UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF LOUISIANA

MARGARET GOETZEE NAGLE and JOHN ERIC GOETZEE	*	CIVIL ACTION
	*	NUMBER:
VERSUS	*	SECTION: 12-1910
SHERIFF MARLIN GUSMAN, DR. SAMUEL GORE, DR. CHARLES "MIKE" HIGGINS,	*	JUDGE: SECT. R MAG. 2
DR. JOSE HAM, MARY ANNE BENITEZ, DARRYL JACKSON, LPN WALLACE, S. PEMBO, S. BATISTE,	*	MAGISTRATE:
DAVID SCHAIBLE, E. BARGKY, C. JOHNSON, FNP, WARDEN CARLOS LOUQUE, HOD WATCH COMMANDERS JOHN	*	CIVIL RIGHTS
DOES I and II, SGT. NICOLE HARRIS, SGT EVERETT MARSHALL, DEPUTY WILLIAM THOMPSON,	*	
DEPUTY MICHAEL WILLIAMS and DEPUTY SHELIA CRADER	*	JURY TRIAL DEMANDED

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COMPLAINT

I. INTRODUCTION

1. This case involves the tragic death on August 7, 2011 of U.S. Coast Guard Commander William ("Bill") Goetzee, a 48-year-old federal career civilian

employee of the U.S. Coast Guard and active member and Commander of the U.S. Coast Guard Reserves, who, while working in highly responsible and high-stress positions with the Coast Guard, including duties related to the BP oil spill, experienced a profound mental health crisis and breakdown. This breakdown manifested in a desperate attempt by Commander Goetzee to commit suicide on August 2, 2011 by attempting to grab the gun of a federal protective officer in order to kill himself. As a result of this dire crisis, Commander Goetzee was arrested, transported and placed in the custody of the defendants, all of whom had responsibility for his care and safety in his time of need.

2. Instead of providing adequate, appropriate and necessary care and treatment to Commander Goetzee, the defendants failed in their professional duties and their legal obligations. Commander Goetzee was treated by the defendants in a callous, harsh and indifferent manner, resulting in his death by suicide in a barren cell on the tenth floor "mental health" unit of the House of Detention (HOD), an outmoded, dangerous and completely inadequate facility which, at all relevant times, was a critical part of the Orleans Parish Prison (OPP) complex and which was not a reasonable accommodation for a person suffering from Mr. Goetzee's illness and disability and in his condition. The OPP complex was operated and supervised by the Orleans Parish Sheriff's Office (OPSO), under the leadership of Sheriff Marlin Gusman, at all relevant times.

3. Commander Goetzee was not properly diagnosed, treated or cared for

while in the custody of the defendants. He was denied appropriate and necessary medical, psychiatric, nursing and therapeutic care, treatment and supervision. Instead, he was confined in a hostile, barren and isolated environment that exacerbated and aggravated his condition, which was fragile and precarious to begin with. Defendants and their staff provided Commander Goetzee with access to materials to harm himself while in an acute state of emotional and psychological crisis. The mistreatment of Commander Goetzee by the defendants and their staff in this facility was in contravention of the community standard of care and violated applicable federal and state constitutional and statutory standards.

4. The defendants' actions and omissions, manifested in inadequate medical screening and intake, inadequate staffing, inadequate training and supervision of staff, inadequate facilities, inadequate policies and procedures relating to diagnosis and treatment of mentally ill and suicidal persons in custody, as well as inadequate care, treatment, and monitoring of Commander Goetzee, were directly and causally related to Commander Goetzee's death.

5. For too many years there have been numerous other similar, avoidable, unnecessary and unconscionable injuries, sufferings and deaths of prisoners in the custody of the Orleans Parish Sheriff's Office related to the denial of adequate medical care, inadequate supervision and training of staff, and lack of reasonable accommodations for individuals with disabilities, mental illness in particular. The instant case represents yet another instance of a shocking degree of callous and inexcusable

disregard for the serious medical needs of a prisoner at OPP, in this instance, Commander Goetzee, by those very persons who were responsible for his care.

II. JURISDICTION

6. This action is brought pursuant to 42 U.S.C. 1983, pursuant to the First, Fourth, and Fourteenth Amendments to the United States Constitution, Section 504 of the Rehabilitation Act of 1973 which authorizes actions to redress discrimination based on disability and handicap, Title II of the Americans with Disabilities Act of 1990, 42 USC 12131, 42 USC 1988 and 42 USC 12205, et seq. Jurisdiction is founded on 28 U.S.C. Sections 1331 and 1343 and the aforementioned statutory and constitutional provisions. Plaintiff further invokes the pendant jurisdiction of this Court to consider claims arising under state law pursuant to 28 USC Section 1367. A jury trial is requested.

III. PARTY PLAINTIFF

7. Margaret Goetzee Nagle is the sister and John Eric Goetzee is the brother of William "Bill" Goetzee, who died while under the custody and care of the defendants as further described herein. Margaret Nagle is a person of the full age of majority, who resides in Scotch Plains, New Jersey. John Eric Goetzee is a person of the full age of majority, who resides in Winfield Park, New Jersey. At the time of his death, William "Bill" Goetzee was unmarried, had no children and was pre-deceased by both of his parents. He was a resident of LaPlace, Louisiana.

IV. PARTY DEFENDANTS

8. Defendant Sheriff Marlin Gusman was Sheriff of Orleans Parish at all times described herein, and, as such, is responsible for the hiring, training, supervision, discipline and control of the employees of the OPSO, including medical and correctional staff. He is also responsible for the supervision, administration, policies, practices, customs and operations of the OPSO and its correctional facilities. He is a final policymaker. He is liable both directly and vicariously for the actions complained of herein. He is sued in his individual and in his official capacity for those acts and omissions, which occurred while he was Sheriff. As Sheriff of Orleans Parish, defendant Sheriff Gusman accepts federal funds and is charged with providing custodial care to prisoners in custody of the Orleans Parish jail and directed all medical providers in the care of William Goetzee, deceased. He is a person of the full age of majority and, on information and belief, a resident of the Eastern District of Louisiana.

9. Defendant Dr. Samuel Gore is the Medical Director of the Orleans Parish Sheriff's Office and is an employee of the OPSO. At all pertinent times herein, he was responsible for the provision of medical care and health care services for persons incarcerated in OPSO facilities, both directly and as a supervisor. He was responsible for recommending and hiring qualified health care professionals and staff, insuring adequate staffing for the medical needs of prisoners, for the supervision, training, discipline and oversight of personnel and provision of medical services at OPSO correctional facilities and was responsible to insure access and provision of reasonable

and adequate health care for persons in custody at the jail. He is responsible for supervising the development and revision of policies, procedures, and protocols concerning the delivery of medical and mental health services at the jail. He is also responsible for monitoring compliance with all health services policies, procedures and protocols. He negotiates and monitors contracts with outside agencies involved in providing health care services to persons in custody of the OPSO. All matters of medical and mental health judgment are the sole province of the Medical Director. He is a final policymaker with regard to the provision of medical and psychiatric services to persons in the custody of the OPSO. He was responsible for the direction, supervision and discipline of the medical/psychiatric defendants named herein as well as medical/security co-ordination and training and supervision of correctional employees in health-related matters. He is sued in his individual and official capacity. He is a person of full age of majority and, on information and belief, is a resident of the Eastern District of Louisiana.

10. Defendant Dr. Michael Higgins is the Mental Health Director for OPP and is an employee of the OPSO. At all pertinent times herein, he was responsible for the provision of psychiatric services for persons incarcerated in OPSO facilities, both directly and as a supervisor. He was responsible for recommending and hiring qualified mental health care professionals and staff, insuring adequate staffing for the medical needs of prisoners, for the supervision, training, discipline and oversight of personnel and provision of mental health services at OPSO correctional facilities, and was

responsible to insure access and provision of reasonable and adequate health care for persons in custody at the jail. He is responsible for supervising the development and revision of policies, procedures, and protocols concerning the delivery of mental health services at the jail. He is also responsible for monitoring compliance with all health services policies, procedures and protocols. He negotiates and monitors contracts with outside agencies involved in providing health care services to persons in custody of the OPSO. All matters of mental health judgment are within his duties as Mental Health Director. He is a final policymaker with regard to the provision of medical and psychiatric services to persons in the custody of the OPSO. He was responsible for the direction, supervision and discipline of the medical/psychiatric defendants named herein as well as medical/security co-ordination and training and supervision of correctional employees in health-related matters. He is sued in his individual and official capacity. He is a person of full age and majority and, on information and belief, is a resident of the Eastern District of Louisiana.

11. Defendant Mary Anne Benitez performed duties relating to health services administration for the OPSO, at all pertinent times herein, and was responsible for assisting with supervising daily administrative operations within the department including quality control, review of medical records, establishing and maintaining functional information systems within the medical department and between medical and security personnel. She was also responsible for oversight, training and supervision of medical employees and health care training for correctional officers, as well as

coordination between medical and security personnel. She was responsible for insuring the provision and adequacy of care and safety of William Goetzee at the time of Mr. Goetzee's incarceration and death. She was responsible for insuring that appropriate and adequate medical, psychiatric and nursing care was given to persons at risk for suicide in the custody of the OPSO. She is sued in her individual and official capacity. She is a person of the full age of majority and, on information and belief, is a resident of the Eastern District of Louisiana.

12. Defendant Dwayne Johnson was the Director of Nursing (DON) for the OPSO at all pertinent times herein and as such was responsible for hiring, training, supervision, discipline and co-ordination of nursing services, including co-ordinating physician/nursing sick call and follow-up care, staffing and implementation of appropriate nursing standards and procedures. He was responsible for insuring that appropriate and adequate nursing care was given to persons at risk for suicide at OPP including intake procedures and those being held on HOD-10 at OPP.

13. Defendant Dr. Jose Ham is a medical doctor employed by OPSO, who was the Health Services Administrator at all pertinent times herein, and was responsible for assisting with supervising daily administrative operations within the department including quality control, review of medical records, establishing and maintaining functional information systems within the medical department and between medical and security personnel. He was also responsible for oversight, training and supervision of medical employees and health care training for correctional officers, as well as

coordination between medical and security personnel. On information and belief, he was responsible for co-ordinating the medical care for Mr. Goetzee and assisted in the care and treatment of Mr. Goetzee. He was responsible for insuring that appropriate and adequate medical, psychiatric and nursing care was given to persons at risk for suicide in the custody of the OPSO. At all pertinent times herein he was responsible for providing appropriate and adequate medical care to persons in custody of the OPSO, including William Goetzee. He had supervisory responsibilities over other medical staff as well as correctional officers and medically trained personnel who had responsibilities related to patient care. He also was responsible for reviewing charts and doing quality control regarding the standards and practices of the Medical Department at OPP. He is sued in his individual and official capacity. He is a person of the full age of majority and, on information and belief, is a resident of the Eastern District of Louisiana.

14. Defendant Dr. Marcus Dileo is a medical doctor employed by OPSO, who provided medical services to William Goetzee. At all pertinent times herein he was responsible for providing appropriate and adequate medical care to persons in custody of the OPSO, including William Goetzee. He was responsible for medical care and treatment of William Goetzee as described herein. He had supervisory responsibilities over other medical staff as well as correctional officers and medically trained personnel who had responsibilities related to patient care. He is sued in his individual and official capacity. He is a person of the full age of majority and, on information and belief, is a resident of the Eastern District of Louisiana.

15. Defendant LPN Wallace was an employee of the OPSO in the position of Licensed Practical Nurse (LPN) and at all pertinent times herein, was responsible for providing reasonable and adequate medical care to persons held in the custody of the OPSO and in particular, in medical screening, evaluation and care of individuals as they were booked into the jail. She was directly involved in the screening, evaluation and care of William Goetzee as described herein. She is sued in her individual and official capacity. She is a person of the full age of majority and, on information and belief, is a resident of the Eastern District of Louisiana.

16. Defendant C. Johnson, FNP was an employee of the OPSO in the position of Nurse Practitioner (FNP) and at all pertinent times herein, was responsible for providing appropriate and adequate medical care to persons held in the custody of the OPSO. She had direct involvement in the evaluation and care of William Goetzee as described herein. She had supervisory responsibilities regarding other medical personnel employed by the OPSO, including Licensed Practical Nurses (LPN) and Medical Assistants (MA). She is sued in his individual and official capacity. She is a person of the full age of majority and, on information and belief, is a resident of the Eastern District of Louisiana.

17. Defendants S. Pembo, S. Batiste, David Schaible, and E Bargky were each employees of the OPSO, licensed and employed as LPNs, at all pertinent times herein, and were responsible for providing appropriate and adequate nursing care, including documentation and paperwork necessary for continuity of care of persons in

the custody of the OPSO, including assessing and monitoring the medical and psychiatric condition, health and safety of William Goetzee and providing appropriate and adequate nursing care and assessments for him, with proper documentation of same. Defendants Pembo, Batiste, Schaible and Bargky had the authority and responsibility to monitor and make regular and periodic checks relative to William Goetzee's physical and mental status, including the duty to insure that he was in a safe, appropriate environment and that he was not held in conditions that would exacerbate or worsen his medical and mental conditions. These defendants are sued in their individual and official capacities. These defendants are persons of the full age of majority, and on information and belief, are residents of the Eastern District of Louisiana.

18. Defendant Carlos Louque was employed by the OPSO as Warden of HOD where William Goetzee was held, and at all pertinent times was responsible for training, supervising, monitoring and disciplining OPSO deputies at HOD, including those named as defendants herein and overseeing the security and well-being of persons held on HOD-10. He was also responsible for co-ordination between security officers and medical personnel regarding prisoners in need of medical care, including William Goetzee. He is sued in his individual and official capacity. He is a person of the full age of majority and, on information and belief, he is a resident of the Eastern District of Louisiana.

19. Defendants HOD Watch Commanders on Duty August 5-7, 2011 John Does I and II were employed by the OPSO as Watch Commanders of HOD where William Goetzee was held, and at all pertinent times were responsible for training, supervising, monitoring and disciplining of OPSO deputies, including those named as defendants herein and overseeing the security and well-being of persons held on HOD-10. These Watch Commanders were also responsible for co-ordination between security officers and medical personnel regarding prisoners in need of medical care, including William Goetzee. They are each sued in their individual and official capacity. They are each persons of the full age of majority and, on information and belief, are each residents of the Eastern District of Louisiana.

20. Defendants Sgt. Everett Marshall and Sgt. Nicole Harris were each employed by the OPSO as correctional officers and were each supervisors, assigned to the House of Detention (HOD) of the Orleans Parish jail. At all pertinent times herein each defendant supervisor was responsible for observing and communicating reported or obvious medical needs of prisoners, including William Goetzee, to medical staff and for properly supervising, monitoring, training and overseeing the proper job performance of OPSO employees under their supervision, including the defendant deputies in this matter. Each was responsible for monitoring, checking on, and supervising the condition of William Goetzee, and those employees responsible for his care and safety, while Mr. Goetzee was held at HOD, and for insuring that Mr. Goetzee was in a safe environment and was being properly monitored. They were each responsible for

insuring that proper documentation was done for the observation of Mr. Goetzee on "suicide watch", as well as being responsible for the supervision and training of defendant deputies, both named and unnamed, who had responsibilities relative to the care and custody of William Goetzee. They are each persons of the full age of majority and, on information and belief, are each residents of the Eastern District of Louisiana. They are each sued in their official and individual capacities.

21. Defendants OPSO Deputies William Thompson, Michael Williams and Shelia Crader were all employed by the OPSO as correctional officers. At all pertinent times herein they were each responsible for insuring that there was appropriate and constant monitoring of William Goetzee while he was on "suicide watch" and of communicating reported or obvious medical needs of prisoners, including William Goetzee to appropriate persons. They were responsible for monitoring, checking on, and supervising the condition of William Goetzee as described herein. They each also had the duty to report and to intervene if and when they became aware that other deputies or employees of the OPSO were not properly performing their duties relative to William Goetzee. They are each sued in their official and individual capacities. They are each of full age of majority and, on information and belief, they are each residents of the Eastern District of Louisiana.

V. STATEMENT OF FACTS

22. On Tuesday, August 2, 2011, William ("Bill") Goetzee, a 48- year- old civilian employee and Commander, U.S. Coast Guard Reserves, experienced a severe

mental breakdown during which time he attempted to commit suicide by trying to grab a gun from a federal protective officer in order to kill himself. Commander Goetzee had been on extended sick leave as a result of an automobile accident in June, 2011, where he was injured. He had been suffering from symptoms from extreme exhaustion, chronic insomnia, stress, and mental illness, which had seriously impacted his ability to function properly. He was treated in an emergency room with prednisone for injuries from the accident, which resulted in an episode of "prednisone induced psychosis" which required in-patient treatment in a local mental health facility. He was under physician's care and was being treated for depression, chronic insomnia and other manifestations of mental illness. He was still under treatment and in a state of physical and mental exhaustion and illness, when he returned to work on August 2, 2011 and tried to kill himself outside the federal courthouse.

23. After he was subdued by federal agents, Mr. Goetzee was taken by ambulance to Tulane Medical Center (TMC), where he was treated for physical injuries, including contusions to his forehead, related to his scuffle with the federal officers. It was clear that Mr. Goetzee was attempting to harm himself, not the federal officer. At TMC Mr. Goetzee was treated for his physical injuries but he was not evaluated by a psychiatrist nor did he receive appropriate mental health care. Instead, he was released by TMC. Preparations were being made by his fiancée to transport him to East Jefferson hospital, which has an in-patient psychiatric unit, for appropriate medical and psychiatric care. However, en route to East Jefferson, Mr. Goetzee was stopped and

arrested by federal agents who took him to the Orleans Parish Prison, operated by defendant Sheriff Marlin Gusman and the Orleans Parish Sheriff's Office. This facility housed federal prisoners in the custody of the U.S. Marshall's Office, which was Mr. Goetzee's status when he arrived at the jail.

24. Upon arrival at the Intake and Processing Center (IPC) of the Orleans Parish Prison, Mr. Goetzee was seriously mentally ill, suicidal, and in need of medical and psychiatric care in an appropriate setting, which the OPP could not provide. Instead of referring Mr. Goetzee for appropriate medical care, Mr. Goetzee was booked into the jail. As part of that process, defendant LPN Wallace conducted the OPSO Medical Intake Screening, which is used to determine the medical status and appropriate housing for arrestees.

25. Defendant LPN Wallace failed to adequately assess, evaluate or document Mr. Goetzee's serious medical condition, failed to provide adequate medical care or treatment for him, failed to adequately or properly record or report his condition, or to properly alert other medical and correctional personnel so as to insure that Mr. Goetzee would receive adequate medical care for his serious medical needs.

26. The medical intake screening questionnaire has two sections, one for visual observations by medical intake screening personnel and the other involving "questions for all inmates". The intake form specifically requires the intake screener to note any obvious injury, including wounds, on the arrested subject. Defendant LPN Wallace failed to note that Mr. Goetzee had contusions on his forehead which had been

documented at Tulane Medical Center earlier that afternoon, injuries resulting from his efforts to kill himself that morning.

27. In response to the question, "Does the inmate "appear despondent or depressed or voice suicidal ideation?" defendant LPN Wallace marked "N" for "No". Yet in the sections where the arrestee is asked to respond to questions, in response to the questions "Are you currently taking any medications including medications for mental illness or bad nerves?" defendant Wallace noted "states takes and (sic) anti-anxiety name unk". In response to the question "How are you feeling right now" defendant LPN Wallace noted : "OK", yet in response to the following question "Do you have any mental health problems or have you been under the care of a psychiatrist within the last year?" the following is noted: "Yes. River Oaks 6/11 states have racing thoughts, mind reading manic thoughts." River Oaks is a well-known mental health clinic and in-patient treatment facility. When asked "have you recently thought about hurting or killing yourself?" the response was recorded as "Yes. This AM last suicide thought". When asked if he had "ever tried" to commit suicide, the response is recorded as "No". When asked "do you feel like you might hurt someone else now" the response is recorded as "No." Mr. Goetzee is not asked whether he felt like he might want to hurt himself now, a logical question in light of his admission that he had suicidal thoughts that morning, as well as "racing thoughts, mind reading, manic thoughts." Defendant LPN Wallace reported that Mr. Goetzee "denies any S.I. or H.I." which is obviously contradicted by his own admission to suicidal thoughts that same morning. Defendant LPN Wallace cleared

Mr. Goetzee for "general population" while also recommending "contact psychiatrist for disposition". There is no record that defendant LPN Wallace followed up or that any psychiatrist was ever contacted or saw Mr. Goetzee to assess his condition or the appropriateness of his admission to the jail or the adequacy of the jail's facilities and staff to provide appropriate care and reasonable accommodation for his condition. On information and belief, defendant LPN Wallace had the authority to request an immediate physical and mental examination of Mr. Wallace by appropriately trained medical personnel, which she failed to do.

28. In addition, there is no indication that vital signs were taken or that any physician or other appropriately trained medical personnel conducted a physical examination of Mr. Goetzee at any time during the booking process or while he was being admitted to the jail, to determine whether he was in adequate physical or mental condition for admission to the jail. On information and belief, no assessment was made to determine whether his condition required hospitalization or whether he should be assigned to any infirmary or specialized medical or mental health unit within the jail for treatment and/or observation. Defendant LPN Wallace didn't even refer him for the next psychiatric or medical sick call. No steps were taken to obtain further information regarding his medications or to contact River Oaks.

29. The Medical Intake Screening form itself was inadequate and failed to provide for pertinent questions regarding mental and physical health of arrestees or suicidality. Defendant LPN Wallace failed to take appropriate or necessary steps to

properly screen, evaluate or refer Mr. Goetzee for psychiatric evaluation, diagnosis or treatment. Defendant LPN Wallace failed to properly or adequately address Mr. Goetzee's report of recent suicidal thoughts, his need for medication, or his obvious physical injury. Defendant LPN Wallace was aware, must have been aware, or should have been aware, that Mr. Goetzee was psychologically fragile, required psychiatric evaluation, intervention and review of his medication status, yet failed to take appropriate steps to insure that would occur.

30. Despite Mr. Goetzee's condition, defendant LPN Wallace referred Mr. Goetzee for housing in "general population". Defendant LPN Wallace knew, must have known or should have known, at Mr. Goetzee was at high risk of serious harm due to his disability and his medical condition and that the jail lacked adequate and appropriately trained staff and facilities to properly tend to Mr. Goetzee's medical needs or to provide reasonable accommodations for his disabilities. Yet she failed to take necessary and appropriate steps to insure that he was either referred to a hospital for treatment or for medical clearance as to the appropriateness of housing him at the jail, or, if to be admitted to the jail, that he was adequately and reasonably examined, housed and treated and afforded reasonable accommodation for his disability and his condition.

31. Mr. Goetzee was booked into OPP and taken to Templeman V, the "federal tier". The following morning he appeared in federal court for a first appearance hearing. His medical and psychiatric condition had deteriorated overnight and he was

delusional, combative, disoriented and non-responsive. He had to be physically restrained in a wheelchair. At some point he was tased. He had spent the night in the jail with no medical treatment, no medication and no appropriate intervention or accommodation for his condition, thereby aggravating and worsening his condition. On information and belief, various deputies and other employees of the defendant Sheriff, acting in the course and scope of their employment, knew, must have known or should have known that Mr. Goetzee was in serious need of medical attention, yet failed to report or seek appropriate care for him during this time.

32. Mr. Goetzee was removed from federal court and returned to the jail, where he received a "Psychiatric Nursing/MA Assessment" for the first time while in custody, due to "suicidal ideation", and referred to University Hospital by defendant Dr. Higgins, through a verbal order to defendant E. Bargky, LPN, to "Rule Out Delirium". By that time, he had blood pressure of 181/122, a pulse rate of 128, respiration rate of 20 and a temperature of 100.1. His allergy to prednisone was noted at this time, as was the fact that he was without any medication. His skin was warm and moist to touch. He was described as oriented OX1, oriented as to name only, a marked deterioration of the AAOX3 orientation described at Intake by defendant LPN Wallace. The Nurse Notes completed by defendant Bargky identified his name as "William Wesley", despite the booking information which gave his name as "Goetzee, William W." This error regarding his name persisted through his hospitalization at University and when he returned to the jail, causing confusion and inconsistencies in his medical treatment. He

was described as semi-alert, with bizarre behavior, a loud speech pattern and unclear thought processes and judgment/insight. He is also described as verbalizing "inappropriately".

33. Upon admission to University hospital, he was diagnosed as suffering from acute psychosis, rhabdomyolysis, hypertension, chest pain and hypokalemia. He was found to have suicidal ideation and auditory and visual hallucinations. It was noted that his behavior and speech were bizarre. He was given an i.v. of Ativan, which sedated him. He was transferred to a medical floor to address his medical condition. He was also the subject of an emergency commitment, a 72 hour PEC (Physician's Emergency Commitment) due to his obvious psychotic and suicidal state.

34. On August 4, 2011, a psychiatric consultation was performed at University hospital. At that time Mr. Goetzee told the University psychiatrist that, on August 2, 2011, he had grabbed the gun of the federal officer at the courthouse, with the intention to commit suicide so that "China will stop reading his thoughts." He stated that "he feels China has the technology to read his thoughts and that suicide was the only way to make them stop." He was positive for suicidal ideation but denied having a plan. It was noted that he "laughs inappropriately". He reported that his work was stressful, that he was suffering from chronic insomnia and that he believed that sleep deprivation had put him into a "manic and psychotic state." He is described as being "acutely psychotic with anxiety stemming from paranoia". He was reported as having a GAF (Global Assessment of Functioning) score of 20. He was medicated with

Risperdal, Vistaril for anxiety and Lisinipril for blood pressure.

35. On August 4, 2011, University hospital personnel requested an examination by a representative of the Coroner's office to determine whether Mr. Goetzee should be committed by the Coroner for an additional 14 days. He was discharged from University Hospital on August 5, 2011, before the Coroner's office had the opportunity to examine him.

36. Shortly after midnight, on August 5, 2011. Mr. Goetzee became agitated and pulled out the catheter and grabbed at a nurse. He was found, upon examination, to be disoriented and trying to get out of bed, despite being handcuffed to the bed. He was placed in 4 point restraints and given Ativan as a sedative. The restraints were discontinued at 6:50 A.M. as he was "sleeping peacefully". When he was interviewed by a psychiatrist later that morning, he stated that he "didn't want to be tortured when he died" and was not able to answer questions logically. It was noted that he remained on the Risperdal and Visteril but still had "intermittent agitation" . At 1335 (1:35 pm) it was noted that he "remains delusional" . It was also noted that he was showing "gradual improvement" on his current medication.

37. On August 5, 2011, University discharged him to the care of defendant Dr. Higgins, with recommended prescribed medications of Risperdal, Visteril and Lisinipril, all medications which he been receiving at University.

38. Mr. Goetzee was still very ill and delusional when transferred, on Friday afternoon, August 5, 2011, to the jail from University hospital. His diagnosis upon

transfer to the jail was: (1) Psychosis NOS (2) Rhabdomyolysis-mild (3) HTN (hypertension) (4) Chest Pain (5) Hypokalemia and (6) Macrocylic Anemia. The discharge papers from University hospital stated "Needs Psych Follow Up ASAP". Recommended treatment was Risperdal, Lisinopril and Vistaril. These recommendations were duly noted in the OPP Medical Department records. However, immediately upon arriving back at the jail, these recommendations were disregarded. The prescription for Vistaril, the anti-anxiety medication, was discontinued with no explanation. The last time Mr. Goetzee received it was at 2:00 pm on August 5, 2011, at University, shortly before being transferred back to the jail. It had been prescribed at University for three times a day and as needed. Instead, the defendants withheld this medication from Mr. Goetzee, despite his diagnosis, condition and the obvious need for continuity of care. No anti-anxiety medication was prescribed by the defendants or given to Mr. Goetzee from the time he arrived at the jail until he died. Meanwhile, Mr. Goetzee remained in a state of acute psychosis, delusion, paranoia and suicidal ideation, without adequate or appropriate care or medication.

39. On information and belief, the defendants, and especially defendant Higgins, have a policy and practice of withholding and not prescribing anti-anxiety medications for persons in custody, even when the need for the medication is clearly evident, is medically indicated and when it has been prescribed by the inmate's treating physician. On information and belief, defendants knew, must have known or should have known that it would cause detrimental effects upon an individual in Mr. Goetzee's

condition, to deprive him of medication which would help to calm him and provide some relief from his acute anxiety, particularly given the conditions in which he was confined. On information and belief, the defendants were involved with and/or aware of the general policies and practices in this regard as well as the decision to deprive Mr. Goetzee of the recommended anti-anxiety medication or any other similar, anti-anxiety medication or treatment. The defendants knew, must have known, or should have known that withholding anti-anxiety medication could cause undue suffering, trauma and serious harm to a patient in Mr. Goetzee's situation.

40. Defendants as well as other staff and employees of the OPSO not named herein but acting in the course and scope of their employment, also knew, must have known, or should have known that the facilities, staff and operations at HOD were grossly inadequate and incapable of adequately, properly or humanely providing reasonable accommodations, adequate treatment, monitoring or care for Mr. Goetzee, especially on a weekend when staffing and supervision were minimal, and that there was a serious risk of harm or self-harm to accept him back into the jail in his condition. The defendants knew, must have known or should have known that he would be placed in a barren cell and hostile environment on HOD-10, which was not a therapeutic or appropriate placement for an acutely psychotic, suicidal individual in Mr. Goetzee's situation. The defendants knew, must have known or should have known that he would more likely than not be required to sit and sleep on the floor, without any of the basic comforts provided in a hospital, such as a bed, covers, appropriate clothing, and

appropriate medical attention. The defendants knew, must have known, or should have known, that the HOD-10 lacked the capacity to provide appropriate medications, such as Ativan or any other similar sedatives via i.v., treatment which he had received in the hospital when he became disoriented and needed sedation.

41. The defendants also knew, must have known or should have known that there was a problem with the air conditioning on the 10th floor, in August, and that the physical conditions would be challenging, uncomfortable and difficult, particularly for an individual who was actively delusional, psychotic and suicidal.

42. The defendants also knew, must have known, or should have known, that, while confined on HOD-10, Mr. Goetzee would not have access to a telephone or to visits from attorneys or others, particularly over the weekend, and that he would basically be held in isolation and incommunicado from friends, family, loved ones and professional, legal and spiritual advisors. They also knew, must have known or should have known that, more likely than not, Mr. Goetzee would be stripped of his clothing and made to wear a "suicide smock" or "turtle suit" as it was sometimes called, as a suicide prevention method, an ordeal that Mr. Goetzee would not be subject to had he remained in the hospital for his care. Nevertheless, the defendants re-admitted Mr. Goetzee to the jail, and sent him to HOD-10, stripped also of anti-anxiety medication to help him through this ordeal.

43. Defendant nurses also knew, must have known or should have known, that the conditions under which a suicidal and psychotic patient like Mr. Goetzee would

be held on HOD-10, were not conducive to appropriate or adequate medical or nursing care or treatment for a person in his condition and were not a reasonable accommodation for his disability. Defendant nurses knew, must have known or should have known that the anti-anxiety medication prescribed at University Hospital had been discontinued by the doctors at the jail. They knew, must have known, or should have known that HOD-10 was not adequately staffed or supervised. They also knew, must have known or should have known that the conditions under which Mr. Goetzee were being held were not therapeutic and would in fact exacerbate and worsen his condition, and contribute to the severe feelings of isolation and despair that he was experiencing. Defendant nurses knew, must have known , or should have known that, unlike at the hospital, suicide monitoring was not conducted by licensed health care professionals but by security guards. The nurses knew, must have known, or should have known that compliance by deputies with orders for direct, continuous monitoring and observation by correctional staff of suicidal patients on the 10th floor of HOD, was inconsistent and was frequently completely lacking or absent. Defendant nurses violated their ethical and professional duties and standards of care by failing to report, intervene or take appropriate or necessary measures to insure that Mr. Goetzee's treatment would be adequate, humane and appropriate for his condition and his situation.

44. Nevertheless, when Mr. Goetzee was brought back to the jail, he was accepted and admitted to the jail, as per instructions from defendant Dr. Dileo and defendant S. Pembo, despite the fact that Dr. Dileo and Nurse Pembo knew that he

remained positive for suicidal ideation and was not responsive to questions. On information and belief, Dr. Dileo and Nurse Pembo failed to take necessary and appropriate steps to obtain more information about Mr. Goetzee's condition or the circumstances of his hospitalization at University Hospital. They failed to request or review the mental health assessments which were performed at University hospital or related records. There is also no indication that the August 2, 2011 jail medical intake records were reviewed or the computer checked for medications. Documentation regarding the appropriateness of Mr. Goetzee's re-admission to the jail from the hospital, as handled by defendants and other staff at the jail, was sparse, inadequate and lackadaisical, reflecting a lack of care and professional responsibility regarding the seriousness of Mr. Goetzee's condition. This same attitude persisted throughout Mr. Goetzee's tragic confinement at the jail, reflected even in the persistent disregard for his correct name and his allergy to prednisone.

45. Defendant S. Batiste, an LPN, performed the first "Medical Assessment: Suicide Watch" by trained medical personnel of Mr. Goetzee on August 5, 2011 at 2000 (8:00 pm), hours after his re-admission to the jail. Mr. Goetzee was reported to be "lying on the floor in uniform". He is described as positive for suicidal ideation though no description or other information is provided. Nevertheless, she described his comfort level as "fair". No vital signs were taken, despite the fact that he was recently discharged from the hospital with hypertension and rhabdomyolysis. There is no documentation of any comfort care or any effort to provide him with

encouragement or therapeutic support. There is no indication that defendant Batiste took any steps to intervene or to inform any appropriate authorities that the conditions under which Mr. Goetzee was being held were unacceptable and medically contra-indicated for a person in Mr. Goetzee's condition and mental state. Nor did she attempt any intervention during the entire period of time for which she was responsible for his care. Her conduct in this regard was mirrored by the actions of the other LPN's involved in Mr. Goetzee's "care" at the jail.

46. Precisely two hours later, at 2200, (10 pm) Defendant S. Batiste reported that Mr. Goetzee was "lying on floor eyes open to verbal stimuli". He was positive for suicidal ideation. He was "alert, orient and awake". His "comfort level" was described as "fair". There was no documentation of any therapeutic interventions. No vital signs were taken.

47. Precisely four hours later, at 0200, (2 a.m.) defendant S. Batiste reported again on Mr. Goetzee. At this time she failed to give any description of Mr. Goetzee's appearance. She reported that he still had suicidal ideation, was oriented and that his comfort level was "fair." There was no indication of any therapeutic intervention. No vital signs were taken

48. Precisely three hours later, at 0500, (5 a.m.) defendant S. Batiste described Mr. Goetzee's appearance as "lying on the floor awake talking to himself". He had suicidal ideation. He was alert. His comfort level was "WNL" (within normal limits).. For the first time there was an "additional comment": "I/M (inmate) moaning stating he

wants to die". Again, there was no indication of any therapeutic intervention by defendant nurse S. Batiste. No vital signs were taken.

49. There was no indication in any of defendant Batiste's notes or indeed of any of the nurse defendants who later performed similar functions, of the presence of any correctional officers who were supposed to be monitoring Mr. Goetzee, or that any of the nurses reviewed any of the observation records which were supposedly being filled out by the deputies on a continuous basis, every 15 minutes, regarding Mr. Goetzee's condition.

50. On August 6 at 0602 am, defendant Dr. Higgins conducted an "Initial Psychiatric Evaluation" of Mr. Goetzee at which time Dr. Higgins noted that Mr. Goetzee was suicidal, that he had come to the jail from University, where he had been treated for "delirium vs psychosis". He was aware that Mr. Goetzee had previously been on anti-anxiety and anti-insomnia medication. Despite this information, he did not prescribe any medication to Mr. Goetzee to treat either his anxiety or insomnia and discontinued the anti-anxiety medication, Vistaril, which Mr. Goetzee had been prescribed at the hospital. Dr. Higgin's "Psychiatric Treatment Plan" was to continue Mr. Goetzee on Risperdal and to place him on the "Mental health tier", under "watch" with "direct observation" and a "suicide smock" and to follow up the next day.

51. Dr. Higgins knew, must have known or should have known that Mr. Goetzee was at serious risk of suicide. He knew, must have known, or should have known that the monitoring and assessments that Mr. Goetzee would receive on HOD-

10, particularly on a weekend, would be of poor quality, with superficial and incomplete accounts, erratic documentation and no therapy or comfort care. He knew, must have known or should have known that the staffing, facilities, housing conditions, and the type and quality of care which Mr. Goetzee would receive at the jail would be inadequate for his needs and significantly deficient compared to treatment he would receive in a hospital. He knew, must have known or should have known that the jail was not an appropriate place for Mr. Goetzee, given his condition and his disability. Dr. Higgins knew, must have known or should have known of a number of other deaths by suicide of mentally ill patients at the jail, and at HOD-10, which were related to inadequate care, treatment and monitoring. In a number of instances, those prisoners who committed suicide or who died on HOD-10 were under Dr. Higgins care. Yet he made no effort to return Mr. Goetzee to the hospital for appropriate care. He gave no orders to increase the frequency or improve the quality of Mr. Goetzee's medical assessments or to insure that medical and correctional staff would be vigilant in observing and monitoring Mr. Goetzee. He gave no orders to monitor Mr. Goetzee's vital signs though he knew, must have known or should have known that he had recently been released from the hospital with hypertension and rhabdomyolosis and that untreated anxiety can trigger panic attacks which can be manifested in increases in blood pressure, heart rate and pulse rate. He made no effort to obtain the psychiatric consults and records from University hospital, which would have provided important information as to Mr. Goetzee's condition. He knew the jail could not provide necessary

and appropriate care for Mr. Goetzee and that the standard of care at the jail for mentally ill, suicidal patients was not consistent with the standard of care in the community yet he failed to take any appropriate measures to address this problem.

52. On August 6, 2011, at 0715 am, defendant E. Bargky, who had been involved with the transfer of Mr. Goetzee to University hospital on August 3, 2011 to "rule out delirium", reportedly conducted a "Medical Assessment: Suicide Watch" assessment of Mr. Goetzee while Mr. Goetzee remained in a cell on HOD-10. Mr. Goetzee was reported to be "awake, sitting on the floor". He is described as positive for suicidal ideation though no description or other information is provided. Nevertheless, his comfort level is "fair". As with all of defendant Bargky's "assessments" of Mr. Goetzee, no vital signs were taken. There is no documentation of any comfort care or any effort to provide him with encouragement or therapeutic support. There is no indication that defendant Bargky took any steps to intervene or to inform any appropriate authorities that the conditions under which Mr. Goetzee were being held were unacceptable and medically contra-indicated for a person in Mr. Goetzee's condition and mental state. Nor did she attempt any intervention during the weekend when she was responsible for his care.

53. According to OPSO records, Defendant Bargky conducted an assessment at 1615 (4:15 pm) where Mr. Goetzee was "awake, standing at the gate". She failed to document whether or not he was continuing to experience suicidal ideation. He was reported, however, to be oriented, with no complaints voiced.

Defendant Bargky reportedly did another assessment at some undocumented time on August 6, 2011, where Mr. Goetzee was reported to be "awake, standing at the gate". At that unknown time, according to defendant Bargky, Mr. Goetzee did not have suicidal ideation, although there is no description of his behavior or further information given to substantiate that assessment. There was no assessment of his "LOC" (Level of Consciousness) while his comfort level was reported as "fair" with no complaints "voiced". Again, no vitals were taken.

54. Defendant David Schaible, the nurse who was on duty at HOD-10 on "night shift" on August 6-7, 2011, apparently prepared his "suicide watch assessments" on a computer, as they are neatly typed and printed out, covering four entries beginning on 8/6/11 at 21:00 (9:00 pm) and continuing on 8/7/11 at 00:01 am, 3:00 am and 6:00 am. All four reports are identical, with no comments, no descriptions, no information except that apparently Mr. Goetzee was in the cell, his appearance was "NADN" (No apparent distress noted), he was suicidal, he was oriented X 3, he voiced "no complaints" and his comfort level was "okay". There is no documentation of what Mr. Goetzee was saying or doing. Vital signs were not recorded.

55. Every defendant nurse who checked on Mr. Goetzee from August 5-7, 2011, over a 48-hour period, reported that he was awake everytime he was checked. However, there is no inquiry made by any of them as to whether he was suffering from insomnia, which he had reported to Dr. Higgins as a chronic problem, and no treatment or intervention was provided to enable him to get some sleep. The defendant nurses

and Dr. Higgins knew, must have known, or should have known that Mr. Goetzee had a history of insomnia, and had previously taken anti-insomnia medication, which was not currently being prescribed or given to him at the jail. The defendant nurses and Dr. Higgins knew, must have known or should have known that chronic lack of sleep can have a serious impact on an individual's judgment, thought processes and mental status, yet nothing was done for Mr. Goetzee to provide relief or treatment for this serious condition.

56. There is no documentation of any efforts by any of the nurse defendants to seek additional medical intervention or medications for Mr. Goetzee during this entire time. There is no documentation that he was offered any comfort care or that there were any efforts to provide him with encouragement or therapeutic support. There is no indication that any of the nurse defendants or any other staff at the jail took any steps to intervene or to inform any appropriate authorities that the conditions under which Mr. Goetzee were being held were unacceptable and medically contra-indicated for a person in Mr. Goetzee's condition and mental state. The nurses also failed to provide adequate documentation regarding Mr. Goetzee's condition and behavior.

57. There is no indication on any of defendant nurses' reports that any supervisor ever checked their reports or participated in or reviewed the monitoring of Mr. Goetzee during the time he was confined at the jail. Defendant Daryl Jackson, the Director of Nursing, was responsible to insure adequate training and supervision of nursing staff and failed to do so. Defendants Jose Ham and Mary Ann Benitez were

responsible to do quality control and to review medical charts and to see that nurses were properly performing their duties consistent with professional standards and the standard of care in this community. They failed to do so.

58. Defendants Dr. Gore and Dr. Higgins, as the medical and psychiatric directors at the jail, respectively, each had responsibility for training, supervising and overseeing the services provided by medical staff including nurses, as well as correctional officers assigned to HOD-10. All of the defendants who were in supervisory positions with oversight responsibilities failed to properly carry out their responsibilities.

59. On information and belief, none of the OPSO nursing or medical staff, including the defendants, were disciplined for their acts or omissions regarding the events described herein.

60. On Sunday, August 7, 2011, defendant Nurse Bargky resumed "suicide watch" for Mr. Goetzee. At 0800 (8 am) and over six hours later at 1410 (2:10 pm) defendant Bargky reported that Mr. Goetzee was "awake, sitting on the floor". At 0800 he is reported as having suicidal ideation, with no further information as to how that condition manifested itself, while at 1410 (2:10 pm) he had no suicidal ideation, again with no explanation reported. There is also no explanation for the six-hour delay between assessments.

61. At 2:20 pm, 10 minutes after defendant Bargky reported that Mr. Goetzee no longer had suicidal ideation, he was evaluated by defendant C. Johnson, FNP, who, as a nurse practitioner, had more training, a higher level of professional

licensing and more responsibility than the LPNs. For the first time in over 24 hours, there is a minimal narrative account of what Mr. Goetzee is saying: "states he 'has things he hears in his head that may convince him to harm himself'. The "Impression/Assessment & Plan" is "suicide assessment" which, on information and belief, is to continue what had been going on already. For "medications" defendant Johnson ordered "continue suicidal direct observation with smock." She failed to prescribe or recommend any anti-anxiety, anti-insomnia, or other medication. There is no documentation that Mr. Goetzee was offered any comfort care or that there were any efforts to provide him with encouragement or therapeutic support. There is no indication that defendant Johnson took any steps to intervene or to inform any appropriate authorities that the conditions under which Mr. Goetzee were being held were unacceptable and medically contra-indicated for a person in Mr. Goetzee's condition and mental state. Instead, she merely ordered that he be followed up the next day by Dr. Higgins, for him to conduct another "eval suicidal assessment."

62. At 1615 (4:15 pm) defendant Bargky documented that Mr. Goetzee was "awake standing at the cell gate" and once again he was reported by defendant nurse Bargky as having "no" suicidal ideation. There is no documentation of any therapeutic intervention, care, or treatment for Mr. Goetzee.

63. Approximately 2 hours and 15 minutes later, at about 1836 (6:36 pm), deputies were informed, on information and belief by another inmate, that Mr. Goetzee was on the floor of his cell, unresponsive. Deputies informed defendant nurse Bargky,

and a "code" was called, and resuscitation efforts were initiated. During resuscitation efforts it was discovered that Mr. Goetzee had toilet tissue stuffed down his throat, blocking his airway. On information and belief, Mr. Goetzee had been given access to toilet paper, which was not otherwise provided in his cell, by OPP staff, including defendant nurses and deputies, which allowed him to collect a sufficient quantity of the paper so as to kill himself.

64. Placing a prisoner on "Direct observation" under "Suicide watch" at HOD-10 required that the patient would be under continuous, direct supervision at all times. On August 7, 2011, defendant former deputy William Thompson was assigned to perform "direct observation" of William Goetzee. Deputy Thompson was to sit in a chair, outside Mr. Goetzee's cell, and watch him. He was to fill out, every fifteen minutes, an observation sheet of Mr. Goetzee's behavior and activities.

65. The OPSO suicide watch procedures, using a checklist filled out by deputies, is a poorly designed, inadequately monitored procedure which fails to ensure adequate observation of suicidal prisoners and which facilitates the entry of false and/or misleading information. The defendants knew, must have known, or should have known that the practice of deputies failing to maintain direct, continuous observation of suicidal prisoners was widespread, as was falsification of these checklists. Yet the defendants failed to take appropriate or necessary steps to intervene or to ensure that direct, continuous observation by qualified, medically trained staff, with accurate and meaningful documentation of suicidal prisoners took place. In addition, medical

personnel were not required to review these documents, they were not routinely made a part of the prisoners' medical records and as a result, there was no effective monitoring program to ensure accurate and truthful documentation relevant to the diagnosis and treatment of prisoners on "direct observation suicide watch".

66. Defendants knew, must have known or should have known that the monitoring of Mr. Goetzee for August 5-7, 2011, was not being properly performed, documented or reviewed, yet failed to report or intervene. Defendant former deputy William Thompson was assigned on August 7, 2011, to provide continuous, direct monitoring of Mr. Goetzee. Defendant deputies Williams and Crader were also assigned to HOD-10 on August 7, 2011. Deputy Thompson showed up late for his assignment and left his post on at least three different occasions. On one occasion he was with defendant deputy Williams, assisting with "feed-up". Defendant deputies Williams and Crader knew, must have known or should have known that defendant Thompson had abandoned his post to directly and continuously observe Mr. Goetzee, yet they failed to take any action to report that abandonment or to take appropriate steps to ensure that Mr. Goetzee was being observed at all times. In addition, defendant Thompson left his post to go to the restroom, without having anyone fill his place, a practice that was common and known to be common among OPSO staff who worked at HOD, including deputies, nurses, doctors, supervisors, watch commanders and the warden.

67. Defendant Thompson also left his required duties to provide direct,

continuous observation of Mr. Goetzee, for a period of time of approximately 2-3 hours, complaining that it was "too hot" to maintain his assigned post. During that time, on information and belief, defendant Thompson was visiting and/or napping in the nurse's office. Defendant Bargky, other defendants and OPSO staff, were aware that defendant Thompson was "hanging out" in the air conditioned nurses' office and that he had abandoned his post. Despite this flagrant act, no defendants or any other OPSO staff who were aware of defendant Thompson's actions, reported him or intervened in any way to insure that direct, continuous observation of Mr. Goetzee would be maintained.

68. In addition, supervisor Sgt. Nicole Harris and Assistant Watch Commander Sgt. Everrett Marshall knew, must have known or should have known that, on August 7, 2011, defendant Deputy Thompson was derelict in his duties and was not at his post on the 10th floor directly observing Mr. Goetzee on a continuous basis. On information and belief, the morning of August 7, 2011, Sgt. Harris telephoned the 10th floor to check on defendant Thompson. He was not at his post, which was confirmed by Deputy Crader. Deputy Crader knew, must have known or should have known, that defendant Thompson was not at his post yet she failed to intervene or report it. Sgt. Harris located defendant Thompson and told him to return to his post. On information and belief, Sgt. Harris had previously had problems with defendant Thompson failing to perform his duties as he was instructed. She knew, must have known or should have known that defendant Thompson was unreliable and that he himself required close monitoring and supervision to ensure that he was properly performing his duties. On information and

belief, defendant Sgt. Marshall was also aware of the problems regarding defendant Thompson. Defendants Sgt. Harris and Sgt. Marshall failed to properly supervise and monitor defendant Thompson's behavior or to take appropriate disciplinary action against him. It was during defendant Thompson's absence from duty on August 7, 2011, that Mr. Goetzee killed himself.

69. On information and belief, the practice of deputies abandoning the assigned post of direct, continuous observation of suicidal prisoners on HOD-10, was widespread and customary and was known, must have been known or should have been known by the defendants herein, as well as other OPSO staff. The defendants knew, must have known or should have known that any reasonable evaluation of staffing levels and job duties at HOD-10 would reveal that it would be highly unlikely that direct, continuous observation of prisoners on suicide watch at HOD-10 could be sustained.

70. On June 15, 2012, defendant former deputy William Thompson pled guilty in Orleans Parish Criminal District Court to one felony count of malfeasance, a violation of La. R.S. 14:134, for violating his duty to maintain direct, continuous observation of William Goetzee on August 7, 2011, and for falsifying OPSO direct observation records. At all relevant times he was acting in the course and scope of his employment as a deputy sheriff with the Orleans Parish Sheriff's Office and defendant Sheriff Gusman is vicariously liable for his acts and omissions.

71. In addition, defendants HOD Warden Carlos Louque, HOD Watch

Commanders John Does I and II, Assistant Watch Commander Sgt. Everett Marshall and Sgt. Nicole Harris, immediate supervisor of defendant former deputy William Thompson, all had supervisory responsibilities relating to defendant Thompson and failed to properly exercise those responsibilities.

72. During the time Mr. Goetzee was held at HOD-10, he was essentially held incommunicado. There was no telephone in his cell and he had no access to a phone to make calls. He was denied visits by his attorney and the Coast Guard chaplain. No medical or security personnel intervened with him in any meaningful or medically appropriate way to adequately assess his physical condition or mental status. His anti-anxiety medication was taken away and he was not prescribed anything for anxiety or insomnia. He was even denied a bed, and the most basic comforts and therapeutic interventions, such as soothing.

73. Prior to his death, William Goetzee endured significant pre-death physical, mental and emotional pain and suffering, anxiety, pain and terror due to the actions and omissions of the defendants as described herein.

74. The defendants knew, must have known or should have known that OPP had a history of serious injuries and deaths of prisoners due to the lack of adequate medical and correctional treatment and care of prisoners suffering from an acute mental health crises and suicidal ideation. As with Mr. Goetzee, OPSO staff failed to take appropriate or necessary action with regard to these prisoners, resulting in their deaths, serious injuries and/or suffering, as described below:

1. On March 27, 1995, in the case entitled William P. DeMouy, Sr., v Foti, Docket No. 94-423, the prisoner survived but judgment was entered against then-Orleans Parish Criminal Sheriff Charles C. Foti, Jr. and a deputy for improper monitoring and inadequate care of a suicidal prisoner placed in 5 point restraints on the psych floor of the OPCSO.

2. On Nov. 29, 1996, Regie S. Hargrove, an inmate who was supposedly being monitored for suicide, hung himself with a bed sheet in a cell which was out of the line of vision of the nurses and deputies stations and which had numerous "anchor" or "tie-off" points. Mr. Hargrove had also been the subject of improper use of restraints and inadequate monitoring and care while in restraints.

3. On August 10, 2001, Shawn Duncan Sr., an arrestee charged with DWI, reckless driving and other traffic offenses, who was alleged to have suicidal/homicidal ideation, died of dehydration on HOD-10 after having been in 5 point restraints for 42 hours and given inadequate food, water and medical care to sustain life.

4. On April 3, 2004, Matthew Bonnette, a young man who was arrested after a car accident, professed suicidal ideation, was placed in 4-point restraints and was on "suicide watch". On April 4, 2004, while in 4-point restraints, Mr. Bonnette hanged himself on HOD-10, using the 5-point restraint belt which had been left in his cell, after deputies failed to consistently monitor him.

5. On August 29, 2007, Julio Sortes hanged himself with a telephone cord in his cell. There is no evidence that he was referred for a psychiatric assessment or treated for his illness.

6. On October 3, 2008, Louis Prince was found dead in his cell on HOD-10. Mr. Prince had been arrested in New Orleans on September 26, 2008 and had been held on the sixth floor of HOD. Even after reports of escalating bizarre behavior, Mr. Prince was never placed on suicide watch, and he ultimately hung himself in his cell on October 3, 2008.

7. On January 5, 2009, Cayne Miceli, a 43-year-old woman with a history of asthma, panic attacks and depression, died on HOD-10 as a result of being tied down in 5-point restraints for over four hours and being denied medication and appropriate treatment.

8. On or about July 18, 2010, Jose Nelson Reyes Zelaya committed suicide at OPP.

9. On or about June 8, 2011, an ICE (Immigration) detainee whose name is unknown at this time, committed suicide at the jail.

75. The deliberate indifference of defendants to the serious medical needs of prisoners at OPP is also reflected in the failure of defendants to provide adequate medical and correctional care of arrestees at intake, including inadequate screening, assessment, monitoring and treatment. The failure of defendants to provide adequate medical treatment during the intake process resulted in serious injury and death in the following incidents:

1. On January 12, 2009, John Sanchez was found dead in an isolation cell after being booked into the jail in an extremely intoxicated state. Despite the potential for fatal medical complications associated with alcohol withdrawal, Mr. Sanchez was inadequately monitored, diagnosed or treated.

2. On February 6, 2009, Richard Rowzee was not adequately assessed when he entered the jail and was booked into the jail despite significant medical problems in part related to alcohol withdrawal. Deputies reported to the medical department that he was attempting to kill himself and was beating himself against the wall. By the time the medical department intervened, Mr. Rowzee had given himself a black eye. Ultimately, Mr. Rowzee was routed to University, where he died, because of potential brain injury and complications from delirium tremens.

3. On April 16, 2010, 32-year-old Michael Hitzman, was in the intake and processing center, being booked, when he

informed OPSO staff that he had ingested drugs. He was treated with charcoal and placed in isolation where he was not properly monitored and hung himself.

76. At the time of the admission and retention of William Goetzee in the Orleans Parish jail, the defendants knew, must have known or should have known of serious deficiencies in the policies, practices and procedures at the jail related to medical and psychiatric screening on intake and on HOD-10 for the treatment, care and observation of prisoners who were in need of mental health care and those being monitored for suicide prevention. Defendants were also well aware of the inadequate staffing and inadequate training and supervision of medical and correctional staff with regard to medical and psychiatric problems of prisoners. Despite their knowledge of these serious deficiencies, the defendants failed to take appropriate actions to make necessary changes to policies, procedures, training, supervision or staffing or to intervene to see that Mr. Goetzee and others in their custody, were provided with adequate care and treatment for serious medical needs.

77. On information and belief, defendants herein have been involved in other incidents involving inadequate care and treatment for prisoners with serious medical needs, which resulted in serious harm, injury, suffering and/or death to inmates in their care. Yet none of these defendants, nor other OPSO staff who were similarly derelict in their duties, were appropriately disciplined or held accountable for their acts or omissions. In addition, those responsible for training and supervising OPSO staff who have failed in their own responsibilities to provide adequate care to prisoners, have not

themselves been subject to disciplinary action or accountability for failing their supervisory and/or training responsibilities. On information and belief, other than defendant former deputy William Thompson, no OPSO staff were disciplined or held accountable for the mistreatment and lack of adequate care for Mr Goetzee as described herein.

78. Defendant Gusman, Orleans Parish Sheriff, at all relevant times herein knew, must have known or should have known of these serious deficiencies yet failed to take necessary or appropriate actions to address and correct them.

79. On October 10, 2008, a report was submitted to defendant Sheriff Marlin Gusman entitled "An Operational Review of the Orleans Parish Jail" funded by the National Institute of Corrections. This report documented significant, pervasive and serious problems at the jail relating to the lack of adequate and trained staff, the poor quality of the physical facilities (including HOD) and poor staff-inmate relations. The report also found "the mental health program in the jails is dramatically understaffed and the program is much too limited in scope". At the time of that report, the jail had experienced only one suicide in the three years since Katrina. The jail also had a substantially smaller population during that time. Since that time, on information and belief, there have now been at least 6 known suicides, a marked increase since the NIC report was completed. On information and belief, Sheriff Gusman receives reports regarding each suicide that occurs in the jail and knew, must have known or should have known, of the number and problematic circumstances of suicides at the jail The

NIC report also reported that the jail lacked adequate therapeutic services for mentally ill prisoners. The report recommended that prisoners who are "deemed actively suicidal should be refused intake, and the police should transport them directly to Charity Hospital, per policy".

80. On September 11, 2009, the U.S. Department of Justice, Civil Rights Division, issued a "findings letter" addressed to defendant, Sheriff Marlin Gusman regarding the Orleans Parish Prison system. The Department of Justice, after conducting an investigation for approximately 18 months, found that "OPP fails to provide inmates with adequate mental health care that complies with constitutional standards." The Department of Justice found that the following deficiencies existed:

a. Inadequate suicide prevention;

b. Inadequate intake and referral process;

c. Inadequate staffing;

d. Inadequate assessment and treatment; and

e. Inadequate quality assurance review.

81. In addition, the Department of Justice findings letter of September 11, 2009 found that "suicide prevention practices" at OPP were grossly inadequate. The Department of Justice found that the OPP suicide prevention policy requiring direct observation by staff practices deviated from generally accepted standards and that the actual practice deviated from the stated policy. The Department of Justice also found that there were "an alarmingly high number of inmates with mental health issues,

including past mental health treatment, history of suicidal behavior attempts and/or being on psychotropic medications, who consistently were not referred to mental health service providers at Intake. The Department of Justice noted that "inmates who were not timely referred remained untreated and have suffered from a worsening of their symptoms, including suicidal and homicidal ideation".

82. The Department of Justice September 11, 2009 findings letter also stated that "OPP fails to employ sufficient mental health staff to insure that inmates receive adequate services". In addition, the report found that "OPP fails to appropriately and timely assess and treat inmates with mental illness". The Department of Justice also found that the failure of the OPP to have multi-disciplinary treatment teams contributed to the failure of the mental health program to meet general accepted professional standards. In addition, the DOJ investigation revealed a "lack of attention to past mental health information and a failure to provide timely psychiatric assessment and treatment. These failures are inconsistent with generally accepted professional standards and resulted in mental health deterioration and unnecessary suffering".

83. The Department of Justice September 11, 2009 findings letter also found that "OPP fails to engage in consistent, effective quality assurance review in order to monitor and assess the quality of mental health offered at the facility".

84. The defendants were aware of these findings by the National Institute of Corrections and the Department of Justice. However, the defendants, and in particular defendants Gusman, Dr. Gore and Dr. Higgins, failed to take necessary and appropriate

actions to address these issues or to insure that the mental health services at the Orleans Parish jail conformed with community standards and constitutional standards.

85. On April 23, 2012, the Department of Justice issued a second findings letter, based on an on-going and renewed investigation of the Orleans Parish jail and documented continued serious constitutional violations and policies and practices which violated generally accepted standards of care with regard to the provision of medical and mental health services at the Orleans Parish Prison.

86. In the April 23, 2012 findings letter the Department of Justice found that "suicide prevention measures at OPP are grossly inadequate, resulting in unnecessary suffering, and very likely leading to at least 5 suicides since our findings letter in 2009. The jail has inadequate mechanisms to identify suicidal prisoners, inadequate treatment and staffing and poor training of officers. The Department of Justice found that prisoners at OPP identified as being at risk of self-harm were subjected to inhumane treatment.

87. In its April 23, 2012 findings letter, the Department of Justice found that "the Orleans Parish Prison is deliberately indifferent to prisoners with serious medical and mental health needs. The jail has inadequate mechanisms to identify prisoners with mental illness and too few treatment staff to address urgent and chronic conditions". The Department of Justice also found that as a result of the policies and practices of the Orleans Parish Prison, prisoners suffered during their incarceration and were returned to the community, in far too many cases, sicker and less equipped to avoid future involvement with the criminal justice system than when they entered.

88. The findings of the Department of Justice in April, 2012, were consistent with the findings in Sept., 2009, that the operations of the Orleans Parish jail were deliberately indifferent to the risk of serious harm to prisoners who were seriously mentally ill and suicidal. The Department of Justice findings letters of April 23, 2012, found that in two of the five completed suicides which had occurred since 2009, "deficient monitoring contributed to the prisoners suicides".

89. The Department of Justice also found, in the April 23, 2012 findings letter, that the practice of "placing suicidal prisoners in a "turtle suit" and placing them in a cell with no toilet, beds, blankets, sink or telephone, constituted inhumane conditions which would exacerbate mental illness. In addition, the Department of Justice found that "once prisoners were placed on suicide watch, the mental health evaluations were cursory and rarely addressed suicide risk issues". The findings letter also concluded that "prisoners did not receive meaningful treatment, aside from being medicated and monitored".

90. The Department of Justice findings on April 23, 2012 found that "OPP fails to adequately monitor its prisoners on suicide watch". The Department of Justice observed and found clear violations of the defendants' own policies with regard to direct observation of prisoners on suicide watch.

91. The conclusion of the Department of Justice in April, 2012, after having investigated the OPP facility for over a three year period, which included the time period when Mr.Goetzee was confined at the jail, was that OPP continued to lack the

appropriate staffing structure to provide constitutionally adequate mental health care. "OPP's mental health services continue to be deficient in the following areas: (1) evaluation and screening; (2) staffing; (3) assessment and treatment; (4) treatment planning; and (5) quality assurance review. These deficient OPP practices cause prisoners serious harm and create an unreasonable risk of harm."

92. Defendants Gusman, Gore and Higgins knew, must have known or should have known of these deficient conditions yet they failed to take adequate steps to insure that appropriate and necessary changes in policies, procedures, staffing, training and/or facilities were taken in order to provide adequate care to suicidal and mentally ill patients on HOD-10, and on admission to the jail. These defendants also failed to insure that appropriate supervision and disciplinary action was taken in situations where prisoners suffered or died as the result of inadequate or inappropriate care or treatment by OPSO staff.

93. The defendants knew, must have known or should have known of the dangers and obvious risk of serious harm to mentally ill and suicidal prisoners at OPP because of inadequate and improper monitoring and care of patients experiencing an acute mental health crisis and on suicide precautions, yet failed to take appropriate and necessary steps to insure that reasonable and adequate care was provided. On information and belief, other than the discipline of defendant William Thompson after the death of Mr. William Goetzee, none of the individuals responsible for the care and safety of Shawn Duncan, Regie Hargrove, William DeMouy, Sr., Matthew Bonnette,

Louis Prince, Julio Sotres, Cayne Miceli, Richard Rowzee, John Sanchez, Michael Hitzman, Jose Nelson Reyes Zelaya, William Goetzee, or any other suicidal prisoners at OPSO who received inadequate, improper or harmful treatment, were disciplined or held accountable for their acts or omissions. The defendants ratified or condoned acts or omissions by OPSO staff which caused serious harm, suffering and death to prisoners at OPP, and maintained a custom and practice whereby there was no accountability for OPP staff who mistreated prisoners or who violated policies, procedures or standards of care for prisoners in need of adequate care for serious medical needs.

94. In addition to the reports from the National Institute of Corrections and the Department of Justice, the defendants were aware of the deficiencies in the physical facilities and HOD-10 in particular, through the monitoring and oversight of the psychiatric department of the Orleans Parish jail from 1992 through 2008, by the federal court in the proceedings entitled Hamilton v Morial, No. 69-2443. Defendants Gusman, Gore and Higgins were aware, prior to William Goetzee's death, that the physical facilities in which severely mentally ill and suicidal prisoners were being held, which included HOD-10, were inadequate, dangerous, un-safe and posed an obvious risk of serious harm to prisoners held there. They were aware that the cells for confinement of inmates who were suicidal did not meet acceptable or community standards of care, that the conditions in which the suicidal prisoners were being held was inhumane and anti-therapeutic and that these conditions presented an obvious risk of serious harm to

mentally ill and suicidal prisoners. Yet defendants continued to accept and house prisoners, such as Mr. Goetzee, whose serious medical needs could not be met under these conditions and in fact, whose mental and medical condition would deteriorate if confined at HOD-10.

95. Defendants knew, must have known, or should have known, that the standard of care for suicidal patients and those experiencing an acute mental health crisis, could not be met by the policies, procedures, staffing or physical facilities of the OPSO but failed to order or to take appropriate steps to see that Mr. Goetzee or other prisoners in similar situations, were transferred and admitted to a hospital where they could receive appropriate and adequate care in accordance with community standards of care.

96. On information and belief, there are other instances where prisoners who were mentally ill and suicidal, suffered harm due to inadequate medical care and monitoring by the defendants and other OPSO staff, yet there was little or no accountability, consequence or discipline imposed on said staff.

97 Defendants Dr. Gore, Dr. Higgins, Benitez, Dr. Ham and Jackson were the supervisors and trainers of defendant nurses, and were responsible to properly train and supervise them and to insure that the nurses under their training and supervision gave proper treatment and monitoring of prisoners, including William Goetzee, which they failed to do.

98. Defendants Gusman, Dr. Gore, Dr. Higgins, Benitez, Dr. Ham and Jackson, at all pertinent times herein, were responsible for the hiring, training, supervision and discipline of OPSO medical personnel and were responsible for the policies, procedures and customs of the medical and psychiatric departments and medical personnel of the OPSO, including medical training of correctional staff at HOD-10. They failed to properly or adequately fulfill their responsibilities.

99. Defendants Dr. Gore, Dr. Higgins, Dr. Dileo, Benitez, Dr. Ham and Jackson, were all persons with the responsibility and duty for oversight, review, monitoring, supervision and evaluation of prisoners' medical and psychiatric needs and the policies and procedures governing the provision of adequate medical care. On information and belief, these defendants were also responsible for the training and supervision of medical and correctional staff, which they failed to adequately perform and also failed themselves to provide adequate medical care. They, along with the defendant Sheriff, were also responsible for receiving and reviewing daily and regular reports regarding persons on suicide watch at the jail and of reviewing and correcting any improper, abusive or inadequate treatment of suicidal prisoners, which they failed to do. These defendants also had the responsibility to conduct thorough and reliable mortality reviews of all deaths of prisoners who were in custody of the OPSO in order to take corrective action, as needed, to prevent further deaths, injury and harm, yet they failed to properly fulfill that duty.

100. Defendants deputies Thompson, William and Crader each had the responsibility and duty to properly monitor Mr. Goetzee while he was on suicide watch, and to communicate his medical needs to the appropriate medical staff for treatment. They were also responsible to insure that he was in a safe and secure environment. They each failed their responsibilities as described herein.

101. Defendants Warden Louque, HOD Watch Commanders John Does I and II, Sgt. Harris and Sgt. Marshall all had responsibility for the training and supervision of defendant deputies and other correctional staff assigned to HOD-10 yet failed in their responsibilities, as described herein.

102. There was no reasonable justification for the manner in which Mr. Goetzee was treated at OPP or for the denial of appropriate treatment, medication and comfort for his serious mental illness, suicidal ideation and anxiety. There was an obvious risk of harm in placing a person with the history and condition of Mr. Goetzee in such conditions as existed at the Orleans Parish jail. The risk of serious harm caused by withholding anti-anxiety medication was obvious. This risk was greatly compounded by failing to properly monitor or evaluate him and withholding appropriate and necessary medical treatment and care from him. The conditions of confinement of Mr. Goetzee constituted punishment, not treatment. In addition, the actions of the defendant deputies and nurses, in ignoring Mr. Goetzee's obvious distress and then essentially abandoning him, was deliberate and cruel and directly contributed to his suffering, pre-death terror and death.

103. Defendants Sheriff Gusman, Dr. Gore, Dr. Higgins, Benitez, Dr. Dileo, Dr. Ham and Jackson, as well as defendant nurses, knew, must have known, or should have known, that the policies and procedures of the jail for providing medical services and treatment of psychiatric patients, including the "suicide watch" procedures, facilities and staff, were seriously deficient and inadequate and posed a serious risk of harm to the serious medical and psychiatric needs of prisoners so confined, yet they failed to take appropriate or necessary steps to correct them.

104. The defendants Sheriff Gusman, Dr. Gore, Dr. Higgins, Benitez, Dr. Dileo, Dr. Ham and Jackson, knew, must have known, or should have known of the serious inadequacies of the policies, procedures, customs and practices at the OPSO jail relating to prisoners who were suicidal, had the obligation and ability to correct these deficiencies but failed to do so.

105. On information and belief, defendants Sheriff Gusman, Dr. Gore, Dr. Higgins, Benitez, Dr. Dileo, Dr. Ham and Jackson, participated in a "mortality review" of the circumstances of Mr. Goetzee's death which sought to cover-up and hide the deficiencies in the policies, customs and practices of the OPSO and inadequate care and treatment provided to Mr. Goetzee while he was in their custody and care, in order to excuse, condone, and ratify their own actions as well as that of their subordinates, and to avoid liability or responsibility for Mr. Goetzee's death.

106. On information and belief, Defendant Gusman knew, must have known or should have known that the defendants were providing false, incorrect and/or

misleading information in order to obfuscate and avoid accountability for their actions and those of others involved in providing inadequate medical care to Mr. Goetzee, as well as other prisoners, yet defendant Gusman failed to take any reasonable or necessary actions to uncover the true facts and instead excused, condoned and ratified their acts and omissions.

107. The risk of serious harm and/or death to Mr. Goetzee was known, must have been known or should have been known to the defendants, who failed to take appropriate and necessary measures to protect and preserve his life and safety, as set forth herein.

108. The actions of the defendants as set forth herein, resulted in the suffering and death of Mr. Goetzee.

109. The acts and omissions of the defendants, as described herein, were under color of law and in the course and scope of their employment.

VI. FIRST CAUSE OF ACTION

110. Plaintiffs repeat and re-allege each and every allegation of the complaint.

111. The defendants, acting individually and together, and under the color of law, engaged in a course of conduct and conspired to engage in a course of conduct which acted to deprive William Goetzee of his constitutional rights and did deprive him of said rights, specifically, the right of William Goetzee to reasonable and adequate medical care, the right to be free from cruel and unusual punishment, the right to be free from unreasonable search and seizures, the right to liberty, the right to be free from

undue bodily restraint, and the right to due process and equal protection of the laws as protected by the First, Fourth, and Fourteenth Amendments of the United States Constitution and 42 U.S.C. 1983.

112. At all times pertinent herein the defendants, acting individually and collectively, acted unreasonably, recklessly and with deliberate indifference and disregard for the constitutional and civil rights and life and serious medical needs of the deceased, William Goetzee.

113. The defendants' actions were reckless, willful, wanton and malicious.

114. Defendants, individually and collectively, had the duty and ability to intervene to prevent the violations of the rights of William Goetzee, deceased, described herein, but failed to do so.

115. Plaintiffs further allege that such acts and omissions as stated herein were the proximate cause and cause in fact of the injuries sustained and the death of William Goetzee and the damages incurred thereby.

VII. SECOND CAUSE OF ACTION

116. Plaintiffs repeat and re-allege each and every allegation of the complaint.

117. Defendants Sheriff Gusman, Dr. Gore, Dr. Higgins, Benitez, Dr. Ham and Jackson, acting individually and collectively, established, condoned, ratified and encouraged customs, policies, patterns and practices at the Orleans Parish Prison which directly and proximately caused the deprivation of the civil and constitutional rights of the deceased as alleged herein, and the injuries and damages described

herein, in violation of the First, Fourth and Fourteenth Amendments to the U.S. Constitution and 42 USC 1983.

118. These written and unwritten policies, customs and practices included, among others:

1. Inadequate, improper and unreasonable screening, treatment, monitoring and supervision of the serious medical and psychiatric needs of persons in custody.
2. Inadequate and unreasonable sick call, referral and followup procedures relative to the serious medical and psychiatric needs of persons in custody.
3. Inadequate and unreasonable on-site medical and psychiatric staffing and coverage.
4. Hiring of inadequately trained persons to render medical and psychiatric treatment to persons in custody.
5. Inadequate training, supervision and discipline of medical personnel responsible for furnishing medical and psychiatric treatment and services to persons in custody.
6. Inadequate hiring, training, supervision and discipline of deputies and supervisors responsible for the observation and monitoring of suicidal prisoners and the identification and communication of serious medical needs of persons in custody to appropriate medical

personnel.

7. A pattern and practice of deputies and medical personnel ignoring prisoners' requests and needs for medical and/or psychiatric attention so that prisoners' serious medical and psychiatric needs were frequently ignored and, in those instances where medical and/or psychiatric treatment was ultimately obtained, it was often unreasonably delayed and inadequate to the medical and psychiatric needs of the prisoners, causing serious pain, suffering, injury and/or death.

8. Inadequate and unacceptable policies, procedures and practices relating to placing persons on suicide watch, including but not limited to the following:

   a. Failing to require regular, frequent and meaningful assessment of the physical and mental status and condition of suicidal prisoners.

   b. Failing to require regular, frequent, meaningful and proper documentation of prisoners under suicide watch by nurses and/or qualified medically trained personnel which include but are not limited to conducting meaningful assessments, taking vital signs, and providing therapeutic care.

c. Failing to require that policies, procedures and practices in the jail for treatment of suicidal and mentally ill prisoners comport with medically accepted standards in the community.

d. Inadequate training, supervision and discipline of deputies who are required to observe and monitor prisoners on "suicide watch" and report and record accurately their observations.

e. Failing to require adequate physical and mental evaluations of inmates to determine whether the use of "suicide watch" procedures were effective.

f. Allowing prisoners to be held in "suicide watch" for unreasonable periods of time without requiring adequate physical and psychiatric examinations by a physician, psychiatrist or other appropriately licensed and trained medical personnel.

g. Permitting and condoning violations by medical and security personnel of written policies and procedures regarding medical and psychiatric care of persons who were suicidal or in acute mental health distress, resulting in significant discrepancies between written

policies and procedures and actual practice and custom, with no meaningful discipline, consequence or accountability for said violations or discrepancies, to the detriment of the health, safety and welfare of the prisoners in their care.

h. Inadequate review or quality control of suicide watch orders, procedures and conditions to insure that they are being properly implemented and monitored.

i. Inadequate documentation and record keeping of suicide watch observation forms of individuals who are under "suicide watch" by failing to adequately train personnel who fill out these reports, failing to require detailed, content-based reporting, failing to make these reports an integral part of the prisoner's medical records, and failing to require or insure frequent, regular review of these documents by medically trained personnel, among other deficiencies.

j. Failing to provide adequate staffing for monitoring, evaluating and treating prisoners under "suicide watch".

k. Improper use of "suicide watch" as punishment and

discipline.

l. Allowing medical and security personnel to prepare inadequate progress notes and records regarding the condition of prisoners who are suicidal or experiencing acute mental health crisis, without appropriate discipline or accountability.

9. Inadequate and unacceptable policies, procedures and practices relating to treatment, observation and monitoring of persons who are suicidal or in need of care for serious medical issues, including but not limited to the following:

a. Accepting prisoners into the jail who are suicidal when the facility lacks appropriate and safe facilities, and has inadequate staff, policies and procedures for their care and safety.

b. Designing and implementing a "Suicide Watch" program that is dehumanizing, counter-productive, anti-therapeutic, harmful and ineffective.

c. Allowing, condoning, permitting and/or ratifying

untrained and undisciplined correctional officers to do monitoring and observation of suicidal prisoners.

d. Allowing, condoning, permitting and/or ratifying the practice of correctional officers not properly or truthfully filling out OPSO Suicide Watch Observation Checklists contemporaneously with the observation.

e. Accepting prisoners into OPSO who have serious medical and psychiatric conditions, when the facility lacks appropriate and safe conditions, and had inadequate staff, policies and procedures for the care and safety of the prisoners.

10. Inadequate, deficient or non-existent treatment plans for patients who were suicidal and experiencing an acute mental health crisis.

11. Inadequate quality control policies, procedures and practices, inadequate critical incident review, inadequate mortality reviews and inadequate identification and correction of serious deficiencies in policy and practices affecting the delivery and quality of medical and psychiatric services.

119. At all times pertinent herein the defendants acted unreasonably and with deliberate indifference and disregard for the constitutional and civil rights and life and safety of the deceased, William Goetzee. The actions of the defendants were malicious, willful, wanton and reckless.

120. Plaintiffs further allege that such acts and omissions as alleged herein were the proximate cause and cause in fact of the injuries sustained, the death of William Goetzee and the damages incurred.

VII. THIRD CAUSE OF ACTION

121. Plaintiffs repeat and re-allege each and every allegation of the complaint.

122. William Goetzee was a person with a disability under Section 504 and the Americans with Disabilities Act (ADA). He suffered from mental illness, psychosis, paranoia, acute anxiety and was at high risk of suicide.

123 Defendant Sheriff Marlin Gusman is in charge of the Orleans Parish Sheriff's Office and is a public entity that must comply with Section 504 and the Americans with Disabilities Act.

124. Plaintiffs are entitled to relief against the defendant Sheriff Marlin Gusman, as he and the Orleans Parish Sheriff's Office had notice of William Goetzee's disability, had the means to reasonably accommodate his disability, and failed to make that reasonable accommodation.

125. Section 504 of the Rehabilitation Act requires recipients of federal funds, including defendant Sheriff Marlin Gusman and the Orleans Parish Sheriff's Office, to

reasonably accommodate persons with disabilities in their facilities, program activities and services. It further requires such recipients to modify such facilities, services and programs as necessary to accomplish this purpose. Defendant Sheriff Marlin Gusman and the Orleans Parish Sheriff's Office have been and are recipients of federal funds.

126. The ADA defines discrimination as the failure to take necessary steps to ensure that no individual with a disability is excluded, denied services, segregated, or otherwise treated differently than other individuals because of the absence of services for the disabled. Such services include, inter alia, provisions necessary to achieve effective mental health care and protect a person from suicide.

127. Instead of accommodating William Goetzee's needs, defendant Sheriff Gusman and the Orleans Parish Sheriff's Office denied Mr. Goetzee services and programs available to others, including but not limited to access to appropriate medication, access to attorney-client and spiritual/religious visits, family contact, access to a telephone, and access to appropriate care and treatment that could have protected him from suicide and could have reduced the risk of harm of suicide. The failure to accommodate William Goetzee's disability was intentional and/or deliberately indifferent to William Goetzee's rights under Section 504 and Title II of the ADA and was a proximate cause of his death.

IX. FOURTH CAUSE OF ACTION

128. Plaintiffs repeat and re-allege each and every allegation of the complaint.

129. The pendant jurisdiction of the Court is invoked for all claims under state

law.

130. At all times described herein, the defendants, individually and collectively, acted negligently, with gross negligence and/or intentionally in denying reasonable, adequate and necessary medical care to William Goetzee, confining him in unsafe, unreasonable and dangerous conditions providing him with access to material with which to harm himself and inflicting physical injury and severe emotional, mental and physical pain and suffering upon him, in violation of Louisiana law.

131. The actions of the defendants also caused the wrongful death of William Goetzee. At all pertinent times the defendant employees of the OPSO were acting in the course and scope of their employment and the defendant sheriff Gusman in his official capacity is vicariously liable for the injuries sustained and damages incurred herein as a result of their actions.

132. The defendants Dr. Gore, Dr. Higgins, Dr. Dileo, Dr. Ham, Jackson, Wallace, Pembo, Batiste, Schaible, Bargky, and Johnson each acted in derogation of their duties as medical professionals and their treatment of William Goetzee was beneath the community standard of care.

133. The defendants are liable for the wrongs complained of herein by virtue of encouraging, aiding, abetting, counseling, ratifying and condoning the commission of the afore described acts, by their failure to properly administer, organize and staff the medical and correctional program at the jail and for the failure to properly screen, hire,

train, supervise and discipline persons under their supervision and control whose acts and omissions contributed to the injuries sustained and the death of William Goetzee.

134. The defendants are liable individually and jointly for their actions as alleged herein.

135. Plaintiffs further allege that the above described acts and omissions were the proximate cause and cause in fact of the injuries described herein.

X. DAMAGES

136. As a result of the actions of the defendants as described above, damages have been incurred as follows:

1. William Goetzee (deceased) suffered conscious and severe physical, mental and emotional distress, pain and suffering and pre-death terror prior to his death and lost his life.

2. Margaret Goetzee Nagle, the sister of William Goetzee, John Eric Goetzee, the brother of William Goetzee, suffered emotional pain and suffering, past, present and future, and suffered the loss of love, affection, and companionship of their brother, William Goetzee.

3. Funeral and burial expenses in excess of $11,000.00 were incurred as a result of the actions alleged herein.

XI. PRAYER FOR RELIEF

WHEREFORE, plaintiffs pray that after due proceedings there be judgment rendered herein in plaintiffs' favor and against all defendants individually and jointly, as follows:

1. Compensatory and punitive damages as prayed for herein;

2. Reasonable attorneys fees, all costs of these proceedings including expert witness fees under 42 USC 1988 and 12205, et seq. and legal interest;

3. That this matter be tried by jury; and

4. All other relief that this Honorable Court deems just and proper.

Respectfully submitted,

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Goetzee.Complaint20July2012