IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF INDIANA

TARRA GARNER-JONES, as Administrator of the ESTATE OF ARCHON GARNER, Plaintiff, v. ROBERT CARTER, DENNIS REAGLE, DUSHAN ZATECKY, RICHARD LATOUR, VEDORA HINSHAW, JESSICA HEATHERLY, JOHN DOES 1–4, WEXFORD OF INDIANA, LLC, DR. CHRISTINE LIEDTKE, ERIN DAY, DR. CARLA ARELLANO, DR. MARTIAL KNIESER, and HERBERT TROYER, Defendants.	)	Case No. 21-2928 JURY TRIAL DEMANDED

COMPLAINT

Plaintiff Tarra Garner-Jones, as Administrator for the Estate of her son, Archon Garner, by her undersigned attorneys, for her complaint against Defendants Commissioner Robert Carter, Warden Dennis Reagle, former Warden Dushan Zatecky, Counselor Richard Latour, Unit Team Manager Vedora Hinshaw, Officer Jessica Heatherly, Officers John Does 1–4, Wexford of Indiana, LLC, Dr. Christine Liedtke, MHP Erin Day, Dr. Carla Arellano, Dr. Martial Knieser, and MHP Herbert Troyer, alleges as follows:

INTRODUCTION

1. Archon Garner (or "Shawnie," as he was known to family and friends) struggled with severe mental illness since the young age of five years old. He was frequently hospitalized as a child and first attempted to take his own life at the age of ten by cutting his wrists. As an adult he was diagnosed with Bipolar I Disorder, Schizophrenia, and Post-Traumatic Stress Disorder, conditions which manifested in chronic mania and paranoia.

2. After experiencing intensifying manic episodes, and with the support of his family, Mr. Garner began inpatient treatment in the spring of 2016. He was admitted to St. Anthony's Memorial Hospital for psychiatric care. A judge later issued a commitment order extending his hospital stay, and he was transferred to other facilities for inpatient psychiatric care.

3. While still under court commitment, Mr. Garner struck a staff member at Richmond State Hospital. The State prosecuted him for battery. Despite his lengthy history of severe mental illness, Mr. Garner was convicted and received a five-year prison sentence. He entered the Indiana Department of Corrections ("IDOC") on August 27, 2018. IDOC assigned Mr. Garner to the Intensive Residential Treatment Unit ("IRT") at Pendleton Correctional Facility ("Pendleton").

4. At Pendleton, Mr. Garner attempted suicide at least four times. Instead of transferring Mr. Garner to an outside psychiatric care facility for inpatient care that he desperately needed, the Defendants left Mr. Garner on suicide watch, in highly restrictive conditions, for weeks at a time. These long stays on suicide watch did nothing to improve his mental state; indeed, they likely worsened it.

5. On June 23, 2020, mental health staff at Pendleton took Mr. Garner off suicide watch. Within hours, he cut his neck in a serious suicide attempt, requiring stitches. The next day he ripped out the stitches and re-opened the wound in his neck. Still, Defendants took no steps to send him to an outside hospital for acute psychiatric care. Instead, they put Mr. Garner back on suicide watch in the IRT.

6. On July 14, 2020, Defendant Erin Day discontinued Mr. Garner's suicide protocols and approved him for return to the general population in the IRT. Mr. Garner's peers alerted staff that Mr. Garner was actively suicidal, yet he was left alone in a single-man cell overnight. On

information and belief, the correctional officer(s) charged with conducting thirty-minute cell checks in Mr. Garner's unit failed to do so.

7. A mental health worker discovered Mr. Garner's body in his cell the morning of July 16, 2020. Mr. Garner was dead of an apparent suicide, with a gaping wound to his throat, and a razor blade nearby.

JURISDICTION AND VENUE

8. This Court has jurisdiction pursuant to 28 U.S.C. §§ 1331 and 1367.

9. Venue is proper in this district pursuant to 28 U.S.C. § 1391(b) because the events giving rise to the claims asserted in this complaint occurred in this judicial district.

PARTIES

Plaintiff

10. Archon Garner, the decedent, was a twenty-nine-year-old Black man held in the Pendleton IRT from September 25, 2018, until his death on July 16, 2020. Under the terms of the Americans with Disabilities Act and the Rehabilitation Act, he was a qualified individual with a disability who suffered from multiple serious mental illnesses, including Bipolar and Schizoaffective Disorders.

11. Plaintiff Tarra Garner-Jones is Mr. Garner's mother and the duly appointed administrator of Mr. Garner's estate.

Correctional Defendants

12. Defendant Robert Carter is the Commissioner of the IDOC. The IDOC is a public entity and a recipient of federal funding. At all times relevant to the events at issue in this case, Defendant Carter was responsible for ensuring prisoners with disabilities, including the decedent

Mr. Garner, were not excluded from IDOC services, programs, or activities, or subjected to discrimination by IDOC. Defendant Carter is sued in his official capacity as IDOC Commissioner.

13. Defendant Dennis Reagle is the current Warden of Pendleton Correctional Facility and the former Deputy Warden. At all times relevant to the events at issue in this case, Defendant Reagle was responsible for establishing and implementing policies and procedures to protect the health and safety of prisoners confined in Pendleton, including Mr. Garner, supervising all staff, and managing all operations at Pendleton. As such, his actions and omissions were under color of law. He is sued in his individual capacity.

14. Defendant Dushan Zatecky is the former Warden of Pendleton Correctional Facility, and was employed in this capacity from February 2013 to July 2020. At all times relevant to the events at issue in this case, Defendant Warden Zatecky was responsible for establishing and implementing policies and procedures to protect the health and safety of prisoners confined in Pendleton, including Mr. Garner, supervising all staff, and managing all operations at Pendleton. As such, his actions and omissions were under color of law. He is sued in his individual capacity.

15. Defendant Richard Latour is a counselor (also known as a caseworker) in the IRT and was employed by the IDOC during the relevant period. Defendant Counselor Latour was a member of Mr. Garner's treatment team. At all times relevant to the events at issue in this case, Defendant Counselor Latour was acting under color of law. He is sued in his individual capacity.

16. Defendant Vedora Hinshaw was the Unit Team Manager in the IRT and was employed by the IDOC during the relevant period. At all times relevant to the events at issue in this case, Defendant Unit Team Manager Hinshaw was acting under color of law. She is sued in her individual capacity.

17. Defendant Jessica Heatherly is a correctional officer at Pendleton. She was employed by IDOC during the relevant period and worked in the IRT B Building July 15-16, 2020. At all times relevant to the events at issue in this case, she was acting under color of law. She is sued in her individual capacity.

18. Defendants John Does 1–4 are correctional officers at Pendleton. Defendant John Doe 1 was the lieutenant responsible for the safety, security, and operations of the IRT. At all times relevant to the events at issue in this case, Defendant Lieutenant Doe 1 was responsible for the health and safety of prisoners confined to the IRT, including Mr. Garner, supervising all IRT staff, and managing all operations in the IRT. Officer Does 2–4 were working in the IRT the night of July 15–16, 2020, and the morning of July 16, 2020, and were responsible for the safety and security of the prisoners in their care. At all times relevant to the events at issue in this case, the Officer Doe defendants were acting under color of law. Their identities are currently unknown. The Officer Doe defendants are sued here in their individual capacities.

Wexford Defendants

19. Defendant Wexford of Indiana, LLC ("Wexford"), a limited liability company, was at all times relevant to the events at issue under contract with the IDOC to provide healthcare services to people incarcerated in the IDOC. At all times relevant to the events at issue in this case, Wexford was responsible for the implementation, oversight, and supervision of policies and practices at Pendleton related to the provision of mental health care. As an agent of IDOC, Wexford was at all times relevant to the events at issue in this case acting under color of law by and through its employees and/or agents.

20. Defendant Dr. Christine Liedtke is a psychologist employed by Wexford who provided mental health care to Mr. Garner during the relevant period, including through

supervision of other mental health staff. At all times relevant to the events at issue in this case, Dr. Liedtke was acting under color of law and within the scope of her employment with Wexford. She is sued in her individual capacity.

21. Defendant Erin Day is a clinical social worker (also known as a mental health professional, or "MHP") employed by Wexford who was responsible for Mr. Garner's mental health care in the IRT. At all times relevant to the events at issue in this case, MHP Day was acting under color of law and within the scope of her employment with Wexford. She is sued in her individual capacity.

22. Defendant Dr. Carla Arellano is a psychiatrist employed by Wexford. She was responsible for providing psychiatric care services to Mr. Garner during the relevant period, including supervision of other mental health staff. At all times relevant to the events at issue in this case, Dr. Arellano was acting under color of law and within the scope of her employment with Wexford. She is sued in her individual capacity.

23. Defendant Dr. Martial Knieser is a physician employed by Wexford. He was responsible for Mr. Garner's healthcare, including responding appropriately to Mr. Garner's multiple suicide attempts, and supervising other medical staff, including staff responsible for assessing Mr. Garner's condition on suicide observation. At all times relevant to the events at issue in this case, Dr. Knieser was acting under color of law and within the scope of his employment with Wexford. He is sued in his individual capacity.

24. Defendant Herbert Troyer is a mental health counselor (also known as a mental health professional or "MHP") employed by Wexford. He was responsible for providing mental health care to Mr. Garner. At all times relevant to the events at issue in this case, Mr. Troyer was

acting under color of law and within the scope of his employment with Wexford. He is sued in his individual capacity.

FACTUAL ALLEGATIONS

Mr. Garner's History of Serious Mental Illness

25. Mr. Garner was funny, kind-hearted, loving, and thoughtful. He loved his family, especially his young nieces, and he loved his grandmother's home-cooked meals.

26. Mr. Garner also struggled with debilitating mental illness from an early age. As a young boy, he was diagnosed with Intermittent Explosive Disorder, Bipolar Disorder, and Attention Deficit Hyperactivity (ADHD) Disorder.

27. Mr. Garner's first psychiatric hospitalization occurred at the age of five for emotional and behavioral issues.

28. By the age of ten, Mr. Garner was struggling with severe depression, anxiety, and manic episodes. He attempted to commit suicide for the first time at the age of ten by cutting his wrists.

29. At the age of eleven he went to Porter-Starke Residential Hospital in Valparaiso, Indiana for ten months. When he was eighteen, he spent three years at Richmond State Hospital.

30. Mr. Garner's medical records indicate a lengthy history of suicide attempts, substance use, and frequent inpatient hospitalization, all of which placed him at an elevated risk of suicide. Between 2008 and 2015, Mr. Garner received psychiatric care in both in- and outpatient treatment facilities, lived periodically in residential and group homes, and was committed by court order for extended treatment several times. In 2015, he was diagnosed with Schizophrenia.

Events Leading Up to Mr. Garner's Incarceration in the IDOC

31. In 2016, Mr. Garner again required psychiatric help for his illness, and was admitted to St. Anthony's Memorial Hospital. Soon after, a judge issued a civil commitment order extending his stay. He was transferred first to Madison State Hospital, and later to Richmond State Hospital, where he stayed for twelve months.

32. While receiving psychiatric care at Richmond, Mr. Garner struck a staff member. Mr. Garner was sentenced to five years in prison for battery. In issuing Mr. Garner's criminal penalty, the sentencing court recommended confining Mr. Garner to a facility where he would receive mental health counseling and treatment.

33. On August 27, 2018, Mr. Garner entered IDOC custody, and on September 25, 2018, he was transferred to the Pendleton Correctional Facility. It was his first incarceration in state prison.

Mr. Garner's Mental Health Deteriorates in IDOC Custody

34. Mr. Garner's initial prison medical screening indicated a preliminary diagnosis of Bipolar I with possible psychotic features, Post-Traumatic Stress Disorder from his placement in the State Hospital, and potential Schizoaffective Disorder.

35. Mr. Garner alerted screening staff to his history of substance dependency, a severe risk factor for suicide when coupled with severe mental illness, particularly Bipolar Disorder and Schizophrenia. During an early suicide screening, Mr. Garner reported five additional risk factors, including a previous suicide attempt and a family member who had committed suicide.

36. Mr. Garner was assigned to Pendleton's Intensive Residential Treatment ("IRT") unit in recognition of his serious mental health needs.

37. Prisoners in the IRT are assigned to different phases of the program; the higher the phase, the more privileges a prisoner has. Prisoners with the most privileges are assigned to IRT Building A; prisoners with fewer privileges are assigned to IRT Building B; and prisoners with the fewest privileges are assigned to IRT Building C.

38. Building C operates in part as a disciplinary housing unit for IRT prisoners. Despite its programmatic purpose to address the mental health needs of seriously mentally ill prisoners, the IRT still uses solitary confinement as punishment for disciplinary infractions. Prisoners in Building C are confined to their cell for 23-24 hours a day, and when they leave their cell, they are required to be restrained.

39. Upon information and belief, the IRT is not accredited as a psychiatric facility, nor does it have the capacity to facilitate the kind of hospital-level psychiatric care that Mr. Garner desperately needed in the months leading up to his death.

40. Throughout his time at Pendleton, Mr. Garner struggled with drug use as a way of self-medicating his mental illness. Pendleton staff responded to Mr. Garner's struggles with drug use by regularly punishing him for intoxication and possession of drug paraphernalia. Punishment was also Pendleton's response when Mr. Garner's mental illness created conflicts with other prisoners.

41. Despite Mr. Garner's mental illness, Pendleton staff punished him by restricting access to his tablet, commissary, and importantly, by denying him phone calls to his family. Mr. Garner was deprived of these privileges for extended periods from September 13, 2019, through April 25, 2020. Mr. Garner tried to maintain contact with family, calling them on the phone every week and communicating with them on his tablet, receiving words of love and encouragement.

When Mr. Garner was denied phone calls and the use of his tablet, there were weeks and months at a time when he could not speak with family and could not be reassured of their love and support.

42. Mr. Garner was also punished with the loss of hundreds of days of earned good time credit. Upon entry to IDOC his possible release date was September 19, 2021, but by the time of his death, his earliest possible release date was March 30, 2022.

Conflicts with Other Prisoners and Requests for Protective Custody

43. Mr. Garner's paranoia escalated in IDOC custody. He repeatedly expressed anxiety over conflicts with other prisoners and fear for his own safety during psychotherapy sessions.

44. On March 15, 2019, he reported that he saw his friend assaulted in front of his cell door, which triggered paranoia and hypervigilance. Mr. Garner expressed that he did not like it when people were behind him, or when he was unable to see everything, and reported believing that everyone was talking about him.

45. On December 7, 2019, Mr. Garner had a physical altercation with another prisoner based on Mr. Garner's belief that the prisoner had infected him with an infectious disease. As a result of the altercation, Mr. Garner was placed in C building and confined to his cell for 23-24 hours a day.

46. Following the altercation, Mr. Garner felt he was at risk of retaliation. On December 15, 2019, he requested protective custody. Mr. Garner told officers that he believed there was a $3,200 nationwide hit out on his head and that he believed other prisoners in the IRT were concealing weapons in their cells to use against him. He reported that he was afraid other prisoners were "out to get him." He alerted medical staff that if not placed in protective custody, he would do "whatever he has to do to hurt himself" before others could hurt him.

47. Mr. Garner's family became increasingly concerned for his health and safety. In December 2019, Mr. Garner's family contacted Pendleton staff, including Defendants Deputy Warden Reagle, Counselor Latour, and Unit Team Manager Hinshaw, to express the family's concerns for Mr. Garner's health and safety and to ask for help. Their requests fell on deaf ears.

48. On January 30, 2020, the protective custody committee denied Mr. Garner's request for protective custody. The protective custody committee included Defendant MHP Troyer and other members of Pendleton's custody and mental health staff. On information and belief, Defendants Warden Zatecky and Deputy Warden Reagle were aware of the protective custody committee's denial of protective custody status to Mr. Garner.

49. Following the protective custody committee's denial, mental health staff continued Mr. Garner on Phase 2 Cuff Status, meaning that he was required to be restrained whenever he left his cell. Mr. Garner remained in the C building in restrictive housing until February 6, 2020.

Mr. Garner Experienced an Acute Psychiatric Crisis Leading to Multiple Suicide Attempts in the Months Before his Death

First Suicide Attempt

50. In early April 2020, Mr. Garner began demonstrating increased paranoia, including fears that he was seriously ill with dementia or cancer.

51. On April 16, 2020, Mr. Garner was found in another prisoner's cell with blood on his face and clothing. Ligature marks found around his neck indicated a hanging attempt.

52. Mr. Garner told Defendant MHP Troyer that he had tried to hang himself because "someone was trying to kill him," and that another prisoner had punched him in the face. On information and belief, Mr. Garner had asked the other prisoner to kill him.

53. Mr. Garner told his family that another prisoner had attacked him by throwing gasoline on him and attempting to set him on fire, and that he had to harm himself to get the attention of corrections staff so that they would take this threat seriously.

54. Mr. Garner again made it known that he required protective custody, saying he was not safe in the IRT and needed to be moved. On information and belief, Pendleton staff members again failed to act on this request, with knowledge of both Defendants Warden Zatecky and Deputy Warden Reagle.

55. Despite the seriousness of this suicide attempt and the acuity of Mr. Garner's obvious psychiatric illness, none of the Defendants assessed Mr. Garner for referral to an inpatient psychiatric facility or referred him to such a facility. Contrary to the standard of care, he was not assessed by a psychiatrist. Instead, Defendant MHP Troyer ordered that Mr. Garner be placed on constant suicide watch, where he was deprived of all personal items and allowed nothing in his cell but a mattress, suicide blanket, and suicide smock.

56. Suicide watch in the IRT is not a therapeutic intervention or mental health treatment; rather, it is punishment, especially for people with severe mental illness. Prisoners on suicide watch have no personal property or clothing, are confined to their cell 24 hours a day, and are mostly unable to contact family by phone. IDOC assigns other prisoners to "eyeball" suicidal prisoners by watching them constantly and reporting on their behavior. Suicide watch is not an effective intervention for a suicidal prisoner and is no substitute for commitment to an inpatient psychiatric facility.

57. On April 21, 2020, Defendant Dr. Liedtke evaluated Mr. Garner on suicide watch. She acknowledged that his suicidality was "significant," in part because Mr. Garner reported to her that he would "harm himself to get away from perceived threats."

58. On April 22, 2020, Mr. Garner told mental health intern Taylor Kolditz that he would rather "kill himself than get stabbed." Ms. Kolditz continued Mr. Garner's suicide watch. The next morning, however, Ms. Kolditz removed him from suicide watch, even though Mr. Garner said that he was "about the same as yesterday" and that he would hurt himself again if he felt that others were after him. On information and belief, no supervisor signed off on Ms. Kolditz's decision to discontinue Mr. Garner's suicide watch.

59. Later that day, Mr. Garner was returned to suicide watch after he told a nurse that he was not feeling safe and thought he would start trying to kill himself.

60. Ms. Kolditz again discontinued Mr. Garner's suicide watch on April 29, 2020. She discontinued his watch despite Mr. Garner saying that he was still afraid of other prisoners and informing her that if he was ever sent back to the IRT general population, he would have to return to suicide watch.

61. In May 2020, Mr. Garner repeatedly informed staff including Defendants MHP Day and MHP Troyer that he feared for his life because other prisoners were "out to get him." He told Defendant MHP Troyer that he was in danger in the IRT program, would hurt himself if sent back to the IRT general population, and that he needed to be transferred elsewhere for his own safety. On information and belief, Defendants nevertheless took no steps to have Mr. Garner transferred to another facility or address his safety concerns.

62. On May 20, 2020, Mr. Garner's treatment team met to discuss his situation. They acknowledged the decline in Mr. Garner's mental status and attributed it to either an increase in psychosis due to organic reasons, drug debt, or illicit substances.

Second Suicide Attempt

63. On June 11, 2020, Mr. Garner told Defendant MHP Day that he was stressed due to not being safe, and that someone was after him. He again asked to be sent to another facility. Defendant MHP Day assessed Mr. Garner as having made "minimal progress" and noted his anxiety as significant. Defendant MHP Day was an intern, yet no supervisor signed off on her report.

64. On June 15, 2020, Mr. Garner attempted suicide by swallowing approximately fifty Remeron pills, a prescription antidepressant. He reported the overdose to nursing staff an hour after taking the pills, who in turn reported this to Defendant Dr. Knieser.

65. Despite the seriousness of this suicide attempt and the acuity of Mr. Garner's obvious psychiatric illness, none of the Defendants assessed Mr. Garner for referral to an inpatient psychiatric facility or referred him to such a facility. Contrary to the standard of care, no psychiatrist evaluated him until five days later. Instead, a Wexford employee ordered Mr. Garner again be placed on constant suicide watch in his cell. Mr. Garner was allowed no property on suicide watch except a mattress, suicide blanket, and suicide smock.

66. On June 18, 2020, Defendant Dr. Liedtke moved Mr. Garner from constant to close suicide watch. While under close observation, staff were still required to conduct regular visual checks of Mr. Garner at least every fifteen minutes.

67. When Defendant Dr. Arellano finally met with Mr. Garner on June 20, 2020, she found that he was still suicidal and was having auditory hallucinations telling him to kill himself. Mr. Garner told Dr. Arellano that he was going to kill himself, "it's just a matter of time." Dr. Arellano still took no steps to refer Mr. Garner to an outside hospital where he could receive intensive inpatient psychiatric care.

68. That same day, one of the IRT nurses reported to mental health staff, including to Defendants MHP Troyer and Dr. Liedtke, that Mr. Garner was "hopeless, distraught, devastated/tearful/paranoid." Mr. Garner described issues with substance abuse, the death of his grandmother, debts owed to other prisoners, and a history of self-harm. He requested transfer to the mental health treatment program at New Castle Correctional Facility ("New Castle Psychiatric Facility" or "New Castle"). Mr. Garner's depression and suicidality were both assessed as significant. He described a plan to kill himself by jumping over a cellhouse railing and breaking his neck several times. Mr. Garner stated that due to his fear of other prisoners, he would rather take his own life than be hurt by the people he believed to be "after him." Pendleton security staff was also notified of Mr. Garner's plan to kill himself, including, on information and belief, Defendants Warden Zatecky and Deputy Warden Reagle.

69. On June 23, 2020, Mr. Garner reported to Defendant MHP Day that he feared for his own safety, believing that other prisoners were "out to get him." Defendant MHP Day nevertheless discontinued Mr. Garner's suicide watch. Defendant MHP Day recognized that Mr. Garner's anxiety and psychotic symptoms were significant, but assessed that his depression and suicidality were not significant. Although Defendant MHP Day was an intern, no supervisor signed off on her decision to remove Mr. Garner from suicide watch.

Third Suicide Attempt

70. Within hours of being taken off suicide watch by Defendant MHP Day on June 23, 2020, Mr. Garner attempted suicide. He was found covered in blood. Mr. Garner had lacerated his neck and tried to hang himself with a sock. He told medical staff that he had also swallowed twenty plastic bags.

71. Mr. Garner was transported to an outside medical facility for emergency medical treatment to suture his neck wound. Mr. Garner told Wexford staff that "he was disappointed he did not hit his jugular and that he would do this again along with breaking his neck when he returns."

72. Mr. Garner returned to the prison around 2:45pm on the same day. Despite the seriousness of this suicide attempt and the acuity of Mr. Garner's obvious psychiatric illness, none of the Defendants assessed Mr. Garner for referral to an inpatient psychiatric facility or referred him to such a facility. Contrary to the standard of care, no psychiatrist assessed him until four days later. Wexford's only response was to again place Mr. Garner on constant suicide watch with no property and with a prisoner monitoring him, an order signed by Defendant Dr. Liedtke.

Fourth Suicide Attempt

73. While on constant suicide watch, Mr. Garner made a fourth suicide attempt the following day on June 24, 2020.

74. Medical staff discovered Mr. Garner in a dark cell with the lights turned off. Mr. Garner had used a toenail to remove the sutures from his neck and then put pen ink inside the re-opened wound. Despite his multiple recent suicide attempts, Mr. Garner was found in possession of plastic bags and pens. Defendant Dr. Liedtke described Mr. Garner as "very intent on self harm and will seek any and all opportunities to do so at this time." She acknowledged that "[a]ll encounters with [Mr. Garner] ha[ve] had the same tone/ will to carry out plan." Mr. Garner told her that it was "better for him to 'do it' than to let others get him."

75. After this fourth suicide attempt, Mr. Garner told Wexford staff: "No one cares and God won't help me and I'm just trying to get out of the way."

76. Despite the seriousness of this suicide attempt and the acuity of Mr. Garner's obvious psychiatric illness, still none of the Defendants assessed Mr. Garner for referral to an inpatient psychiatric facility or referred him to such a facility. No psychiatrist evaluated him until three days later. Wexford's only response was to continue Mr. Garner on constant suicide watch, only this time specifying that the lights in his cell were to remain on.

77. On June 26, 2020, Wexford staff noted that Mr. Garner had been placed on suicide watch "several times" due to fearing for his safety. They recommended transfer to New Castle. New Castle has a mental health unit, but it is not a hospital-level inpatient psychiatric treatment facility, as was needed in light of Mr. Garner's acute suicidality.

78. Defendant Dr. Arellano met with Mr. Garner on June 27, 2020, while he was still on suicide watch. Defendant Dr. Arellano observed that Mr. Garner had "a large hole in his neck." Mr. Garner reported causing more harm to his neck wound that same day. Mr. Garner told Defendant Dr. Arellano that "demons are causing suicidal thoughts, creating . . . signs that he should kill himself." He was "depressed" and "paranoid," and believed that other prisoners and a correctional officer wanted to harm him. He again reiterated his request to transfer to another prison facility, and was "quite eager" about the possibility. Mr. Garner told Defendant Dr. Arellano that "if he can be transferred to another facility [he would] dedicate his life to helping others if he can get out of here." He said he wanted "to be there for his family when he gets out."

79. Around this period in June 2020, Mr. Garner's family grew increasingly concerned about his welfare, and they again raised their concerns with IDOC. Ms. Garner-Jones contacted IDOC Ombudsman Charlene Burkett to express her concerns and to initiate an internal investigation. Mr. Garner's grandparents contacted Defendant Deputy Warden Reagle to urge him to transfer Mr. Garner to another facility, and he made clear that it was a matter of life or death.

From speaking with Mr. Garner's family on multiple occasions throughout his incarceration, Defendant Deputy Warden Reagle knew that Mr. Garner needed to be transferred out of the IRT, yet on information and belief, he took no steps to transfer him.

80. On June 30, 2020, Defendant MHP Day assessed Mr. Garner's level of suicidality. She recognized that Mr. Garner expressed suicidal ideation and existence of a suicidal plan, all of which indicated he was still at high risk of suicide. Mr. Garner told her that he spoke to God in a dream. Defendant MHP Day's signature reflects that she was still an intern.

81. On July 1, 2020, Defendant Dr. Liedtke ordered that Mr. Garner be reduced from constant to close suicide watch.

82. On July 7, 2020, Defendant Dr. Lietdke met with Mr. Garner. She assessed his anxiety, impulse control, psychotic symptoms, and suicidality all as significant.

83. As of July 10, 2020, Mr. Garner was still awaiting a bed placement at New Castle. In a session with Defendant MHP Day, Mr. Garner reported impulsive thoughts, delusional thoughts, intrusive thoughts of self-harm, and continued to endorse suicidal intent. He told Defendant MHP Day that he feared for his life and that if he was taken of suicide watch, he would harm himself. He also told Defendant MHP Day that if he went out to the IRT general population, "he would rather kill himself than have someone else kill him." For the first time, Defendant MHP Day signed this note as a mental health professional and not as an intern.

84. On July 11, 2020, Defendant Dr. Arellano met with Mr. Garner. She again noted many symptoms of Mr. Garner's depressed and suicidal state—finding that he had a depressed mood, negative thoughts, "feels hopeless," "feels like people are against him," and "wonders if he has a future." Mr. Garner was only optimistic when they discussed transfer to another facility. He promised that if he were transferred, he would "turn his life around." Defendant Dr. Arellano noted

that Mr. Garner was "pending transfer to another facility for higher level of care," and would "remain in [the Hospital Restraint Unit] until [the] treatment team determines he is safe to return to his cell."

Mr. Garner's Death in IDOC Custody

85. At 7:00 a.m. on July 14, 2020, Defendant MHP Day discontinued Mr. Garner's suicide observation and approved his transfer to the IRT general population in B Building. She did so despite being aware of Mr. Garner's recent history of multiple suicide attempts and his well-known pattern of attempting suicide shortly after the discontinuation of suicide watch, and even though Mr. Garner had repeatedly expressed to her and other staff that he would hurt himself if forced to return to the general population in the IRT.

86. Defendant MHP Day had been an intern only fourteen days before making the decision to discontinue Mr. Garner's suicide watch and return him to the IRT general population. On information and belief, Defendant MHP Day removed Mr. Garner from suicide observation without seeking approval from a supervisor, and despite the fact that she lacked the qualifications to properly assess Mr. Garner and remove him from suicide watch.

87. Defendants Dr. Liedtke and Dr. Arellano failed to supervise Defendant MHP Day and failed to meet with Mr. Garner to assess his suicidality before he was removed from observation in the Hospital Restraint Unit and returned to the IRT general population.

88. IRT staff moved Mr. Garner to the B Building later that same day on July 14, 2020.

89. On July 15, 2020, Mr. Garner notified at least two fellow prisoners that he was going to kill himself. Upon information and belief, those prisoners reported Mr. Garner's ongoing suicidal intent to IRT staff, including Defendant Officer Heatherly. Although Defendant Officer

Heatherly was the officer responsible for the B Building, she failed to take adequate steps to protect Mr. Garner from the risk of suicide.

90. Upon information and belief, after learning of Mr. Garner's suicidal intent, Defendant Officer Heatherly did not contact her supervisor, the prison warden, anyone on Mr. Garner's treatment team, or medical staff who could have acted to preserve Mr. Garner's life, despite a responsibility to do so.

91. Upon information and belief, Defendant Officer Heatherly failed to perform thirty-minute checks in Mr. Garner's housing unit and on Mr. Garner the evening of July 15, 2020, through the morning of July 16, 2020. These thirty-minute checks were required by policy and meant to protect seriously mentally ill prisoners like Mr. Garner from suicide.

92. Defendant Officer Heatherly's supervisor, Defendant Officer Doe 2, failed to adequately supervise Defendant Officer Heatherly to ensure that she completed her thirty-minute rounds during the evening of July 15, 2020, and through the morning of July 16, 2020.

93. Defendant Officer Doe 3 also failed to conduct requisite thirty-minute checks in Mr. Garner's housing unit and on Mr. Garner during the evening of July 15, 2020, and through the morning of July 16, 2020.

94. Defendant Officer Doe 4 failed to supervise Defendant Officer Doe 3 to ensure that he completed his thirty-minute rounds during the evening of July 15, 2020, and through the morning of July 16, 2020.

95. No member of security staff noticed that Mr. Garner was bleeding, injured, or in crisis of any kind, despite it being their responsibility to monitor him and the other seriously mentally ill men in the IRT during the evening of July 15, 2020, and through the morning of July 16, 2020.

96. On July 16, 2020, at 7:40 a.m., a Wexford staff member approached Mr. Garner's cell for the start of group therapy. She observed Mr. Garner lying on the floor with significant amounts of blood on and around him and no bodily movement. Mr. Garner had a single gaping deep incised wound (9.2 x 3.5 cm) to the left side of the neck. Efforts to revive Mr. Garner at the prison failed. Defendant Dr. Knieser pronounced Mr. Garner dead at 7:55 a.m.

97. The coroner found that the sharp force injury to Mr. Garner's neck caused injury to his left external carotid artery, the left jugular vein, and the left sternocleidomastoid muscle. The coroner also found multiple linear healing incised wounds to Mr. Garner's right neck, which he deemed evidence of a previous suicide attempt approximately three weeks before his death.

98. A razor blade was located near Mr. Garner's body inside his cell. Mr. Garner was not supposed to have access to a razor blade. Defendants Officer Heatherly and Officers Does 2–4 failed to adequately search Mr. Garner's person and cell to ensure that he did not have access to a razor blade upon his return to IRT general population and his placement in a single-man cell with no observation.

99. Defendants Counselor Latour, Unit Team Manager Hinshaw, Officer Heatherly, Dr. Liedtke, MHP Day, Dr. Arellano, Dr. Knieser, MHP Troyer, and Officer Does 1–4 were all working in the IRT shortly before or at the time of Mr. Garner's death and were responsible for his safety and wellbeing. These Defendants also had knowledge of the fact that Mr. Garner was a suicide risk and had expressed a clear intent and plan to kill himself if returned to the IRT general population. They failed to take necessary and appropriate measures to monitor and protect him and to treat his acute psychiatric condition.

100. As Warden and Deputy Warden, Defendants Zatecky and Reagle supervised all staff and managed all aspects of Pendleton operations. On information and belief, Defendants

Warden Zatecky and Deputy Warden Reagle had knowledge of Mr. Garner's multiple prior suicide attempts and his suicide risk. IDOC policy specifically requires that "All appropriate facility staff including the Warden, Nursing staff, and the [mental health provider] shall be notified of an offender's suicide attempt." Yet Defendants Warden Zatecky and Deputy Warden Reagle made the decision not to take necessary and appropriate measures to monitor and protect Mr. Garner and to treat his acute psychiatric condition.

101. Defendants Warden Zatecky, Deputy Warden Reagle, and Lieutenant Doe 1 were aware of a severe staffing shortage at Pendleton and the IRT, which had resulted in the presence of the National Guard. In July 2020, there were 142 staff vacancies at Pendleton, representing an estimated 27% of the allotted positions. Despite their awareness of these vacancies, these Defendants decided not to take adequate measures to ensure that Mr. Garner was properly monitored upon his return to the B Building of the IRT after weeks of suicide watch.

102. As Commissioner, Defendant Carter failed to provide Mr. Garner the benefits of IDOC's services, programs, and activities by refusing to provide him and other acutely suicidal prisoners with inpatient psychiatric care at an outside hospital, even though prisoners with emergent medical (but not mental health) issues were provided inpatient care at outside hospitals for those conditions.

Wexford's *De Facto* Policies, Practices, Customs, and Systemic Failures to Supervise and Train Mental Health Staff to Prevent Mr. Garner's Suicide

103. In addition to Mr. Garner, at least thirty-two other IDOC prisoners have died by suicide since April 1, 2017, when Wexford began providing healthcare services for IDOC. Seven of those suicides occurred at Pendleton.

104. In 2019, there were twelve suicides by IDOC prisoners. In 2020, there were eleven suicides by IDOC prisoners, including Mr. Garner. By contrast, in 2016, the year before Wexford took over the IDOC contract, there were five suicides.

105. IDOC prisoners who have died by suicide during the time Wexford has been the IDOC's mental health care provider include, but are not limited to, the following:

(a) Tranell Nash died by suicide on or about February 16, 2021, while incarcerated at Pendleton Correctional Facility. He was thirty-five years old.

(b) Michael Jefferson died by suicide on or about December 27, 2020, while incarcerated at Indiana State Prison. He was twenty-nine years old.

(c) Derrick Whitbeck died by suicide on or about November 17, 2020, while incarcerated at Indiana State Prison. He was thirty-two years old.

(d) Joshua Campbell died by suicide on or about September 1, 2020, while incarcerated at Indiana State Prison. He was thirty-three years old.

(e) Travis Dade died by suicide on or about June 9, 2020, while incarcerated at Indiana State Prison. He was twenty-eight years old.

(f) Ricky Davis died by suicide on or about May 31, 2020, while incarcerated at Pendleton Correctional Facility. He was twenty-eight years old.

(g) David Rodenbarger died by suicide on or about March 3, 2020, while incarcerated at Pendleton Correctional Facility. He was twenty-eight years old.

(h) Dennis Vandiver died by suicide on or about November 30, 2019, while incarcerated at Indiana State Prison. He was forty-three years old.

(i) Jorge Cardenas died by suicide on or about November 30, 2019, while incarcerated at Indiana State Prison. He was thirty-nine years old.

(j) Clinton Bryan Mackey died by suicide on or about August 10, 2019, while incarcerated at New Castle Correctional Facility. He was thirty-nine years old.

(k) Andrew Swank died by suicide on or about February 27, 2019, while incarcerated at Indiana State Prison. He was twenty-six years old.

106. The number of suicides by IDOC prisoners in 2019 and 2020 exceeds the number of suicides in other mid-sized prison systems. For example, the Alabama Department of Corrections reported six deaths by suicide in 2019 and seven in 2020. The New Jersey Department of Corrections reported one death by suicide in 2019, and two in 2020. The Illinois Department of Corrections, which has custody of more people than the Indiana Department of Corrections, reported fewer deaths by suicide in both 2019 and in 2020 (three and six, respectively).

107. In 2020, data from IDOC indicates that there were 29 "serious" suicide attempts by IDOC prisoners. On information and belief, IDOC defines "serious" suicide attempts as requiring life-saving care at an outside hospital. For example, IDOC categorized Mr. Garner's third suicide attempt, on June 23, 2020, as "serious." However, IDOC did not characterize Mr. Garner's first, second, and fourth suicide attempts as "serious." Ten of the 29 "serious" suicide attempts reported by IDOC occurred at Pendleton.

108. Pursuant to both Wexford and IDOC policy, a patient may be admitted to an inpatient psychiatric unit if he is determined to "be a continual danger" to himself, and "is deemed high risk for continued self-injurious behavior as a result of [his] mental illness." Inpatient psychiatric care is also warranted when a patient "is experiencing an acute psychiatric crisis for which the onsite treatment team is unable to provide services that are effective in returning the patient to a previous level of functioning."

109. Additionally, Wexford's contract with IDOC promises that, "[if] necessary, Wexford will transfer [a] patient to the most appropriate location for his or her needs," including to an offsite mental health or medical facility. Pursuant to Wexford's formal policies, admission to an inpatient psychiatric unit is appropriate when any facility-level or Wexford staff member recognizes that a patient is experiencing ongoing suicidal behavior or ideation, or is otherwise experiencing a mental health emergency.

110. Wexford, however, maintained a *de facto* policy and practice of failing to refer suicidal prisoners for psychiatric hospitalization at an outside facility. Wexford also failed to adequately supervise and train mental health staff to assess and refer suicidal prisoners like Mr. Garner for inpatient psychiatric treatment in a hospital setting. In accordance with this *de facto* policy and practice, in response to a public records request, IDOC stated that in the past five years, "[t]here have been zero transfers to a non-IDOC [facility] for receiving behavioral health inpatient care."

111. As a result of Wexford's *de facto* policy, the Mental Health Defendants chose not to facilitate outside inpatient psychiatric care to treat Mr. Garner's suicidality, despite severe indicators showing a need for immediate hospitalization stemming from his ongoing psychosis and suicidality. Mr. Garner experienced an acute psychiatric crisis, and the Mental Health Defendants made the conscious decision not to transfer Mr. Garner to an acute psychiatric care facility for appropriate treatment. Instead, the Mental Health Defendants kept Mr. Garner for weeks on suicide watch as he continued to deteriorate, have psychotic thoughts, and focus on his suicidal plan.

112. Wexford also failed to adequately train and supervise mental health staff charged with providing care to suicidal prisoners like Mr. Garner. Wexford maintained a *de facto* policy

and practice whereby unqualified mental health practitioners like Defendant MHP Day were responsible for assessing the risk of suicide for seriously mentally ill prisoners like Mr. Garner, including making decisions to discontinue suicide watch protocols. Pursuant to Wexford's *de facto* policy and practice, unqualified mental health practitioners like Defendant MHP Day were able to make these decisions without supervision and approval from a licensed psychologist or psychiatrist.

113. Mr. Garner's injuries, and ultimately his death, were caused in substantial part by Wexford's *de facto* policies and practices. On information and belief, these *de facto* policies and practices that were the cause of Mr. Garner's death also contributed to the deaths of the thirty-two other IDOC prisoners who have died by suicide since Wexford took over the IDOC contract.

114. Wexford of Indiana, LLC is a subsidiary of Wexford Health Sources, Inc. ("Wexford Health"), which is a national private correctional healthcare corporation. Wexford Health has a history of providing inadequate medical care to prisoners, including mental health care. In 2017, the Florida Department of Corrections terminated its contract with Wexford Health after a state watch dog exposed a pattern of Wexford Health providing poor mental health services to prisoners with serious mental health needs. The state watch dog described the conditions in a Florida inpatient mental health unit as "life threatening and serious." The same year in Illinois, a federal court monitor criticized Wexford Health for its "grossly insufficient and extremely poor quality of psychiatric services."

COUNT I
Failure to Protect in Violation of the Eighth Amendment under 42 U.S.C. § 1983

115. Plaintiff repeats and realleges paragraphs 1–114 as if fully set forth in this Count.

116. Count I is alleged against all the individual Defendants.

117. Under settled United States Supreme Court authority, and in accordance with the Eighth Amendment, Mr. Garner was entitled to be free from a known and substantial risk of serious harm while in the custody of IDOC.

118. In violation of the Eighth Amendment, the individual Defendants knew of and disregarded the substantial risk of serious harm that Mr. Garner would commit suicide.

119. The individual Defendants' above-described actions and omissions were undertaken with malice and/or reckless disregard for Mr. Garner's constitutional rights.

120. As a result of the unjustified and unconstitutional conduct of the individual Defendants, Mr. Garner experienced pain, suffering, emotional distress, injury, and ultimately death.

121. The individual Defendants' actions and omissions were the direct and proximate cause of the violations of Mr. Garner's constitutional rights, of Mr. Garner's death, and of the damages suffered by his heirs.

COUNT II
Wexford's Constitutional Liability under 42 U.S.C. § 1983

122. Plaintiff repeats and realleges paragraphs 1–114 as if fully set forth in this Count.

123. Count II is alleged against Defendant Wexford.

124. Defendant Wexford was responsible for the creation, implementation, oversight, and supervision of policies, practices, and procedures regarding the provision of medical and mental health care to prisoners at Pendleton, including in the IRT.

125. Defendant Wexford failed to provide adequate training and supervision of its medical and mental health care staff working in the IRT at Pendleton, thereby allowing for the widespread practice by its employees under which prisoners with serious mental health issues were routinely denied access to adequate suicide prevention care.

126. Pursuant to Defendant Wexford's *de facto* policy and practice, acutely suicidal prisoners like Mr. Garner were not assessed or referred for transfer to an outside hospital for inpatient psychiatric care.

127. Defendant Wexford had a further custom, policy and practice of making cost a factor in the timeliness of sending prisoners with serious medical needs to specialty hospitals.

128. Defendant Wexford's actions were the direct and proximate cause of the violations of Mr. Garner's constitutional rights, of Mr. Garner's death, and of the damages suffered by his heirs.

129. Defendant Wexford is liable for the policy, practice, and custom of providing inadequate mental health care to IDOC prisoners.[1]

COUNT III
Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132

130. Plaintiff repeats and realleges paragraphs 1–114 as if fully set forth in this Count.

131. Count III is alleged against Defendant Commissioner Carter in his official capacity.

132. As described more fully in the preceding paragraphs, Mr. Garner is a qualified individual with a disability under the Americans with Disabilities Act, and his disability was known to the individual Defendants.

[1] Under current law, Plaintiff must plead a policy or practice under *Monell v. Department of Social Services*, 436 U.S. 658 (1978), in order to recover under Section 1983 against a private corporation that contracts with a government actor—respondeat superior does not apply. However, the Seventh Circuit has questioned whether the *Monell* policy or practice requirement, as opposed to ordinary respondeat superior, should apply to Section 1983 claims in this circumstance. *See Shields v. Ill. Dep't of Corr.*, 746 F.3d 782, 786 (7th Cir. 2014). Accordingly, *Monell* and respondeat superior liability are pled in the alternative. The respondeat superior claim is pled pursuant to Section 1983 on the basis of "a nonfrivolous argument for extending, modifying, or reversing existing law or for establishing new law." Fed. R. Civ. P. 11(b)(2).

133. The Defendants had an obligation to provide Mr. Garner the benefits of IDOC services, programs, and activities, and not to discriminate against him. The Defendants failed to provide Mr. Garner transfer to an outside hospital for receipt of inpatient psychiatric care, a service that they extended to other prisoners with emergent medical, but not mental health, needs.

134. The Defendants also discriminated against Mr. Garner by isolating him for weeks and months on end on suicide watch, during which time he was denied access to programming, clothing, congregate meals, and phone calls to family. They failed to accommodate Mr. Garner's mental illness by transferring him to another facility.

135. The Defendants' discrimination against Mr. Garner on account of his mental illness caused him pain and suffering, and ultimately led to his death.

COUNT IV
Rehabilitation Act, 29 U.S.C. § 794

136. Plaintiff repeats and realleges paragraphs 1–114 as if fully set forth in this Count.

137. Count IV is alleged against Defendant Commissioner Carter in his official capacity.

138. As described more fully in the preceding paragraphs, Mr. Garner is a qualified individual with a disability, and his disability was known to the individual Defendants.

139. The Defendants had an obligation to provide Mr. Garner the benefits of IDOC services, programs, and activities, and not to discriminate against him.

140. The Defendants failed to provide Mr. Garner transfer to an outside hospital for receipt of inpatient psychiatric care, a service that they extended to other prisoners with emergent medical, but not mental health, needs.

141. The Defendants also discriminated against Mr. Garner by isolating him for weeks and months on end on suicide watch, during which time he was denied access to IRT programming,

clothing, congregate meals, and phone calls to family. They failed to accommodate Mr. Garner's mental illness by transferring him to another facility.

142. The Defendants' discrimination against Mr. Garner on account of his mental illness caused him pain and suffering, and ultimately led to his death.

COUNT V
State Law Claim for Wrongful Death

143. Plaintiff repeats and realleges paragraphs 1–114 as if fully set forth in this Count.

144. Count V is alleged against all the individual Defendants.

145. As described more fully in the preceding paragraphs, the individual Defendants knew that Mr. Garner had a serious mental illness, prior suicide attempts, and was actively suicidal, and that he should be monitored as a suicide risk. The individual Defendants failed to have him under such watch, failed to refer him to an outside facility for inpatient psychiatric care, and failed to conduct proper monitoring, resulting in Mr. Garner's wrongful death.

146. By their acts and omissions, the individual Defendants breached their duty to provide for Mr. Garner's health and safety and were the proximate cause of Mr. Garner's death and the injuries to his heirs.

147. The individual Defendants' above-described actions and omissions were willful and wanton, and were undertaken with malice and/or reckless disregard for Mr. Garner's rights and his safety.

148. Plaintiff, as administrator of the estate and the next of kin, claims damages for the wrongful death of Mr. Garner, and for the loss of his services, protection, care, future income, assistance, society, companionship, comfort, guidance, counsel and advice, as well as for the mental anguish caused by this loss, as well as for funeral and other expenses and damages in accord with the Indiana Adult Wrongful Death Act.

COUNT VI
Medical Malpractice

149. Plaintiff repeats and realleges paragraphs 1–114 as if fully set forth in this Count.

150. Count VI is alleged against Defendants Dr. Liedtke, MHP Day, Dr. Arellano, Dr. Knieser, and MHP Troyer.

151. At all times relevant herein, the Mental Health Defendants were not qualified healthcare providers under the Indiana Medical Malpractice Act.

152. At all times relevant to the events at issue, these Mental Health Defendants owed Mr. Garner a duty of care.

153. Mr. Garner suffered from a severe and persistent mental illness that was known to these Defendants. He had multiple suicide attempts leading up to his death and was in an obviously acute, psychiatric crisis.

154. Defendants Dr. Liedtke, MHP Day, Dr. Arellano, Dr. Knieser, and MHP Troyer each deviated from the applicable standard of care in one or more of the following ways:

(a) Failing to accurately assess Mr. Garner's risk of suicide in discharging him from suicide watch;

(b) Failing to ensure appropriate monitoring of Mr. Garner and other safety precautions to prevent his suicide;

(c) Failing to timely evaluate Mr. Garner's need for inpatient psychiatric care at an outside hospital;

(d) Failing to refer Mr. Garner for inpatient psychiatric care at an outside hospital;

(e) Continuing Mr. Garner on extended suicide watch in isolation conditions that offered no actual treatment for his mental illness;

(f) Failing to recommend Mr. Garner be transferred to protective custody or another prison facility where Mr. Garner would feel safe and that would not trigger his suicidality;

(g) Failing to promptly and thoroughly evaluate Mr. Garner after his multiple suicide attempts so as to adopt a competent treatment plan for Mr. Garner's severe mental illness and acute suicidality.

155. As a direct and proximate result of the negligence of the Mental Health Defendants, Mr. Garner died.

COUNT VII
State Law Claim for Respondeat Superior

156. Plaintiff repeats and realleges paragraphs 1–114 and 149–55 as if fully set forth in this Count.

157. Count VII is alleged against Defendant Wexford.

158. At all times relevant herein, Wexford was not a qualified healthcare provider under the Indiana Medical Malpractice Act.

159. At all times relevant herein, Defendants Dr. Liedtke, Day, Dr. Arellano, Dr. Knieser, and Troyer were acting at all relevant times within the scope of their employment and/or agency with Wexford.

160. Under Indiana state law, Defendant Wexford is liable as principal for all torts committed by its employees and/or agents.

161. Plaintiff, as administrator of the estate and the next of kin, claims damages for the wrongful death of Mr. Garner, and for the loss of his services, protection, care, future income, assistance, society, companionship, comfort, guidance, counsel and advice, as well as for the

mental anguish caused by this loss, as well as for funeral and other expenses and damages in accord with the Indiana Adult Wrongful Death Act.

REQUEST FOR RELIEF

WHEREFORE, Plaintiff Tarra Garner-Jones, as Administrator of the estate of Archon Garner, prays that this Court enter judgment in her favor against Defendants, awarding compensatory damages, costs and attorneys' fees, and punitive damages against each of the Defendants in their individual capacities, and for such further additional relief as this Court may deem appropriate and just.

JURY DEMAND

Plaintiff demands trial by jury.

Dated: November 30, 2021

Respectfully submitted,

TARRA GARNER-JONES

By: /s/ Vanessa del Valle
One of her attorneys

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