UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
ORLANDO DIVISION

RUTH DENHAM, as Personal Representative of the Estate of Tracy Lee Veira, Deceased,
Plaintiff,

vs.

Case No. **6:12-cv-**897**-Orl-**37DAB

VOLUSIA COUNTY, FLORIDA, a political subdivision of the State of Florida; and PRISON HEALTH SERVICES, INC., a Delaware corporation;
Defendants.
_____/

COMPLAINT AND DEMAND FOR JURY TRIAL

Plaintiff, RUTH DENHAM, as Personal Representative of the Estate of Tracy Lee Veira, Deceased, by and through undersigned counsel, sues Defendants, VOLUSIA COUNTY, FLORIDA (hereinafter "the COUNTY"), a political subdivision of the State of Florida; and PRISON HEALTH SERVICES, INC. (hereinafter "PHS"), a Delaware corporation; and alleges:

Jurisdiction and Venue

1. This is an action for money damages brought pursuant to 42 U.S.C. §§ 1983 and 1988, and the Fourteenth Amendment to the United States Constitution.

2. Venue is proper in this Court because all of the wrongful acts complained of occurred within Volusia County, Florida.

3. All conditions precedent to the filing of this action have occurred, been performed or been waived.

4. This action is brought without prejudice to any related claims against the above-named defendants or other persons arising under state or federal law including, but not limited to,

claims under Ch. 766 and § 768.28 of the Florida Statutes, and claims under 42 U.S.C. §§ 1983 and 1988.

Parties

5. Plaintiff is the personal representative of the Estate of Tracy Lee Veira, Deceased. Letters of administration were granted to her by the Circuit Court of the Seventh Judicial Circuit in and for Volusia County, Florida.

6. PHS is a duly organized corporation of the State of Delaware, doing business in the State of Florida.

7. The COUNTY is a duly organized political subdivision of the State of Florida.

8. Beneficiaries of this action include the Estate of Tracy Lee Veira (hereinafter "the ESTATE") and the decedent's surviving minor children, Nathan Michael Weeks (DOB October 3, 2001) and Nevaeh Lashawnti Davis (DOB July 17, 2007) (hereinafter collectively, "the CHILDREN").

General Allegations

9. At all times material hereto, the COUNTY owned and operated the Volusia County Branch Jail (hereinafter "the jail facility") pursuant to Fla. Stat. §§ 951.06 and 951.23(1)(a) and was responsible for establishing customs, policies, and procedures to regulate the conduct of persons working in the jail facility.

10. By its ownership and operation of the jail facility, the COUNTY assumed responsibility for the confinement, segregation, supervision and care of, and provision of medical services to, pretrial detainees generally, and Tracy Lee Veira (hereinafter "MS. VEIRA") specifically.

11. At all times material hereto, PHS was under contract with the COUNTY to provide health care services to detainees housed in the jail facility. Accordingly, at all times material hereto, PHS assumed responsibility for the health, safety, well-being, supervision and care of, and provision of medical services to, pretrial detainees generally, and MS. VEIRA specifically, at the jail facility.

12. At all times material hereto, PHS acted within the scope of its contractual authority from the COUNTY and in furtherance of the COUNTY's interests with regard to its operations at the jail facility.

13. Prior to MS. VEIRA's death, the Defendants were informed of problems in the care, custody, and control of inmates housed in the facility, which problems they knew to create a substantial risk of physical injury or death. Such problems included, but were not limited to, low staffing levels, use of non-medical staff to perform professional medical functions, lack of training concerning recognition and response to emergent conditions, failure of staff to properly conduct and document medical screening of inmates, failure of staff to properly conduct and document segregation watches, difficulty in delivery of medical care to inmates housed in solitary confinement, lack of an infirmary in the facility, and delay in treatment and transfer to outside facilities, including emergency facilities.

14. Notwithstanding the foregoing, the Defendants failed to address or correct these deficiencies, failed to enact or promulgate sufficient policies or procedures or employed a custom of violating their own policies and procedures, and failed to properly equip, staff, hire, train, re-train and supervise competent administrators, officers and health care providers, whose job it was to confine, segregate, supervise and care for, and provide medical services to, pretrial detainees generally, and MS. VEIRA specifically, resulting in the conduct described below.

15. From September 9, 2009, until her death on September 16, 2009, MS. VEIRA was a pretrial detainee confined in the jail facility.

16. At the time she was booked into the jail facility, MS. VEIRA reported to Defendants' medical intake staff that she was prescribed a daily regimen of opioid pain medications and had regularly been taking them, including as recently as that morning.

17. Defendant's staff at that time failed to properly document the information provided by MS. VEIRA, failed to conduct any follow-up inquiry of her healthcare providers or dispensing pharmacy, designated MS. VEIRA for housing in general population, made no provision for the continuation of MS. VEIRA's prescribed or other medications, and ordered no follow-up medical care.

18. Within several days of being booked into the facility, MS. VEIRA became ill and was unable to eat or drink, vomiting up any food or fluids which she attempted to ingest.

19. While confined in the facility, MS. VEIRA became progressively more dehydrated and weak, losing more than 20 pounds in one week.

20. From September 12, 2009, to September 16, 2009, MS. VEIRA was held in a solitary confinement cell designed for violent or suicidal inmates, notwithstanding that MS. VEIRA had been compliant and non-violent at all times, and had displayed no indication of suicidal thoughts.

21. MS. VEIRA's segregation in a solitary confinement cell reduced her access to necessary medical supervision and care, prevented her receiving the supervision and care of her fellow inmates, and reduced her ability to contact friends and relatives located outside the facility.

22. While in maximum segregation, MS. VEIRA's condition deteriorated to the point that she had difficulty walking unassisted and began to vomit a dark green bilious fluid.

23. MS. VEIRA expressed that she felt like she was dying and needed to be taken to the hospital.

24. By this time, it was apparent even to a casual, untrained observer that MS. VEIRA was seriously ill and required emergency medical attention.

25. To a qualified medical professional, MS. VEIRA's medical history, signs and symptoms clearly indicated that she was suffering from acute opioid withdrawal.

26. Acute opioid withdrawal is an easily treated medical condition, but one which can be life-threatening if not properly treated.

27. As her condition progressed, the odor in MS. VEIRA's cell became increasingly foul, to the point that even one hour after her death persons entering the cell had difficulty remaining inside and felt compelled to cover their faces.

28. On the morning of September 16, 2009, MS. VEIRA aspirated a quantity of the dark green bilious fluid she had been vomiting and suffocated to death.

29. A postmortem autopsy determined that MS. VEIRA had been suffering from acute paralytic ileus. Specifically, her digestive system had shut down due to severe dehydration.

30. At any time prior to her death, MS. VEIRA's acute condition could have been remedied by a simple IV drip of saline solution.

31. Notwithstanding the foregoing, the Defendants failed to make prescribed, frequent, close observations of MS. VEIRA; failed to correctly document their observations of MS. VEIRA, and in some cases deliberately falsified the documentation of their observations of MS. VEIRA; failed to notify MS. VEIRA's emergency contact concerning their observations of

MS. VEIRA; failed to provide necessary medical care for MS. VEIRA's serious medical condition; failed to alert medical personnel concerning their observations of MS. VEIRA; failed to request medical assistance for MS. VEIRA; and failed to initiate an emergency medical response for MS. VEIRA.

32. As a direct and proximate result of the foregoing described conduct of the Defendants, MS. VEIRA suffered the following compensable injuries and damages:

a. Physical pain and suffering and emotional trauma and suffering; and

b. Loss of her life and the enjoyment of life.

33. As a direct and proximate result of the foregoing described conduct of the Defendants, the ESTATE suffered the following compensable injuries and damages:

a. Funeral and related medical expenses; and

b. Loss of prospective net accumulations.

34. As a direct and proximate result of the foregoing described conduct of the Defendants, the CHILDREN suffered the following compensable injuries and damages:

a. Loss of support and services;

b. Loss of companionship, instruction, and guidance; and

c. Emotional trauma and suffering.

35. As a further direct and proximate result of the foregoing described conduct of the Defendants, Plaintiff has been compelled to retain the services of counsel, and has thereby incurred, and will continue to incur, legal fees and costs, the full nature and extent of which are presently unknown to Plaintiff.

COUNT I
VIOLATION OF CIVIL RIGHTS - 42 U.S.C. § 1983
AGAINST ALL DEFENDANTS

36. Plaintiff realleges and incorporates paragraphs 1 through 35 above as though fully set forth herein.

37. This count is brought pursuant to 42 U.S.C. §§ 1983 and 1988 and the Fourteenth Amendment to the United States Constitution.

38. At all times material hereto, and in all of their acts described herein, Defendants acted under color of the statutes, customs, ordinances, and usage of the State of Florida and of Volusia County, Florida.

39. The foregoing described conduct of Defendants reflects a deliberate indifference to MS. VEIRA's serious medical needs.

40. The deliberate indifference of Defendants to MS. VEIRA's need for medical care violated her clearly established and well-settled constitutional rights.

41. MS. VEIRA's death was the reasonably foreseeable result of the constitutional violations described above.

42. In its foregoing described conduct, PHS acted in the face of a perceived risk and with reckless disregard that its actions would violate MS. VEIRA's constitutional rights.

WHEREFORE Plaintiff demands trial by jury and judgment against PHS for compensatory and punitive damages, costs, attorneys' fees and such other relief as this Court deems just, and judgment against the COUNTY for compensatory damages, costs, attorneys' fees and such other relief as this Court deems just.

Respectfully submitted,

/s/ Spencer Rhodes
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