrist of Mr. Wilson's failure to receive the prescribed medication and the need for immediate psychiatric care.

90.

On December 26, 2018, December 27, 2018, and December 28, 2018, due to his psychosis, Mr. Wilson did not consume a sufficient amount of water to sustain human life.

91.

On December 29, 2018 at 12:17 pm, a code blue was called for Mr. Wilson. Mr. Wilson had died from dehydration, lying in his own feces and urine. [Ex. 2-B, Detention 0479-0480; Ex.

2-D].

92.

On December 29, 2018, Nurse Wise entered a medical note in the CCDC system after his death. The note indicates that, on the morning of his death, Nurse Wise saw Mr. Wilson lying in his cell, covered in feces and urine. He was making noises and moving his fingers. She did not provide him medication because he was "unable to take medication." [Ex, 2-B, Detention 0480]. There is no indication that Nurse Wise made any efforts to inform Dr. Hindash, jail psychiatrist, of the acute nature of Mr. Wilson's symptoms and his refusal to accept the prescribed medication.

93.

Upon information and belief, throughout Mr. Wilson's incarceration, Doe Deputies witnessed Mr. Wilson's obviously psychotic behavior and failed to inform Dr. Hindash, the jail psychiatrist.

K. Total Failure to Supply Care.

94.

Mr. Wilson was never assessed by the psychiatrist. The only hint of medical care that he received was one pill provided approximately a day before his death. This amounted to a complete denial of any medical care to Mr. Wilson.

95.

Throughout his 10 days in jail, Mr. Wilson consistently received the less effective (efficacious) care possible. Rather than alert the jail psychiatrist, the Defendants merely documented his demise. Rather than conducting an in-person assessment, Dr. Hindash merely prescribed medication without ever seeing the patient in question.

96.

This is despite the fact that his psychosis and desperate need for lifesaving care was open and obvious to anyone who saw Mr. Wilson.

L. Plaintiff's *Ante Litem* Notice and Defendants' Stonewalling.

97.

Shortly after his death, the Cobb County Sheriff's Office contacted Ms. Peltier, who was designated as Mr. Wilson's contact, to inform her of his death. The Sheriff's office refused to tell Ms. Peltier any details citing a pending autopsy by the Cobb County Medical Examiner.

98.

On January 22, 2019, Ms. Peltier provided the Sheriff's Office, Cobb County, and the Sheriff with *ante litem* notice and requested records concerning Mr. Wilson's death. [Ex. 5].

99.

On January 28, 2019, Officer Clements of the Cobb County Sheriff's Office responded providing materials related to the Sheriff's Office written policies concerning mental health care but failing to provide any material concerning Mr. Wilson's imprisonment and death. The Sheriff's office cited O.C.G.A. § 50-18-72(a)(4) which permits (but does not require) withholding of certain records in pending criminal investigations. Officer Clements informed Ms. Peltier's counsel that, following release of the medical examiner's report, the investigation would be closed and the file materials released.

100.

On May 14, 2019, the medical examiner released the autopsy report concluding that Mr. Wilson died of dehydration while housed at the jail. [Ex. 2-D]. However, despite prior assurances to the contrary, the Sheriff's Office refused to release any documentation related to the

investigation stating that now the Georgia Bureau of Investigations was reviewing the County's findings.

101.

On June 21, 2019, Ms. Peltier sent an open records request to the GBI for any records related to their investigation. On June 24, 2019, the GBI responded that no records were located. Despite this, the Sheriff's Office continued to refuse to release any information related to the investigation.

102.

At present, then, the Sheriff's Office has refused to provide Ms. Peltier with key information in violation of the Open Records Act. This includes but is not limited to: (a) the videos of Mr. Wilson; (b) any information concerning which deputiess were involved in his detention; (c) any information concerning his fluid intake (other than second hand from the Medical Examiner's report); (d) any information concerning the rounds that the CCDC staff were required to make; (e) any information concerning assistance provided to Mr. Wilson by the deputies; and (f) any internal communications of the Sheriff's Office, the Service Board, or the County on Mr. Wilson.

103.

On July 25, 2019, Plaintiff served proper *ante litem* notices to the Service Board. This included an *ante litem* notice for a wrongful death claim, and a separate *ante litem* notice for pain and suffering. [Ex. 6]. These notices also requested records related to Mr. Wilson's death be disclosed pursuant to the Open Records Act. Id. No records have been provided by the Service Board to date.

M. Written Jail Policies.

104.

The Sherriff's Office has written policies and procedures for addressing mental health and medical care for inmates.

105.

These written policies include, but are not limited to, the following:

A. Policy 2-02-03.00. "No arrestee shall be admitted to the Detention Facility without medical / mental health intervention if he/she presents symptoms of a serious illness, injury, unusual/abnormal behavior or are in an unconscious state."

B. Policy 2-03-07.00. "Employees shall closely monitor and observe the activities of those inmates under the care of a mental health professional in efforts to enhance the safety of staff and maximize facility security."

C. Policy 2-03-07.00 B. "The placement of inmates in Close Observation requires staff to conduct frequent and random observation/security rounds." These shall be no more than 15 minutes apart.

D. Policy 2-03-07.01 H. "Medical, Mental Health, Classification, and Housing staff shall ensure alert codes are entered into OMS identifying those inmates under the care of mental health professionals" including "BHA – Behavioral Alert – indicates that the inmate is currently, or was previously, under the care of mental health professionals"

E. Policy 2-03-07.01 R. "Prescription medication for inmates assigned to Close Observation shall be dispensed directly by medical staff under direct supervision."

F. Policy 2-03-07.02 B. "A mental health professional shall be consulted concerning appropriate items for the inmate considering the inmate's mental health status."

G. Policy 2-06-01.00. “Inmates shall be afforded reasonable healthcare services that are comparable to the standard of care and practice that citizens could expect to receive in the community.”

H. Policy 2-06-03.00. “Upon incarceration, arrestees shall undergo a Preliminary Health Screening Assessment to identify and address any medical or mental health issues/concerns conveyed by the inmate or as observed by staff.”

I. Policy 2-06-03.00 B, C, D. Staff shall notify the Intake Supervisor of any mental health issues noted during the initial health screening. The Intake Supervisor shall promptly notify the Intake Nurse.

J. Policy 2-06-04.01. “Inmates shall have adequate and proper access to emergency medical care. Medical staff shall ensure that prompt medical attention (response) is provided in situations deemed a medical emergency.”

K. Policy 2-06-04.01 A. “Staff shall be observant and responsible to signs of an emergency medical and mental health situation within the facility.”

L. Policy 2-06-04.01 B “The delivery of emergency medical services shall be a top priority, taking precedence over routine duties and responsibilities.”

M. Policy 2-06-04.01 L. “Staff shall notify Infirmary staff when an inmate has obvious signs of injury or illness and request the inmate be transported to the infirmary.”

N. Policy 2-06-11.00. “Inmates shall be afforded access to mental health care from on-side healthcare professionals as needed, ordered by the courts, directed by the Facility Physician or medical staff and when recommended by Detention Staff.”

O. Policy 2-06-11.01 D. “Immediate and prompt attention by a mental health professional shall be given to any inmate observed to be demonstrating behavior indicative of some

form of mental illness or psychotic episode."

P. Policy 2-06-11.01 F. "Staff should be aware of the following behaviors associated with mental illness. 1. Hallucinations…3. Delusions…4. Paranoia...5. Extreme Hyperactivity….10. Catatonia….11. Flight of Ideas."

Q. Policy 2-06-11.01 J. "If an inmate demonstrates symptoms known to be indicative of a mental health issue and a mental health professional is not on duty, the inmate shall be placed in a Close Observation area with all required documentation forwarded to a mental health professional for follow up." [Ex. 2-G].

106.

The written policies of the Sheriff's office were repeatedly violated. [See Affidavit of Dr. Frierson, Ex. 2; Affidavit of Dr. Ioannou, Ex. 3].

**DAMAGES**

107.

Damages for the death of someone killed by the negligence of another includes the full value of the loss of the life of the deceased, without deduction for damages for the pain and suffering of the deceased after the injury and prior to death. O.C.G.A. § 51-4-1. Ms. Peltier as next of Kin and Administrator of the Estate is entitled to bring a claim for wrongful death. O.C.G.A. § 51-4-5.

108.

The Administrator of the Estate is entitled recover on behalf of the Estate the medical, funeral, and other expense proximately caused by the defendant. O.C.G.A. § 51-4-5. The Administrator is also authorized to recover damages for the decedent's conscious pain and suffering due to the fight, shock and mental suffering experienced by the decedent due to the

wrongful acts of the defendant. Ms. Peltier as Administrator of the Estate is entitled to recover this amount on behalf Mr. Wilson's Estate.

109.

Accordingly, Plaintiff is entitled to recover the full value of Mr. Wilson's life, pain and suffering, medical, funeral, and other expenses, which were proximately caused by Defendants.

110.

Under Georgia law, punitive damages are available for acts that constitute "willful misconduct, malice, fraud, wantonness, oppression, or that entire want of care which would raise the presumption of conscious indifference to consequences." O.C.G.A. 51-12-5.1. The acts and omissions of Defendants justify an award of punitive damages to Plaintiff.

**COUNT 1**
**§1983**

111.

Plaintiff incorporates all of the preceding paragraphs of the Complaint as if full restated herein verbatim.

A. A Person.

112.

Plaintiff asserts this count against Sheriff Warren, Doe Deputies, Dr. Hindash, Dr. Ellett, Nurse Merius, Nurse Wise, Nurse Hatney, and Ms. Garner. This count asserted in the Defendants *individual* capacities only. (Collectively, these Defendants may be referred to in this Count as the "§ 1983 Defendants").

B. Acting Under Color of State Law.

113.

"It is undisputed that the treatment a prisoner receives in prison and the conditions under

which he is confined are subject to scrutiny under the Eighth Amendment" and Fourteenth Amendment and subject to actions under § 1983. Estate of Owens v. GEO Grp., Inc., 660 Fed. Appx. 763, 766 (11th Cir. 2016).

114.

The acts of Sheriffs, deputies, doctors, nurses, and jail staff members, in a correctional facility, in addressing an inmate's medical care are acts "under color of state law." Ancata v. Prison Health Servs., Inc., 769 F.2s 700, n. 9 (11th Cir. 1985); Ort v. Pinchback, 786 F.2d 1105, 1107 (11th Cir. 1986).

115.

Defendant Wellstar had a contract with the CCDC to provide mental health services to inmates. Accordingly, all medical personnel acting pursuant to that contract also acted under color of state law.

116.

The §1983 Defendants acted under color of state law under the circumstances of this case detailed above.

C. Violation of Mr. Wilson's Constitutional Rights.

117.

All inmates have a constitutional right "to receive medical treatment for illness and injuries, which encompasses a right to psychiatric and mental health care, and a right to be protected from self-inflicted injuries, including suicide." Cook v. Sheriff of Monroe County, 402 F.3d 1092, 1115 (11th Cir. 2015). The Fourteenth Amendment protects a pretrial detainee's right to mental health care while incarcerated. The Eight Amendment protects a prisoner's right to mental health care

while incarcerated.

118.

Deliberate indifference to a serious medical need is a violation of an inmate's constitutional right to healthcare, protected by the Eighth and Fourteenth Amendments.

119.

Mr. Wilson was incarcerated on an alleged probation violation. Accordingly, Mr. Wilson asserts that both his Eighth and Fourteenth Amendment rights. Mr. Wilson's constitutional rights were violated by the § 1983 Defendants' deliberate indifference to his serious medical need.

*i. Serious Medical Need*

120.

Mr. Wilson was diagnosed with bipolar disorder and schizophrenia. CCDC records indicate that Mr. Wilson had been diagnosed by Nurse Merius, Mr. Morrison, and Dr. Hindash as having a medical need that required treatment. Accordingly, Mr. Wilson had an objectively serious medical need.

121.

In addition, Mr. Wilson's psychosis caused by bipolar disorder and schizophrenia was so obvious that even a lay person would easily recognize he needed immediate medical attention. Mr. Wilson was throwing feces and smearing feces. He was undressing his clothes and behaving oddly, performing acrobatics. There are multiple references in the jail records that he was "psychotic," acting "abnormal," and getting worse. Accordingly, Mr. Wilson had an objectively serious medical need.

*ii. Deliberate indifference to his medical need*

122.

The §1983 Defendants had subjective knowledge that Mr. Wilson was psychotic and in desperate need of medical care. This is evidence from a number of reasons, including but not limited to the following.

a. *First*, the reason that Mr. Wilson had an encounter with law enforcement was that he was standing in the roadway with "hospital scrubs with no shoes" and claiming he was "seeing spirits all around him."

b. *Second*, Mr. Wilson's behavior in the jail demonstrated an obvious need for medical treatment to a layperson.

c. *Third*, this was not the §1983 Defendants first time encountering Mr. Wilson. They had previously seen Mr. Wilson and knew of his serious mental health issues.

123.

The §1983 Defendants disregarded the serious risks to Mr. Wilson's health by conduct that far exceeds gross negligence. The facts and circumstances demonstrating this disregard of the serious risk include but are not limited to the following:

a. Disregarding his psychosis which was so severe that he was lying in his own feces and urine;

b. Disregarding his psychosis which was so severe that he was not consuming enough water to sustain human life;

c. Providing no medication for his psychosis, bipolar disorder, and schizophrenia from December 20, 2018 to December 27, 2018;

d. Providing one dose of medication for his psychosis, bipolar disorder, and

schizophrenia for his entire 10 day incarceration;

e. Never conducting a full assessment or treatment plan by the jail psychologist, Dr. Ellett;

f. Never conducting an in-person assessment of his medical condition by the jail psychiatrist, Dr. Hindash;

g. Failure of Sheriff Warren, Doe Deputies, Dr. Ellett, Nurse Merius, Nurse Wise, Nurse Hatney, and Ms. Garner to inform Dr. Hindash of his severe psychosis and the need for emergency treatment;

h. Failure to provide any medical care to Mr. Wilson despite knowing he was psychotic and in desperate need of care;

i. Failure to transport Mr. Wilson to a hospital; and

j. Failure to provide forced antipsychotic medication upon his refusal to eat, drink, or take medication.

124.

This conduct far exceeded gross negligence. The failure of the §1983 Defendants was so great that it amounts to (1) taking a less efficacious route in treating an inmate; (2) a total denial of adequate care; and (3) behavior so egregious that it shocks the conscience.

D. Qualified Immunity does not apply.

125.

The conduct of the §1983 Defendants was ministerial in nature. There is no qualified immunity or the violation of a ministerial duty.

126.

The conduct of the §1983 Defendants amounted to a total failure to provide medical care. The provision of medical care is a constitutional duty and a ministerial obligation. The failure to provide medical care is a ministerial breach. There is no qualified immunity or the violation of a ministerial duty.

127.

The conduct of the § 1983 Defendants violated the CCDC's own policies and procedures, listed above in paragraph 106A-Q. This is supported by the affidavits of (a) Dr. Frierson, a correctional psychiatrist, (b) Dr. Ioannou, a correctional psychologist, and (c) Nurse Wacasey, a former psychiatric nurse practitioner at the CCDC. [Exs. 2, 3, 4]. These affidavits are incorporated herein by reference as if restated herein verbatim.

128.

The § 1983 Defendants are also not entitled to qualified immunity because their conduct amounted to (a) an intentional refusal to provide medical care; (b) a delay in provided medical care; (c) ignoring obvious symptoms of psychosis in need of medical care; and (d) providing only cursory care of a single dose antipsychotic drug during his incarceration.

129.

In addition, the §1983 Defendants who worked for Defendant Wellstar are not entitled to qualified immunity because they were independent contractors. The Contract between Wellstar and the Sheriff's Office states that they are operating as independent contractors in providing mental health services. [Ex. 1, Contract, Sec. 7.1]. This would include Nurse Merius, Nurse Merius, Nurse Wise, and Nurse Hatney.

E. Damages Recoverable

130.

Under § 1983, Plaintiff is entitled to recover from the §1983 Defendants (a) all pain and suffering of Mr. Wilson; (b) all monetary losses incurred by the Estate; (c) all damages for mental distress, emotional distress, and humiliation; (d) the full value of the life of the decedent as asserted under Georgia law; and (e) attorney's fees and expenses. Thus, Plaintiff as Next of Kin and Administrator of the Estate, is entitled to recover all these damages which were proximately caused by the §1983 Defendants.

**COUNT 2**
**§1983 for Wrongful Death**

131.

Plaintiff incorporates all of the preceding paragraphs of the Complaint as if full restated herein verbatim.

132.

Plaintiff asserts this count against Sheriff Warren, Doe Deputies, Dr. Hindash, Dr. Ellett, Nurse Merius, Nurse Wise, Nurse Hatney, and Ms. Garner. This count asserted in the Defendants *individual* capacities only. (Collectively, these Defendants may be referred to in this Count as the "§1983 Defendants").

133.

Federal law incorporates Georgia's wrongful death statutes under §1988. Mr. Wilson's death was proximately caused by the tortious conduct of the §1983 Defendants as hereinbefore alleged. Thus, Plaintiff is entitled to recover, as administrator of the Estate, the full value of the life from the §1983 Defendants.

134.

Federal law incorporates Georgia's wrongful death statutes under 42 U.SC. §1988. Mr. Wilson's pain and suffering, medical, funeral, and other expenses were proximately caused by the tortious conduct of the §1983 Defendants as hereinbefore alleged. Thus, Plaintiff is entitled to recover, as administrator of the Estate, these damages on behalf of the Estate from the §1983 Defendants.

**COUNT 3**
**Georgia Cause of Action against Sheriff Warren and Doe Deputies for Wrongful Death, Pain and Suffering, Funeral Expenses, and Related Damages**

135.

Plaintiff incorporates all of the preceding paragraphs of the Complaint as if full restated herein verbatim.

136.

Plaintiff asserts this count against Sheriff Warren and Doe Deputies. This count asserted in the Defendants *individual* capacities only. (Collectively, these Defendants may be referred to in this Count as the "Sheriff Defendants").

137.

Providing adequate medical attention for inmates is a ministerial duty. The failure to provide medical care or providing woefully inadequate medical care is a violation of this ministerial duty. Sheriff Warren and the Doe Deputies negligently performed or failed to perform their ministerial functions in providing medical care to Mr. Wilson.

138.

Sheriff Warren and the Doe Deputies negligently performed or failed to perform their ministerial functions, in at least the following ways:

a. Mr. Wilson was totally denied medical care. He never received intervention to assist with dehydration. He went seven days without any antipsychotic medication. He never received an in-person evaluation for psychiatric issues. He only received a single antipsychotic pill throughout his stay at the jail, despite severe and obvious symptoms.

b. Sheriff Warren and the Doe Deputies failed to follow the written policies and procedures of the CCDC. This is supported by the affidavits of (a) Dr. Frierson, a correctional psychiatrist, (b) Dr. Ioannou, a correctional psychologist, and (c) Nurse Wacasey, a former psychiatric nurse practitioner at the CCDC. [Exs. 2, 3, 4]. These affidavits are incorporated herein by reference as if restated herein verbatim.

139.

As hereinbefore alleged, Mr. Wilson was totally denied medical care by the Individual County Defendants. These were ministerial acts.

140.

Following the written policies and procedures of the Sheriff's office is a ministerial duty. Harvey v. Nichols, 260 Ga. App. 187 (2003). In this case, as hereinbefore alleged, the Individual County Defendants failed to follow written policies of the Sheriff's Office. These failures were ministerial.

141.

Mr. Wilson's death was proximately caused by violations of ministerial duties by the Individual County Defendants as hereinbefore alleged. Thus, Plaintiff is entitled to recover, as administrator of the Estate, the full value of the life.

142.

Mr. Wilson's pain and suffering, medical, funeral, and other expenses were proximately caused by violations of ministerial duties by the Individual County Defendants as hereinbefore alleged. Thus, Plaintiff is entitled to recover, as administrator of the Estate, these damages on behalf of the Estate.

**COUNT 4**
**Georgia Tort Claims Act Against**
**the Cobb Community Service Board for the Acts and Omissions of Dr. Hindash**

143.

Plaintiff incorporates all of the preceding paragraphs of the Complaint as if full restated herein verbatim.

144.

Dr. Hindash was an employee of the Service Board acting within the scope and course of his employment with the Service Board at all times pertinent hereto. Accordingly, Plaintiff asserts this Count only against the Service Board, in accordance with O.C.G.A. § 50-21-28.

145.

The Service Board is a State Agency within the meaning of the Tort Claims Act. Youngblood v. Gwinnett Rockdale Newton Comm. Serv. Bd., 273 Ga. 715, 716 (2001).

146.

Pursuant to the Georgia Tort Claims Act ("GTCA"), sovereign immunity is waived for the torts of state officers and employees while acting within the scope of their official duties or employment. The State is liable for such torts "in the same manner as a private individual or entity would be under like circumstances." O.C.G.A. § 50-21-23.

147.

The failures of the Service Board and its employees as hereinbefore alleged were ministerial actions, within the meaning of the tort claims act. Edwards v. Ga. Dep't of Children & Youth Servs., 271 Ga. 890, 892 (2000). The provision of medical care to an inmate, such as Mr. Wilson, is a ministerial duty within the meaning of the Tort Claims Act. Id.

148.

The standard of care for a psychiatrist in a correctional setting includes a thorough in-person assessment of the inmate within 24-48 hours of his referral to the psychiatrist and/or within 24-48 hours of prescribing medication. Dr. Hindash was negligent in his treatment of Mr. Wilson. That is, he violated the applicable standard(s) of care for professionals such as himself in like and similar circumstances. Dr. Hindash violated the standard of care in at least the failure to provide a thorough in-person assessment of Mr. Wilson within 24-48 hours of his referral and/or his prescribing medication.

149.

The negligence of Dr. Hindash directly and proximately caused injury and death to Mr. Wilson. A proper assessment of Mr. Wilson within this time frame would have revealed his acute psychosis and resulted in proper treatment. As such, Mr. Wilson would not have dehydrated to death.

150.

Mr. Wilson's injuries and death were proximately caused by the acts and omissions of the Dr. Hindash as hereinbefore alleged. Thus, Plaintiff is entitled to recover, as administrator of the Estate, the full value of the life of Mr. Wilson, and for Mr. Wilson's pain and suffering, medical, funeral, and other expenses, proximately caused by Dr. Hindash. These items are recoverable from

the Service Board.

151.

As required by Georgia law, Plaintiff attaches hereto as Exhibit 2 and incorporates herein by reference, an affidavit of Richard Frierson M.D., a duly qualified medical doctor, setting forth at least one negligent act or omission of Dr. Hindash and the factual basis for that claim.

**COUNT 5**
**Georgia Tort Claims Act Against**
**the Cobb Community Service Board for the Acts and Omissions of Dr. Ellett**

152.

Plaintiff incorporates all of the preceding paragraphs of the Complaint as if full restated herein verbatim.

153.

Dr. Ellett was an employee of the Service Board acting within the scope and course of his employment with the Service Board at all times pertinent hereto. Accordingly, Plaintiff asserts this Count only against the Service Board, in accordance with O.C.G.A. § 50-21-28.

154.

The standard of care for a psychologist in a correctional setting includes a thorough in-person examination of the inmate within 24-48 hours of referral. This in-person examination should include a diagnosis and treatment plan. Dr. Ellett committed negligence in his treatment of Mr. Wilson. That is, he violated the applicable standard(s) of care for professionals such as himself in like and similar circumstances. Dr. Ellett violated the standard of care in at least the failure to properly diagnose and develop a treatment plan for Mr. Wilson

155.

The standard of care for a psychologist in a correctional setting includes the requirement

that a psychologist immediately inform the psychiatrist and recommend an emergency consultation for psychotropic medication when the inmate exhibits acute psychosis and mania symptoms. Dr. Ellett committed negligence in his treatment of Mr. Wilson. That is, he violated the applicable standard(s) of care for professionals such as himself in like and similar circumstances. Dr. Ellett violated the standard of care in at least the failure to consult with the psychiatrist given the egregious symptoms demonstrated by Mr. Wilson.

156.

The negligence of Dr. Ellett directly and proximately caused injury and death to Mr. Wilson. A proper assessment of Mr. Wilson within this time frame would have revealed his acute psychosis and resulted in proper treatment. As such, Mr. Wilson would not have dehydrated to death.

157.

Mr. Wilson's injuries and death were proximately caused by the acts and omissions of the Dr. Ellett as hereinbefore alleged. Thus, Plaintiff is entitled to recover, as administrator of the Estate, the full value of the life of Mr. Wilson, and for Mr. Wilson's pain and suffering, medical, funeral, and other expenses, proximately caused by Dr. Ellett. These items are recoverable from the Service Board.

158.

As required by Georgia law, Plaintiff attaches hereto as Exhibit 3 and incorporates herein by reference, an affidavit of Ioannis Ioannou, Psy. D., a duly qualified psychologist, setting forth at least one negligent act or omission of Dr. Ellett and the factual basis for that claim.

**COUNT 6**
**Georgia Tort Claims Act Against**
**the Cobb Community Service Board for the Acts and Omissions of Ms. Garner**

159.

Plaintiff incorporates all of the preceding paragraphs of the Complaint as if full restated herein verbatim.

160.

Ms. Garner was an employee of the Service Board acting within the scope and course of his employment with the Service Board at all times pertinent hereto. Accordingly, Plaintiff asserts this Count only against the Service Board, in accordance with O.C.G.A. § 50-21-28.

161.

Ms. Garner negligently performed her ministerial duties in the treatment of Mr. Wilson. Ms. Garner failed to notify the psychiatrist of Mr. Wilson's acute psychosis despite his open and obvious symptoms.

162.

Mr. Wilson's injuries and death were proximately caused by the acts and omissions of the Ms. Garner as hereinbefore alleged. Thus, Plaintiff is entitled to recover, as administrator of the Estate, the full value of the life of Mr. Wilson, and for Mr. Wilson's pain and suffering, medical, funeral, and other expenses, proximately caused by Ms. Garner. These items are recoverable from the Service Board.

**COUNT 7**
**Professional Malpractice against**
**Wellstar, Nurse Merius, Nurse Wise, and Nurse Hatney**

163.

Plaintiff incorporates all of the preceding paragraphs of the Complaint as if full restated

herein verbatim.

164.

Plaintiff asserts this count against Defendants Wellstar, Nurse Merius, Nurse Wise, and Nurse Hatney.

165.

At all material times hereto, Defendants were charged with the duty of using due and proper care in treating, caring for, and attending to Mr. Wilson.

166.

Defendants personally and/or through their agents committed negligence in their treatment of Plaintiff. That is, they violated the applicable standard(s) of care for professionals such as themselves in like and similar circumstances.

167.

The standard of care for a nurse conducting a physical and mental assessment of an inmate at the time of admission to a correctional facility includes immediately alerting the jail psychiatrist that the inmate is acutely psychotic and in need of immediate psychiatric attention, when the inmate displays severe psychiatric symptoms. Nurse Merius committed negligence in her treatment of Mr. Wilson. That is, she violated the applicable standard(s) of care for professionals such as herself in like and similar circumstances. Nurse Merius violated the standard of care in at least the failure to alert the psychiatrist given the egregious symptoms demonstrated by Mr. Wilson.

168.

The standard of care for a nurse in a correctional setting requires the nurse to alert the psychiatrist when an inmate displays severe psychosis such that they are unable to care for

themselves. The standard of care for a nurse in a correctional setting also requires the nurse to alert the psychiatrist when a psychotic inmate refuses to take prescribed antipsychotic medication. Nurse Wise and Nurse Hatney committed negligence in their treatment of Mr. Wilson. That is, Nurse Wise and Nurse Hatney violated the applicable standard(s) of care for professionals such as themselves in like and similar circumstances. Nurse Wise and Nurse Hatney violated the standard of care in at least the failure to alert the psychiatrist given Mr. Wilson's inability to care for himself and refusal to take prescribed medication due to his severe psychosis. They also provided no actions to stabilize Mr. Wilson despite him lying in a floor of feces and urine.

169.

As Nurse Merius, Nurse Wise, and Nurse Hatney were acting within the course and scope of their employment with Wellstar at all times pertinent hereto, Wellstar is liable for acts and omissions of these persons.

170.

The negligence of Nurse Merius, Nurse Wise, and Nurse Hatney directly and proximately caused injury and death to Mr. Wilson. If Nurse Merius, Nurse Wise, and Nurse Hatney had followed the standard of care and alerted the psychiatrist, Mr. Wilson would have been eligible to receive a forcible injection and/or hospitalization which would have resulted in appropriate monitoring of consumption of an adequate amount of food and water. As such, Mr. Wilson would not have dehydrated to death.

171.

Mr. Wilson's injuries and death were proximately caused by the acts and omissions of Wellstar, Nurse Merius, Nurse Wise, and Nurse Hatney. as hereinbefore alleged. Thus, Plaintiff is entitled to recover, as administrator of the Estate, the full value of the life of Mr. Wilson, and for

Mr. Wilson's pain and suffering, medical, funeral, and other expenses, proximately caused by these Defendants. These items are recoverable from Wellstar, Nurse Merius, Nurse Wise, and Nurse Hatney.

172.

As required by Georgia law, Plaintiff attaches hereto as Exhibit 2 and incorporates herein by reference, an affidavit of Richard Frierson M.D., a duly qualified medical doctor who supervises nurses, setting forth at least one negligent act or omission of the Nurse Merius, Nurse Wise, and Nurse Hatney and the factual basis for that claim.

**Count 8**
**Punitive Damages**

173.

Plaintiff incorporates all of the preceding paragraphs of the Complaint as if full restated herein verbatim.

174.

This Count is asserted against the § 1983 Defendants, Wellstar, Nurse Merius, Nurse Wise, and Nurse Hatney. (Collectively, these Defendants may be referred to herein as the Punitive Damages Defendants).

175.

The acts and omissions of the Punitive Damages Defendants as hereinbefore alleged showed intent, willful misconduct, malice, fraud, wantonness, oppression and/or that entire want of care which raised the presumption of conscious indifference to the consequences entitling Plaintiff to an award of punitive damages in an amount sufficient to deter the Defendant from the same or similar actions in the future in accordance with O.C.G.A. § 51-12-5.1.

**Count 9**
**Attorney's Fees**

176.

Plaintiff incorporates all of the preceding paragraphs of the Complaint as if full restated herein verbatim.

177.

This Count is asserted against all of the Defendants.

178.

Defendants have acted in bad faith, have been stubbornly litigious, and/or have caused Plaintiff unnecessary trouble and expense. This entitles Plaintiff to recover reasonable attorney's fees and expenses of litigation from defendants in an amount to be determined at trial.

**JURY TRIAL DEMANDED**

179.

Plaintiffs demand a trial by a jury on all matters that can be so tried.

WHEREFORE Plaintiff demands judgment in her favor on all issues raised by the Complaint against Defendants in excess of $10,000.00 for the damages identified above, and demands she recover punitive damages and attorney's fees, and such other and further relief as the Court deems just and proper.

This 9th day of DECEMBER 2019.

**CARR & WEATHERBY, LLP**

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