IN THE UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF ARKANSAS
EL DORADO DIVISION

Randy Dewayne Rogers, as Administrator of the Estate of Randy James Rogers, and on his own behalf, Plaintiff, v. Columbia County; Columbia County Sherriff's Office; Michael Loe; Matthew Hulet; Aaliyah Rose; Jesse Guise; Mark Moseley; County Facility Healthcare of Arkansas, LLC; Darryl Elkins; Nurse Cassandra; Magnolia Regional Medical Center; Emergency Staffing Solutions; Nurse M. Brazell; Dr. Phillip Pace; Dr. Dilan Samarawickrama; Radiology Associates, P.A., Defendants.	**Case No.** **JURY TRIAL DEMANDED**

COMPLAINT

Plaintiff Randy D. Rogers, as Administrator of the Estate of Randy James Rogers and in his individual capacity ("Plaintiff"), by and through counsel, Loevy & Loevy and Noorwood & Noorwood, P.A., brings this action against the defendants identified herein.

INTRODUCTION

This is an action brought by Randy Dewayne Rogers, the son Randy James Rogers and personal representative of his Estate, to vindicate violations of Mr. Roger's rights under the United States Constitution and the laws of Arkansas.

Mr. Rogers had a heart attack in April 2022. To prevent another heart attack, he was prescribed multiple medications, and stents were placed in his heart.

A few weeks later, on May 20, 2022, Mr. Rogers was arrested on charges of failing to appear for a court hearing, and he was booked into jail in Columbia County, Arkansas. Mr. Rogers filled out intake forms noting his recent heart attack and the multiple medications he had been prescribed. And Mr. Rogers was sent out of the jail twice for chest issues—once because of chest pain, on May 25, and once for a cardiology appointment, on June 30.

Despite ample knowledge of Mr. Rogers's serious medical history and risk of heart attack, the jail repeatedly left Mr. Rogers without the prescriptions he needed to manage his chronic heart condition. Again and again, he had to request vital prescriptions, like blood thinners needed to support his stents, and he went days and weeks at a time without these prescriptions.

Then on in the early morning hours of July 8, 2022, Mr. Rogers fell from his top bunk and hit his head on his cell's concrete floor. In addition to a laceration on his head he related that he had chest pain. He was taken to a local emergency room. Staff there did not conduct sufficient testing to detect internal bleeding from the fall, and even though he told them he was experiencing chest pain, they conducted no cardiac testing at all.

Just before 7:30 AM, that same morning Mr. Rogers, who was back at the jail, began to have shortness of breath and extreme chest pain. Jail staff, however, did not call for an ambulance. Instead they called a jail administrator to ask what to do. That administrator did not give them permission to call an ambulance either. Instead he told them to call the jail's nurse—who never picked up. Jail staff waited another 15 critical minutes, and only called for an ambulance after Mr. Rogers collapsed, nearly 30 minutes after he presented to jail staff with symptoms of a heart attack.

By that time, it was too late. Mr. Rogers's heart had stopped. Paramedics tried to revive him, but they could not do so. He was pronounced dead shortly after arriving at the local hospital, around 8:24 AM.

JURISDICTION AND VENUE

1. This action is brought pursuant to 42 U.S.C. § 1983 to redress the deprivation under color of law of Plaintiff's rights as secured by the United States Constitution.

2. This Court has jurisdiction over those claims that present a federal question pursuant to 28 U.S.C. §§ 1331 and 1343 and has supplemental jurisdiction over claims arising under state law pursuant to 28 U.S.C. § 1367.

3. Venue is proper under 28 U.S.C. § 1391(b). The events giving rise to the claims asserted in this complaint occurred in this judicial district and some of the parties reside in this district.

PARTIES

4. Randy James Rogers was a resident of Columbia County, Arkansas. At the time of his death, he was a pretrial detainee at the Columbia County Jail.

5. Mr. Rogers was pronounced dead at the Magnolia Regional Medical Center on July 8, 2022. He is survived by his sons, Randy Dewayne Rogers and Jimmy Joshua Rogers.

6. Plaintiff Randy Dewayne Rogers is Mr. Rogers's son and the administrator of his estate.

7. Defendant Columbia County, Arkansas ("Columbia County") operates the Columbia County Detention Center ("CCDC") and is responsible for the health and safety of all people who are detained at the CCDC.

8. Defendant Columbia County Sheriff's Office operates the CCDC and is responsible for the health and safety of all people who are detained at the CCDC.

9. Defendant Michael Loe was the Sheriff of Columbia County at the time of the events at issue in this case. He was responsible and responsible for the health and safety of all people who are detained at the CCDC, and was responsible for formulating policies governing the operation of the CCDC.

10. Defendant Matthew Hulet ("Hulet") was a Jail Administrator at the CCDC at the time of Mr. Rogers's death. He was responsible and responsible for the health and safety of all people who are detained at the CCDC, and was responsible for formulating policies governing the operation of the CCDC. This defendant was an employee of Columbia County and/or the Columbia County Sheriff's Office.

11. Defendant Aaliyah Rose ("Rose") was a jailor at the CCDC at the time of Mr. Roger's death. This defendant was an employee of Columbia County and/or the Columbia County Sheriff's Office.

12. Defendant Jesse Guise ("Guise") was a jailor at the CCDC at the time of Mr. Roger's death. This defendant was an employee of Columbia County and/or the Columbia County Sheriff's Office.

13. Defendant Mark Moseley ("Moseley") was a jailor at the CCDC at the time of Mr. Roger's death. This defendant was an employee of Columbia County and/or the Columbia County Sheriff's Office.

14. Defendant County Facility Healthcare of Arkansas, LLC ("CFHA") is an Arkansas corporation. CFHA entered into a contract with Columbia County and/or the Columbia County Sheriff's Office to provide medical services to detainees at the CCDC.

15. Defendant Darryl Elkins ("Elkins") was owner of CFHA. On information and belief, Elkins was responsible for formulating policies regarding medical care at the CCDC. Defendant Elkins was also responsible for providing medical care detainees at the CCDC, including the provision of medication and medical attention.

16. Nurse Cassandra was the on-call Registered Nurse at the time of Mr. Rogers's death. At all relevant times, she acted as an employee and/or agent of CFHA. Nurse Cassandra's last name is currently unknown to Plaintiff. Defendant Nurse Cassandra was also responsible for providing medical care for detainees at the CCDC, including the provision of medication and medical attention.

17. Defendant Magnolia Regional Medical Center ("MRMC") is a hospital in Columbia County Arkansas. On information and belief MRMC employed Defendants Pace and Brazell.

18. Defendant Emergency Staffing Solutions ("ESS") is a corporate entity headquartered in Dallas, Texas that is contracted to provide emergency room staffing to MRMC. On information and belief ESS employed Defendants Pace and Brazell.

19. Defendant Dr. Phillip Pace was a medical doctor practicing at the Magnolia Regional Medical Center ("MRMC"). On information and belief, Dr. Pace has an employment or contractual relationship to provide medical and emergency care at MRMC either directly or through ESS.

20. Nurse M. Brazell is a nurse at the MRMC. On information and belief, Nurse Brazell has an employment or contractual relationship to provide emergency medical care at MRMC either directly or through ESS.

21. Defendant Dr. Dilan B. Samarawickrama is a radiologist.

22. Defendant Radiology Associates, P.A. is an Arkansas professional association that employs Dr. Samarawickrama.

ALLEGATIONS

23. In April 2022, Randy Rogers suffered a heart attack. He survived, but the event left him at increased risk of suffering another heart attack. To reduce this risk stents were placed in his heart and he was prescribed multiple daily medications.

24. On May 20, 2022, Mr. Rogers was taken into custody and booked as a pretrial detainee at the CCDC.

25. Mr. Rogers remained in the custody of the CCDC from May 20, 2022 until his death on July 8, 2022.

26. As part of intake into the CCDC, Mr. Rogers was prompted to provide information about his medical history and medical needs.

27. The purpose of gathering such information from detainees on intake is to make staff at the jail aware of a detainee's medical needs.

28. In response to the prompts at intake to provide medical information, Mr. Rogers stated that he had a number of medical conditions including diabetes, heart trouble, and hypertension.

29. In response to the prompts at intake to provide medical information, Mr. Rogers also stated that he had stents placed in his heart.

30. In response to the prompts at intake to provide medical information, Mr. Rogers also stated that he had been placed on multiple heart and blood pressure medications.

31. In response to the prompts at intake to provide medical information, Mr. Rogers also stated that he had an appointment with a cardiologist scheduled for June 16, and he provided the name and contact information for the cardiologist.

32. On information and belief, staff at the jail was provided with Mr. Rogers' intake information, including the information Mr. Rogers provided about his medical history and medical needs.

33. On May 25, Mr. Rogers reported chest pain and was transported to Magnolia Regional Medical Center ("MRMC").

34. Medical staff at MRMC noted a history of congestive heart failure, ordered a cardiac workup, and entered an order for follow-up with a cardiologist as well as the jail's doctor.

35. On information and belief, information that Mr. Rogers had gone to the hospital on May 25 for chest pain was provided to staff at the jail.

36. Medical staff at the jail, however, did not take any steps to follow up or order additional testing or monitoring.

37. On May 30, 2022, Rogers filed a written medical call note stating that he was not receiving his daily prescriptions. In the medical call note, Mr. Rogers repeated that he had had a heart attack the month before and had two stents placed in his heart.

38. On information and belief, this information was provided to staff at the jail.

39. On June 14, 2022, Rogers wrote another medical call note stating that he was out of his blood thinner medication. In that message, he noted that he had recently had a heart attack and needed his prescription. He also related that he felt as though he was having heart trouble, stating that he did not feel as though his heart flow was not functioning as it should be.

40. On information and belief, this information was provided to staff at the jail.

41. From June 14, 2022 to June 22, 2022, Mr. Rogers repeatedly requested his blood thinner medication. He did not receive the medication until June 22, 2022.

42. Mr. Rogers was not sent out to see his cardiologist for his June 16 appointment.

43. On June 30, Mr. Rogers was transported from the jail to see his cardiologist.

44. The cardiologist prescribed Entresto, a heart medication designed to prevent heart failure.

45. Information about the cardiologist's prescription was shared with medical staff at the jail.

46. Despite this prescription, Mr. Rogers was never provided with Entresto at the jail.

47. On July 7, 2022, Rogers sent a message to CCDC staff complaining of chest pain.

48. Hulet reviewed this message at approximately 8:18 PM that same day.

49. Hulet took no action in response to Rogers's message.

50. On July 8, 2022 at approximately 2:00 AM, Rogers, who slept on the top bunk, fell out of his bunk and hit his head on the floor. The fall caused lacerations and bleeding to his head.

51. Pursuant to policy at CCDC, a correctional supervisor had to authorize sending detainees to the emergency room.

52. Pursuant to this policy, jailor Stephanie Ingle contacted Defendant Hulet at approximately 2:26 AM, and told Hulet about Rogers's head injury, seeking permission to send Rogers to the emergency room.

53. Defendant Hulet asked Ingle whether Rogers's injury could wait until morning or if an ER visit was really "necessary." Ingle responded that she thought it could not wait until morning. Defendant Hulet authorized Rogers's transport to MRMC.

54. Mr. Rogers was sent to MRMC at approximately 3:30 AM.

55. At MRMC, he was seen by Defendant M. Brazell, an MRMC nurse.

56. Mr. Rogers told Defendant Brazell that he was experiencing chest pain, but Nurse Brazell did not note this fact in Mr. Rogers's triage charting.

57. Mr. Rogers next was attended to by Defendant Phillip Pace, M.D.

58. Dr. Pace was informed that Mr. Rogers had fallen from a top bunk at the jail and had hit his head.

59. Dr. Pace was also provided with Mr. Rogers's medical history, including a history of coronary artery disease, and the fact that stents had been placed in his heart.

60. Mr. Rogers had obvious injuries, including deep wound on his scalp.

61. During Dr. Pace's examination, Mr. Rogers told Dr. Pace that he was experiencing chest pain.

62. Despite learning of this information, Dr. Pace did not order any monitoring or examination of Mr. Rogers's heart or heart functioning. Dr. Pace did not order any medical intervention to diagnose or address chest pain.

63. Dr. Pace ordered that Mr. Rogers receive CT imaging of his head and neck.

64. Dr. Pace ordered the CT scan too soon after Mr. Rogers' fall to reliably exclude internal bleeding from the fall.

65. Dr. Pace failed to order contrast imaging to reliably exclude internal bleeding from the fall.

66. The CT scans were read by Dr. Dilan B. Samarawickrama, of Radiology Associates, P.A.

67. Mr. Rogers' neck was fractured, but Dr. Samarawickrama failed to recognize the fracture on the CT scan, and reported that there was no fracture.

68. The CT scan results were negative for internal bleeding.

69. Notwithstanding the CT results, given the timing and nature of the injury Mr. Rogers had suffered, he remained at risk of internal bleeding, and should have been held and monitored at the hospital.

70. Given Mr. Rogers's history of heart problems and his complaints of chest pain, he should have been held and monitored at the hospital.

71. Instead of holding Mr. Rogers for monitoring, however, Dr. Pace had him discharged from MRMC back to the jail.

72. Mr. Rogers was discharged from MRMC at approximately 6:10 AM and returned to the jail at approximately 6:30 AM.

73. At approximately 7:30 AM, Rogers told detainees in his cell that he thought he had a nosebleed.

74. Fellow detainees activated the cell's alert system, and Defendant Guise came to Mr. Rogers's cell.

75. Mr. Rogers told Defendant Guise that he was having trouble breathing, and that he felt as though there was something in his throat.

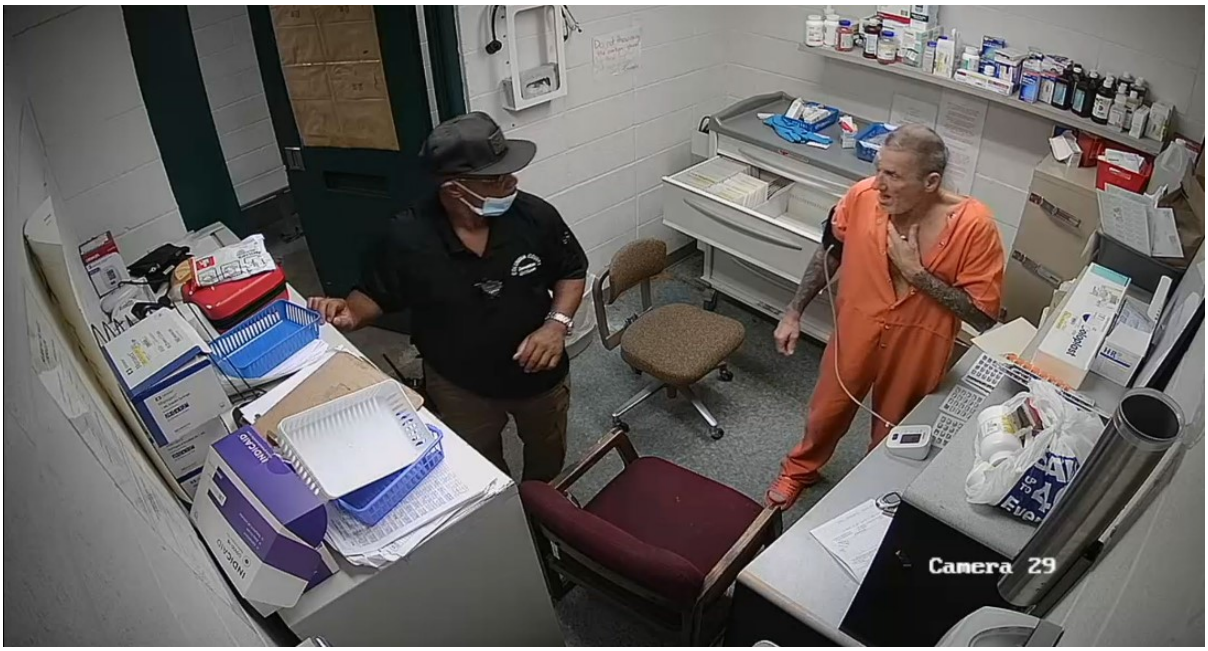
76. At this time, there were no medical staff onsite at the jail.

77. Defendants Guise and Moseley took Mr. Rogers to the jail's medical room. He was coughing and wheezing, and he began to spit mucus into the trash can. His nose was running, and he was sweating profusely.

78. During this time Guise and Moseley took Mr. Rogers' blood pressure, but did nothing with the blood pressure reading.

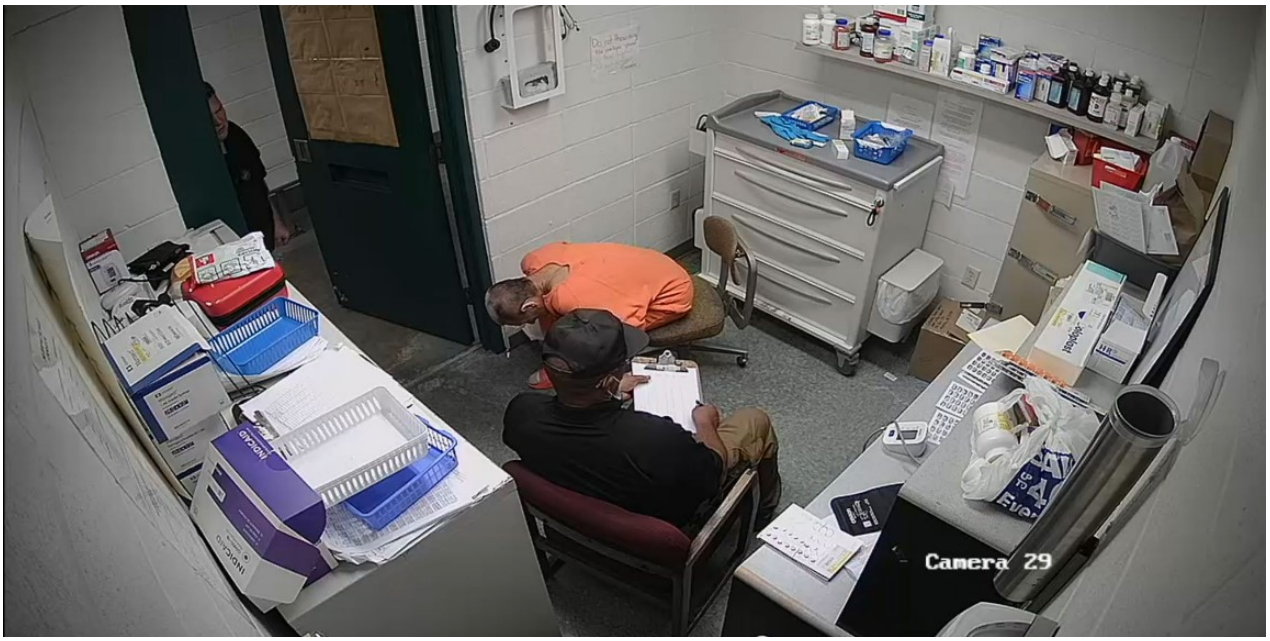
79. During this time both Mr. Rogers' blood pressure and his heart rate were elevated.

80. Meanwhile, Mr. Rogers was under such physical distress that he got up, removed the blood pressure cuff, and began pacing in and out of the medical room, clutching his chest:



81. Neither Guise nor Mosely called 911 or attempted to contact medical personnel.

82. For the ten minutes they watched Mr. Rogers cough, wheeze, and spit up into the trash can for approximately. Mr. Rogers was displaying such distress that he doubled over:



83. Approximately 10 minutes later, Defendant Rose arrived.

84. Mr. Rogers was still in obvious medical distress, and continued to clutch his chest. But Defendant Rose, too, did not call an ambulance.

85. Mr. Rogers told Rose that he had had a heart attack in April.

86. Mr. Rogers told Rose that he thought he was having another heart attack.

87. At approximately 7:41 AM, Rose texted Defendant Hulet: "Got Mr Rogers back. He's wheezing, saying he can't breathe. He thinks he's having a hear attack."

88. Hulet then called Rose. He did not instruct her to call for an ambulance.

89. Instead, Hulet instructed Rose to contact Defendant Nurse Cassandra, the on-call nurse, because Elkins was out that week.

90. Hulet also told Rose to give Rogers his nitroglycerin pills.

91. But Hulet did not give Rose permission to request an ambulance, call 911, or have Rogers transported to the hospital.

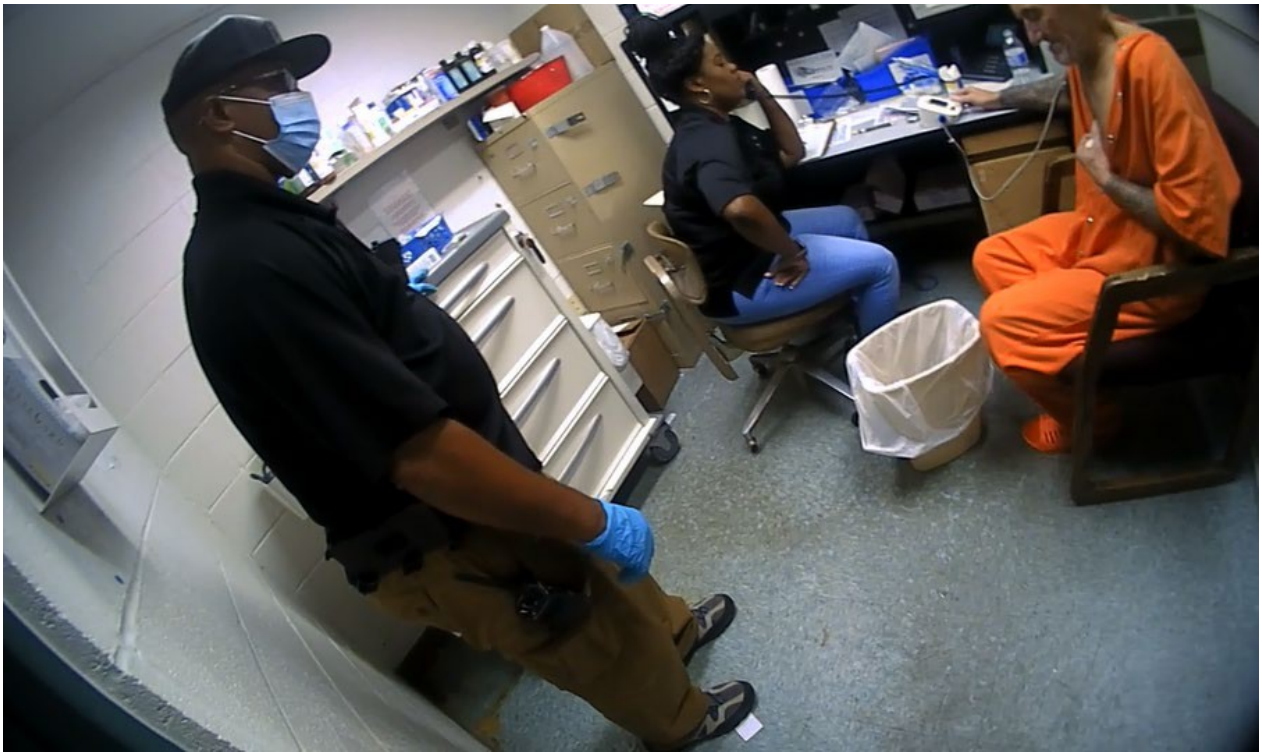
92. The medical office was disorganized, and medications were difficult to find.

93. Rose could not find Rogers prescribed nitroglycerin pills and instead gave him two aspirin.

94. When Rose attempted to call Nurse Cassandra, she did not answer.

95. But Rose did not then call 911. Instead she waited for Nurse Cassandra to call back.

96. All the while, Mr. Rogers continued to clutch his chest and was bent over in obvious distress:



97. For approximately the next 15 minutes, Rogers continued to cough, gasp for air, wheeze, and clutch his chest.

98. Neither Rose, Hulet, Guise, or Moseley tried again to contact the on-call RN, or summon an ambulance, or administer additional medication during that time.

99. None of the defendants called for an ambulance until approximately 25 to 30 minutes after Rogers arrived in the jail's medical room.

100. At approximately 7:57 AM, Mr. Rogers yelled that he could not breathe and fell to the floor, while Rose, Guise, and Moseley still waited, doing nothing:

101. Finally, around 8:00 AM, Rose contacted Hulet again and got Hulet's permission to contact the ambulance.

102. Only then Rose summon an ambulance.

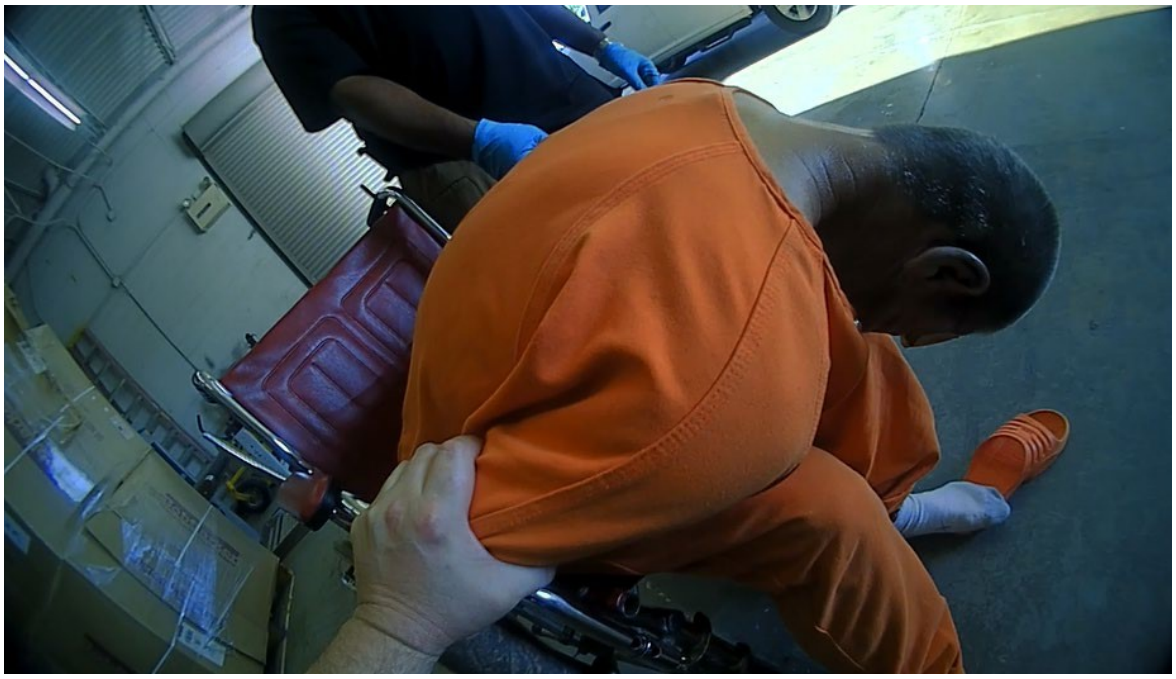
103. At approximately 8:00 AM, Guise and Moseley lifted Rogers into a wheelchair to take him to the jail's loading dock and await the ambulance.

104. At this point Rogers' tongue was hanging outside his mouth, and he was wheezing and gasping for air.

105. Rose and Moseley handcuffed Mr. Rogers at the ankles.

106. The ambulance arrived just after 8:10 AM.

107. By this time, Mr. Rogers was going into cardiac arrest.



108. The ambulance spent approximately seven minutes at the jail while paramedics attempted to revive Mr. Rogers.

109. The ambulance then took Mr. Rogers to the MRMC Emergency Room.

110. En route to the hospital, Mr. Rogers was drooling and largely unresponsive to stimuli. EMTs advised dispatch that he would be arriving in "code blue."

111. Mr. Rogers arrived at MRMC at approximately 8:24 AM. He could not be revived and was pronounced dead shortly thereafter.

112. At 8:44 AM, Nurse Cassandra returned Defendant Rose's call.

COUNT I
42 U.S.C. § 1983
(HULET, ROSE, GUISE, MORSELY, ELKINS, NURSE CASSANDRA)

113. Plaintiff hereby incorporates and realleges each and every preceding paragraph in this Complaint as if set for in full herein.

114. Each of the defendants was aware Mr. Rogers had a serious medical condition calling for adequate medical attention.

115. Despite this knowledge, each of the defendants acted unreasonably and with deliberate indifference to Mr. Rogers's serious medical needs when they failed to consistently provide him with his prescriptions, ignored his clear request for help managing his symptoms, and failed to call for appropriate outside medical care the morning of his death.

116. Each of the defendants engaged in this misconduct and these omissions despite their knowledge that Mr. Rogers exhibited symptoms of a serious medical need.

117. The acts and omissions of the Defendants to this claim were contributing proximate causes of Mr. Rogers's injuries, pain, and death.

118. Plaintiff is entitled to attorney's fees and costs pursuant to 42 U.S.C. § 1983, as well as pre-judgment interest, post-judgment interest, and costs as allowable by federal law.

COUNT II
42 U.S.C. § 1983
(COLUMBIA COUNTY, CFHA, LOE, HULET, ELKINS)

119. Plaintiff hereby incorporates and realleges each and every preceding paragraph in this Complaint as if set for in full herein.

120. The inadequate medical care that led to Mr. Rogers' death was the proximate cause of the policies and widespread practices of Columbia County and CFHA regarding the provision of medical care to people detained at the CCDC.

121. Specifically, there exist policies and widespread practices within the CCDC pursuant to which detainees receive unconstitutionally inadequate healthcare, including policies and practices pursuant to which (1) staff commonly disregard reports by patients of objectively serious medical needs; (2) staff refuse to provide or obtain adequate treatment to detainees complaining of serious medical conditions or in need of medications; (3) employees prioritize cost-saving at the expense of constitutionally adequate care; (4) inadequate levels of health care

staffing are provided, including inadequately qualified staff; (5) staff fail or refuse to arrange for prisoners to be treated in outside facilities, even when an outside referral is necessary or proper; and (6) correctional staff take on medical decision-making while lacking training or qualifications to do so.

122. The foregoing policies and practices are manifested in multiple ways, including the following:

123. The CCDC lacks policies to ensure the prompt and consistent filling of medical prescriptions.

124. The CCDC permits its medical unit to fall into disarray, leading to a disorganized office in which medications and medical supplies cannot be located in a timely manner.

125. CCDC jail staff engage in medical decision-making, even though they lack the qualifications to do so.

126. It is the policy at CCDC that jail staff may not call an ambulance or obtain emergency medical assistance for a jail detainee without the approval of an administrative supervisor, even when a detainee is in apparent medical distress.

127. This policy exists even though the jail does not require administrative supervisors to have training sufficient to determine whether a person who is in apparent medical distress requires emergency medical attention.

128. The CCDC lacks a policy permitting CCDC staff to call for an ambulance or obtain emergency medical assistance for a jail detainee without the approval of an administrative supervisor when a detainee is in apparent medical distress.

129. This policy gap exists even though the jail does not require administrative supervisors to have training sufficient to determine whether a person who is in apparent medical distress requires emergency medical attention.

130. It is the policy at CCDC that jail staff may not call an ambulance or obtain emergency medical assistance for a jail detainee without the approval of a CFHA medical provider, even when a detainee is exhibiting obvious symptoms of a medical emergency.

131. The CCDC lacks a policy permitting CCDC staff to call for an ambulance or obtain emergency medical assistance for a jail detainee without the approval of a CFHA medical provider when a detainee is in apparent medical distress.

132. At the same time, CCDC lacks a policy to ensure that a person onsite at the jail has authority to summon emergency medical assistance.

133. And the CCDC lacks a policy for summoning emergency assistance if a CFHA medical provider is not immediately available for consultation.

134. These policies needlessly endanger people detained at the jail, like Mr. Rogers, who have emergent medical needs.

135. The foregoing policies and practices were allowed to flourish because Defendants Columbia County, CFHA, Elkins, Loe, and Hulet were indifferent to them. These same defendants directly encouraged the very type of misconduct at issue in this case, failed to provide adequate training and supervision of healthcare and correctional employees, and failed to adequately punish and discipline prior instances of similar misconduct.

136. In this way, the same defendants violated the rights of Mr. Rogers by maintaining policies and practices that were the moving force driving the foregoing constitutional violations.

The above-described policies and practices were able to exist and thrive because these same defendants were deliberately indifferent to the problem, thereby effectively ratifying it.

137. These policies and practices were the moving force behind Mr. Rogers's injuries and his death.

138. These Defendants maintain a policy and practice regarding treatment of detainees displaying symptoms of serious medical emergencies that includes denying appropriate medical care to detainees as a cost-saving measure.

139. These policies and practices were the result, among other things, of cost-cutting measures that these defendants put into place and allowed to persist, even though they needlessly endangered people detained at the CCDC, like Mr. Rogers.

140. The acts and omissions of the Defendants as described herein deprived Plaintiff of his constitutional rights and were contributing proximate causes of his injuries and death.

141. Plaintiff is entitled to attorney's fees and costs pursuant to 42 U.S.C. § 1983, as well as pre-judgment interest and costs as allowable by federal law.

COUNT III
ARKANSAS STATE CONSTITUTION ART 2 § 21 - DUE PROCESS
(COUNTY and CFHA DEFENDANTS)

1. Plaintiff hereby incorporates and realleges each and every preceding paragraph in this Complaint as if set for in full herein.

2. Due to his long documented medical history of a series of serious medical conditions, including heart complications, diabetes, and other co-morbidities, Rogers had a serious need for his medications and other medical treatment.

3. Defendants were on notice of Rogers' medical conditions. Throughout his time at CCDC, Rogers repeatedly notified Defendants that he was without his necessary medications

and was left unable to manage his medical needs. His conditions had been diagnosed and treated by physicians before his incarceration, and Defendants ignored his prescribed treatment plans.

4. Each of the Defendants to this claim acted with deliberate indifference to Plaintiff's serious medical needs when they failed to consistently provide him with his prescriptions, ignored his clear request for help managing his symptoms, and failed to call for appropriate outside medical care the morning of his death.

5. Each of the Defendants to this claim engaged in this misconduct and these omissions despite their knowledge of Rogers' series medical conditions and obvious symptoms of a cardiac event.

6. None of the Defendants to this claim are entitled to qualified immunity.

7. Each of the Defendants to this claim is liable to Plaintiff under Arkansas State Constitution Art 2 § 21.

8. The acts and omissions of the Defendants to this claim as described herein deprived Plaintiff of his constitutional rights directly caused his injuries and death.

COUNT IV
AR Code § 16-114-203 MEDICAL MALPRACTICE
(ELKINS, CASSANDRA, CHFA, BRAZELL, PACE, MRMC, ESS, SAMARAWICKRAMA,RADIOLOGY ASSOCIATES, HULET, ROSE, GUISE, MORSELY, COLUMBIA COUNTY, COLUMBIA COUNTY SHERIFF'S OFFICE)

9. Plaintiff hereby incorporates and realleges each and every preceding paragraph in this Complaint as if set for in full herein.

10. The defendants undertook to provide medical care for Randy Rogers.

11. The defendants owed Mr. Rogers a duty to provide medical care consistent with the standard of care.

12. The defendants breached their duty to provide medical care consistent with the standard of care.

13. As a result of Defendants' failure to provide Plaintiff with the appropriate standard of care, Plaintiff suffered injuries and he died.

COUNT V
INTENTIONAL INFLICTION OF EMOTIONAL DISTRESS
(HULET, ROSE, MORSLEY, GUISE, COLUMBIA COUNTY, COLUMBIA COUNTY SHERIFF'S OFFICE)

14. Plaintiff hereby incorporates and realleges each and every preceding paragraph in this Complaint as if set for in full herein.

15. Defendants intentionally and knowingly inflicted emotional distress on Rogers.

16. Through repeated complaints, Plaintiff put Defendants on notice of the medication and diet he was supposed to receive as prescribed by medical professionals and the dire impact of being deprived of these on his physical and emotional wellbeing.

17. Defendants knew the required medications and diet Rogers was supposed to receive and still did not furnish Rogers with the necessary medications and treatment.

18. Defendants' delay in providing Rogers with the medical attention he required forced him to suffer extreme emotional distress as he was experiencing a cardiac and respiratory episode with little provided care.

19. Defendants' delay in calling the ambulance forced Rogers to suffer extreme pain and emotional distress as he was given no clear communication as to when he would receive medical care and was given no meaningful care and was shackled as he awaited the ambulance.

20. The emotional distress that Rogers experienced as he was deprived of the necessary medication and treatment for months while he was detained resulted in emotional distress that no reasonable person should be expected to endure.

21. The agony that Rogers experienced as he waited for medical attention while experiencing a cardiac and respiratory episode resulted in emotional distress that no reasonable person should be expected to endure.

COUNT VI
WRONGFUL DEATH SURVIVAL
(ALL DEFENDANTS)

1. Plaintiff hereby incorporates and realleges each and every preceding paragraph in this Complaint as if set for in full herein.

2. As a direct result of Defendants' failure to provide Rogers with the appropriate medical care and treatment throughout his detention at CCDC, Rogers suffered physically and emotionally and met his eventual death.

3. Mr. Rogers suffered physically and emotionally when he was both deprived of care and provided with inadequate care following his head injury and subsequent cardiac and respiratory episode.

4. Mr. Rogers was a father, brother, and loving partner, and the loss of his life has a substantial impact on those who loved him.

5. Plaintiff, as Administrator of the Estate of Randy J. Rogers, and on her own behalf, brings this claim for wrongful death.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff, RANDY DEWAYNE ROGERS, as administrator of the Estate of RANDY JAMES ROGERS and on his own behalf, respectfully requests that this Court enter judgment in his favor, awarding compensatory damages, attorneys' fees, and costs against each Defendant, and punitive damages against each of the Defendants (with the exception of

Columbia County and the Columbia County Sheriff's Office), as well as any other relief this Court deems appropriate.

JURY DEMAND

Plaintiff demands a trial by jury pursuant to Federal Rule of Civil Procedure 38(b) on all issues so triable.

Dated: June 13, 2024

/s/
Alison Lee

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