UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF
TEXAS, DEL RIO DIVISION

JENNIFER GUADARRAMA,
Individually and as Independent Executor of the Estate of Keegan Killin

PLAINTIFF

V.

THE GEO GROUP, INC., VAL VERDE COUNTY, WARDEN CHRISTOPHER MARTINEZ, ANTONIO CANDENA, JR. M.D., JETHER FARINO, M.D., JESSICA BEACHKOFSKY, M.D., and MAGDALENE GARZA, M.D.

DEFENDANTS.

CIVIL CASE NO._____

JURY DEMANDED

PLAINTIFF'S ORIGINAL COMPLAINT

SUMMARY: Keegan Killin suffered a tragic death at age 21 because of Val Verde County, The Geo Group, and its psychiatrists. Keegan was held in Val Verde County's prison in Del Rio for 15 months without a conviction. He was not a serial criminal nor a violent offender. Keegan had a history of post-traumatic stress disorder (PTSD) and abuse yet was placed in solitary confinement without justification, monitoring, or treatment, and was given psychotropic drugs, known to cause suicide and access to alcohol. Keegan was also given the tools to kill himself including tie offs, bunk beds, razors, lines, and shoestrings despite his documented history of a suicide attempt, fragile condition with night terrors, and the abundance of medical studies documenting the high risk of suicide in solitary. Defendants locked Keegan up to languish and die alone by hanging on March 13, 2021. This case is the Exemplar of human and civil rights violations to a mentally ill Texas detainee.

TO THE HONORABLE UNITED STATES DISTRICT COURT:

Plaintiff files this Complaint and for cause of action will show the following.

I. THE PARTIES TO THE COMPLAINT

A. Plaintiff Jennifer Guadarrama

1. Plaintiff, Jennifer Guadarrama, Individually and as Independent Executor of the Estate of Keegan Killin ("Plaintiff"), is a natural person who resides in Indiana. Ms. Guadarrama was Keegan Killin's legal and biological mother. Ms. Guadarrama sues in her individual capacity as a wrongful death plaintiff and as the Independent Administrator of the Estate of Keegan Killin. Ms. Guadarrama, when asserting claims as the Independent Administrator, does so in that capacity and on behalf of the estate. Letters of Independent Administration were issued to Ms. Guadarrama on November 5, 2021, in Cause Number 6645, in the Val Verde County Court at Law of Val Verde, Texas, in a case styled *Estate of Keegan Killin, Deceased*.

B. Defendant, The GEO Group, Inc.

2. The GEO Group, Inc. ("GEO"), is a Florida corporation with its principal office in Boca Raton, Florida. GEO acted or failed to act at all times through its employees, agents, representatives, guards, nurses, physicians, and/or chief policymakers, and through its designated prison healthcare and mental healthcare providers and is liable for such actions and/or failure to act to the extent allowed by law including, but not necessarily limited to, law applicable to claims under 42 U.S.C. § 1983, the Americans with Disabilities Act, and the Rehabilitation Act. GEO acted under color of state law, and its policies, practices, and/or customs were moving forces behind and caused constitutional violations, and resulting damages and death, referenced

and/or asserted in this pleading.

C. Defendant, Val Verde County, Texas

3. Val Verde County ("Val Verde County"), is a Texas County. Val Verde County acted or failed to act at all times through its employees, agents, representatives, sheriffs, deputies, and/or chief policymakers, and through its designated prison health and mental healthcare provider, GEO, and is liable for such actions and/or failure to act to the extent allowed by law including, but not necessarily limited to, law applicable to claims under 42 U.S.C. § 1983, the Americans with Disabilities Act, and the Rehabilitation Act. Val Verde County's policies, practices, and/or customs were moving forces in causing constitutional violations, and the resulting damages and death referenced, and asserted in this Complaint. Val Verde County acted or failed to act under color of state law. Val Verde County cannot delegate its constitutional duties, to provide medical and mental health care to its prisoners and avoid liability for constitutional violations committed by GEO and its chief policymakers, agents, employees, guards, nurses, and physicians. Val Verde County has non-delegable duties to comply with the United States Constitution regarding prisoners in its care. Therefore, in addition and/or in the alternative to all other allegations made in this Complaint, GEO, to which Val Verde County has delegated health and mental health care of Val Verde County prisoners, is liable under 42 U.S.C. § 1983, for actions and inactions of GEO. Or in addition, Val Verde County and GEO acted and/or failed to act together, in a partnership and/or joint enterprise, or under similar legal principles, to provide care or fail to provide care to prisoners in Val Verde Val Verde County prisons. Thus, Val Verde County is liable for GEO's actions and inaction related to such purported care, and both Val Verde County and GEO are each liable for any policies, practices, and/or customs of the other which were moving forces behind, and which caused the constitution violations, damages, and death referenced in this

Complaint. Val Verde County may be served with process at: 400 Pecan Street, Del Rio, TX 78840.

D. Defendant, Christopher Martinez

4. Christopher Martinez is an individual residing in Val Verde County, Texas. Christopher Martinez ("Warden Martinez") was the Facility Administrator of the Val Verde Correctional Facility during Keegan's intake, detention, and death. Warden Martinez is being sued in his official and individual capacities. Warden Martinez acted at all relevant times under color of state law. Warden Martinez was employed and/or contracted by GEO as the Facility Administrator at Val Verde Correctional Facility at all relevant times and acted or failed to act in the course and scope of his duties for GEO. Warden Martinez was also acting at the behest of, as the agent of, and in the course and scope of her duties for Val Verde County as a result of (1) Val Verde County's inability to delegate its constitutional duties to a third party; and (2) the nature of the relationship between Val Verde County and GEO. Warden Martinez may be served with process at: 141 Kenwood Avenue, Del Rio, Texas 78840, or wherever he may be found.

E. Defendant, Antonio Cadena, Jr. M.D.

5. Antonio Cadena, Jr. M.D. is a licensed physician in Texas residing in Val Verde County, Texas. Dr. Cadena was the Medical Director at Val Verde Correctional Facility during Keegan's intake, detention, and death. Dr. Cadena is being sued in his individual and supervisory capacities. Dr. Cadena acted at all relevant times under color of state law. Dr. Cadena was employed and/or contracted by GEO as the Medical Director at Val Verde Correctional Facility at all relevant

times and acted or failed to act in the course and scope of his duties for GEO. Dr. Cadena may be served at: 2201 North Bedell Avenue, Suite A2201, Del Rio, Texas 78840, or wherever he may be found.

F. Defendant, Jether C. Farino, M.D.

6. Jether C. Farino, M.D. is a licensed physician in Texas residing in Bexar County, Texas. Dr. Farino was licensed in Texas in 2017 with a specialty in psychiatry. Dr. Farino is being sued in his individual capacity. Dr. Farino acted at all relevant times under color of state law. Dr. Farino was employed and/or contracted by GEO at all relevant times and acted or failed to act in the course and scope of his duties for GEO. Dr. Farino may be served at: 21830 Baldacci Vista, Boerne, Texas 78015, or wherever he may be found.

G. Defendant, Jessica Beachkofsky, M.D.

7. Jessica Beachkofsky, M.D. is a Texas licensed physician residing in Bexar County, Texas. Dr. Beachkofsky was licensed in Texas in 2017. Dr. Beachkofsky received her board certification in psychiatry in 2012. Dr. Beachkofsky is being sued in her individual capacity. Dr. Beachkofsky acted at all relevant times under color of state law. Dr. Beachkofsky was employed and/or contracted by GEO at all relevant times and acted or failed to act in the course and scope of her duties for GEO. Dr. Beachkofsky may be served at 311 Camden, Suite 510, San Antonio, Texas 78215, or wherever she may be found.

H. Defendant, Magdalene D. Garza, M.D.

8. Magdalene D. Garza, M.D. is a Texas licensed physician residing in Bexar County, Texas. Dr. Garza was licensed in Texas in 2009. Dr. Garza received her

board certification in psychiatry in 2010. Dr. Garza is being sued in her individual capacity. Dr. Garza acted at all relevant times under color of state law. Dr. Garza was employed and/or contracted by GEO at all relevant times and acted or failed to act in the course and scope of her duties for GEO. Dr. Garza may be served at 17 South New Braunfels, San Antonio, Texas 78223, or wherever she may be found.

I. State Actors under §1983

9. GEO contracted with Val Verde County to provide for medical and mental health services of those incarcerated and detained in Val Verde County.

10. GEO acted under color of state law. Medical care providers, employees, and agents such as Warden Martinez, Antonio Cadena, M.D., and psychiatrists Drs. Farino, Beachkofsky, and Garza (the "Psychiatrist Defendants") employed by a government entity are state actors for 42 U.S.C. § 1983 purposes acting under color of law when treating inmates and/or implementing policies and practices regarding provision of medical and mental health care.

11. Plaintiff tried on several occasions to obtain copies of the contract between Val Verde County and GEO that relates to the management of the Val Verde prison and provision of medical and mental care for Val Verde County prisoners, but defense counsel refused to cooperate preferring to wait until formal discovery. The Court should entertain no motions to dismiss unless and until Plaintiff can obtain discovery on an expedited basis from defendants. Plaintiff is entitled to plead her best case, and the court should not consider foreclosing any claims, if defendants attempt to seek such foreclosure, without allowing Plaintiff basic discovery and the ability to replead if necessary.

II. JURISDICTION AND VENUE

A. Jurisdiction

12. The Court has original subject matter jurisdiction over this lawsuit according to 28 U.S.C. § 1331 and 1343(4), because this suit presents a federal question and seeks relief pursuant to federal statutes providing for the protection of civil rights. This suit arises under the United States Constitution and federal statutes including but not necessarily limited to 42 U.S.C. § 1983 and the Americans with Disabilities Act, and the Rehabilitation Act. Supplemental jurisdiction over the negligence claim against Defendants is proper under 28 U.S.C. § 1367 because that claim is so related to the claim under § 1983 that it is part of the same case.

13. The Court has personal jurisdiction over defendants because defendants regularly conduct business in the State of Texas and within the Western District of Texas, Del Rio Division in a way defendants would be expected to be hailed into federal court in the Del Rio Division of the Western District of Texas.

B. Venue

14. Venue is proper in the Del Rio Division of the United States District Court or the Western District of Texas, under 28 U.S.C. §1391(b)(1) because all or a substantial part of the events or omissions giving rise to the claim occurred in this venue.

15. Val Verde County is a Texas county, and several defendants are Texas residents, domiciled in Texas, and citizens of Texas. Further, GEO regularly conducts business in Texas and specifically in the geographic area covered by the United States District Court for the Western District of Texas. GEO is subject to the Court's

personal jurisdiction in the Western District of Texas, and specifically the Del Rio Division. There are more than sufficient contacts with the Western District of Texas, and specifically the Del Rio Division, to subject GEO to personal general jurisdiction.

III. FACTUAL ALLEGATIONS

A. The High Rate of Suicide in Prisons is Common Knowledge Among Jailers

16. Suicide is a leading cause of mortality in prisoners, accounting for around 30% of all prison deaths.[1] About 90% of prison suicides result from hanging or self-strangulation.[2] In the United States, prisoners have 33-fold higher odds of dying by hanging than do suicide decedents in the general population.[3] These statistics are well known among correctional institutions, prison doctors, psychiatrists, and facility administrators.

B. Keegan Killin's Suicide on March 13, 2021

17. Keegan suffered an unnecessary death on March 13, 2021, in the Val Verde County Detention Center ("Val Verde prison") in Del Rio, Texas due to lack of mental health care. He was only 21 years old. His death was preventable.

18. Keegan was a pre-trial detainee with no significant criminal history other than some infractions as a teen. He suffered for 15 months at the Val Verde prison. Keegan suffered from severe mental illness when he entered the Val Verde prison, wasn't treated for his mental illness, and was placed in isolation without

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[1] Favril L. Epidemiology, Risk Factors, and Prevention of Suicidal Thoughts and Behaviour in Prisons: A Literature Review. *Psychol Belg*. 2021;61(1):341-355. Published 2021 Nov 22. doi:10.5334/pb.1072

[2] *Id.*

[3] Dixon, K. J., Ertl, A. M., Leavitt, R. A., Sheats, K. J., Fowler, K. A., & Jack, S. P. D. (2020). Suicides among incarcerated persons in 18 U.S. states: findings from the National Violent Death Reporting System, 2003–2014. *Journal of Correctional Health Care*, 26(3), 279–291. DOI: 10.1177/1078345820939512.

justification, adequate monitoring, or any lifesaving precautions or protections. He wasn't monitored and was free to make intoxicants in his cell to mask his mental health symptoms right in plain sight of the guards and staff.

19. The Val Verde prison is owned and operated by GEO, a publicly traded, private corporation specializing in the ownership, leasing, and management of prisons, processing centers and reentry facilities in the United States and abroad. As of December 31, 2021, GEO's worldwide operations included the management and/or ownership of approximately 86,000 beds at 106 secure and community-based facilities.[4] In 2021, the year Keegan died, GEO reported $2.26 billion in revenue.[5] As one of largest managers of private prisons in the United States, GEO is intimately familiar with the suicide statistics and high risk of suicide among pre-trial detainees such as Keegan.

20. The defendants each knew about Keegan's serious mental illness through their own intake and screening documents, prescription records, and the plethora of medical and mental health evaluations discussing his PTSD and history of attempted suicide. Despite defendants' actual awareness of Keegan's high risk of suicide and need for protection, defendants were deliberately indifferent to that risk, and objectively unreasonable in their actions and inaction, which caused Keegan's suffering and death.

21. Keegan was placed in an isolated cell by his own request, where he could end his life while under the influence of home-made wine, he was allowed to make

[4] The GEO Group, Inc. SEC, 10K Annual Report, 2021.
[5] The GEO Group, Inc. SEC, 8-K Current Report, Feb. 2021.

right under the nose of the guards.

22. Keegan committed suicide, through strangulation/hanging, by using a self-made cloth ligature he tied to his bed in his isolated cell. He was able to do so, and avoid detection, after dark and in between the guards' 30-minute checks.

23. Keegan's cell was in solitary but was not continuously or adequately monitored by guards or video. Based on information and belief, the cell check log entries for Keegan on the day he died are false. According to the autopsy by the Webb Val Verde County Medical Examiner, Keegan had a blood alcohol level of 1.31. At this level, Keegan's judgment would be severely impaired. However, the jail logs suggest he was fine with good hygiene. This is impossible at this level of alcohol.

24. Based on information and belief, Keegan made home-made wine in his cell using food and/or sugar products such as jelly purchased from the prison's commissary. GEO allowed this practice to the extent it became an established custom and/or practice at the prison.

25. GEO, its guards, and medical staff, knew Keegan's cell was cluttered with empty jelly containers and other items used for wine making but did not require the removal of the contraband, and he received no discipline. Upon information and belief, GEO, its guards, and medical staff, gained this awareness by seeing containers in Keegan's cell in plain sight through visual observations when doing cell checks in the hours leading to Keegan's death. The cell checks were documented, but the alcohol, alcohol making candle, distilling tools, and piles of containers and trash was not. The photos taken on the day of Keegan's death show jelly containers scattered

throughout his tiny cell. GEO, its guards, and medical staff, neither removed such items nor instructed that such items be removed. GEO, its guards, and medical staff, also apparently did not contact any supervisor regarding removal of such items or suggest that Keegan's cell should be inspected, cleared, or that Keegan be alcohol tested. Allowing inmates to make home-made alcohol was a *de facto* pattern, practice, and custom of GEO. Keegan was in the area of the highest level of security at the prison with the most cell checks, and nothing about the alcohol or source of his toxicity at death was recorded in his file, or at his death.

26. GEO, its guards, medical staff, and Warden Martinez were aware, when they allowed Keegan to request and remain segregated in isolation, that he was also allowed tools to make intoxicants and apparatuses and items to hang himself.

27. GEO, its guards, medical staff, and Warden Martinez did so knowing Keegan was a pretrial detainee, an independent risk factor for suicide, with a history of mental illness, drug and alcohol abuse, and a suicide attempt by strangulation. Upon information and belief, GEO, its guards, medical staff, and Warden Martinez learned these facts through his intake and incarceration beginning on or about November 26, 2019, because of speaking to co-workers, reviewing documents related to Keegan's medical and mental intake and ongoing mental health issues and medications, speaking with Dr. Cadena and the Psychiatric Defendants, nursing staff, and and/or through oral shift briefings.

C. **Keegan Gage Killin, Deceased**

28. Keegan was born on July 6, 1999. He would be 23 today. During childhood, Keegan lived in Del Rio, Corpus Christi, and San Antonio with his family.

His parents were divorced at age 4. Keegan graduated from a charter high school in San Antonio in 2018 and was learning skills to become a welder before he went to the Val Verde prison. Keegan was a quiet person with a big heart. He had much to look forward to in life.

29. Keegan was 19 years old when he and Raul Monsivais were arrested on April 4, 2019, in Edwards County, Texas for an alleged "conspiracy to transport illegal aliens." Keegan told the arresting officer he would get $500 to transport individuals from the border area to Rocksprings and San Antonio, Texas. Keegan had never done this and did not have a significant criminal history other than minor infractions as a teen.

30. Keegan was taken to Uvalde, Texas and then released. He was not booked on any charges, and he did not stay in prison. When he was released on April 4, 2019, he was free.

31. The arrest spooked Keegan and propelled him to get his life together. He hired a law firm to do a warrant search to prepare for his application to Gary Job Corp, a life skills and vocational training program. When no warrants came up, Keegan joined Gary Job Corps and moved to San Marcos, Texas.

D. Keegan Killin's Arrest

32. On November 20, 2019, Keegan was arrested in Austin, Texas by the Department of Homeland Security and was booked into the Bastrop County prison in Bastrop, Texas. He was transferred to Karnes County Correction Facility on November 26, 2019.

33. The Karnes County prison in Karnes City, Texas is owned and operated by GEO. In January 1998, GEO purchased the prison from the Karnes County Public Facility Corporation and signed an operational agreement to assume management of the prison beginning on January 15, 1998, including the provision of medical and mental health care.[6]

34. When Keegan arrived at the Karnes County prison on November 26, 2019, he completed the Texas Commission's required suicide screening form, Screening for Suicide and Medical/ Mental/ Developmental Impairments.

35. To the question, "Have you ever received services for emotional or mental health problems?" The prisoner marked "Yes, 2019."

36. To the question, "If yes to 8 or 9, do you know your diagnosis?" The prisoner marked "Yes" and wrote "insomnia, anxiety, depression, and PTSD."

37. A Mental Health Evaluation, also completed on November 26, 2019, noted Keegan was diagnosed in San Marcos, Texas with PTSD, depression, and anxiety and was taking trazodone. Trazodone is an antidepressant used to treat depression, anxiety, insomnia, or a combination of all. The Mental Health Evaluation also noted Keegan's history of physical and sexual abuse while living in San Antonio, Texas.

38. On December 2, 2019, a History and Physical Assessment at Karnes County reported Keegan was upset that his Trazodone prescription was wrong. He was supposed to receive 100 mg a day for sleep and was only receiving 50 mg. Keegan

[6] http://www.GEOgroup.com/FacilityDetailID/57

complained that he was only getting 4 hours of sleep, a PTSD symptom. Keegan's history of suicidal thoughts was documented. Trazodone has a heavy sedating effect and is used for insomnia in addition to depression.

39. On December 5, 2019, Keegan was transferred from Karnes County to GEO's Val Verde prison in Del Rio, Texas. The Val Verde prison is at 253 FM 2523 Hamilton Road, Del Rio, Texas 78840. It is a local and federal detention center with a capacity of 1407 inmates. GEO operates the prison under contact with Val Verde County.

40. While detained in the Val Verde prison, a search of Keegan's cellphone allegedly revealed one image of child pornography. That charge was added in late December 2019. He was never convicted of this or any other crime, nor did he have an opportunity to contest this charge. At all relevant times, Keegan was a pre-trial detainee. He was detained in Val Verde for 15 months, from December 5, 2019, until his tragic death on March 13, 2021.

41. On December 5, 2019, GEO's medical director, Antonio Cadena, Jr. M.D., noted during on Keegan's transfer papers that he had PTSD and should be referred to "psych."

42. On December 11, 2019, a Mental Health Evaluation was completed by Larissa Dovalina, LPC (intern). She noted he was a victim of childhood domestic abuse, was sleeping only 3 hours a night, and was having flashbacks with nightmares -- all symptoms of PTSD. She checked the box for previous suicide attempt and wrote, "2005 in San Antonio." She scheduled him for the next available psychiatry

appointment. Keegan was recommended for general population housing.

43. Over a month went by with no mental health care despite Dr. Cadena's referral at intake.

44. On January 15, 2020, Keegan had an Initial Psychiatric Evaluation via "telehealth" with psychiatrist, Jether C. Farino, M.D. Dr. Farino noted Keegan's history of PTSD and suicide attempt at age 10. Dr. Farino recorded Keegan's current symptoms including anxiety, nightmares every night, sleeping 3-4 hours, isolation, and increased vigilance. All symptoms consistent with PTSD.

45. Dr. Farino diagnosed Keegan with PTSD (posttraumatic stress disorder) and insomnia according to the Diagnostic and Statistical Manual – 5 (DSM-5). The DSM–5 is the standard classification of mental disorders used by mental health professionals in the United States based on symptoms, criteria, risk factors, culture, and gender-related features, and other important diagnostic information presented by the patient. PTSD per the DSM–5 is a trauma and stress induced psychiatric disorder that occurs in people who have experienced or witnessed a traumatic event such as a sexual violence or serious injury. PTSD symptoms include: 1). intrusive thoughts such as repeated, involuntary memories, distressing dreams, or flashbacks of the traumatic event; 2) avoiding reminders of the traumatic event; 3) alterations in cognition and mood leading to ongoing and distorted beliefs about oneself; and 4) alterations in arousal and reactivity such as hyper-vigilance, or having problems concentrating or sleeping.[7] The criteria for PTSD stipulates that "the

[7] DSM 5: American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (DSM-5®). American Psychiatric Pub.

disturbance to the individual, regardless of its trigger, causes clinically significant distress or impairment in the individual's social interactions, capacity to work or other important areas of functioning".[8] Suicidal thoughts or behavior is a feature of PTSD as is severe night terrors.

46. Dr. Farino started Keegan on Zoloft (sertraline) and Trazodone, both antidepressants used to treat anxiety and depression, and recommended a psychiatric follow up in 4-6 weeks. Dr. Farino also didn't schedule follows up for Keegan during the initial of the Zoloft, which is required when initiating an antidepressant. Dr. Farino also did not refer Keegan to a psychologist, social worker, or mental health counselor for psychotherapy. Psychotherapy, in the form of cognitive behavioral therapy (CBT) and its related forms, is the first line of treatment for PTSD.[9]

47. On April 1, 2020, the psychiatrist, Magdalene Garza, M.D., reviewed Keegan's chart to renew his psychiatric medications and scheduled him for follow up in 4-6 weeks. Dr. Garza did not see or talk to him and recommended no psychotherapy for Keegan's PTSD.

48. On May 6, 2020, Keegan saw Cecilia Roberson, LVN via "telehealth" for medication management. Based on information and belief, the "telehealth" was by phone and not video. Nurse Roberson noted Keegan's PTSD diagnosis and continuing

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[8] Paintain, Emma, and Simon Cassidy. "First-line therapy for post-traumatic stress disorder: A systematic review of cognitive behavioural therapy and psychodynamic approaches." *Counselling and psychotherapy research* vol. 18,3 (2018): 237-250. doi:10.1002/capr.12174.

[9] American Psychological Association. "Clinical Practice Guidelines for the Treatment of PTSD in Adults." (2017) (developed to provide recommendations on psychological and pharmacological treatments for posttraumatic stress disorder (PTSD) in adults).

nightmares were "bothersome and stressful." Nurse Roberson recommended Prosazin, which is sometimes used off label to reduce PTSD associated nightmares. Prosazin was added to Keegan's Zoloft (sertraline) and Trazodone medication regimen. Keegan was not seen by a psychiatrist, psychologist, social worker, or mental health counselor for his mental conditions of PTSD and insomnia and was not referred for psychotherapy for PTSD.

49. On July 15, 2020, the psychiatrist, Magdalene Garza, M.D., saw Keegan via "telehealth" for medication management. Dr. Garza noted Keegan's PTSD diagnosis and continuing nightmares and night terrors. No changes were made to Keegan's medications, and he was not referred to counseling or psychotherapy for his PTSD.

50. On October 14, 2020, Dr. Garza discontinued all of Keegan's psychiatric medications, Prozasin, Zoloft, and Trazodone, with no plan or bridge of treatment for Keegan following the sudden discontinuation. There are no notes reflecting the reason for the medication discontinuation or that the risks of discontinuation were discussed with Keegan. Psychiatric medications are not to be stopped suddenly and should not be stopped unless the patient is in remission.

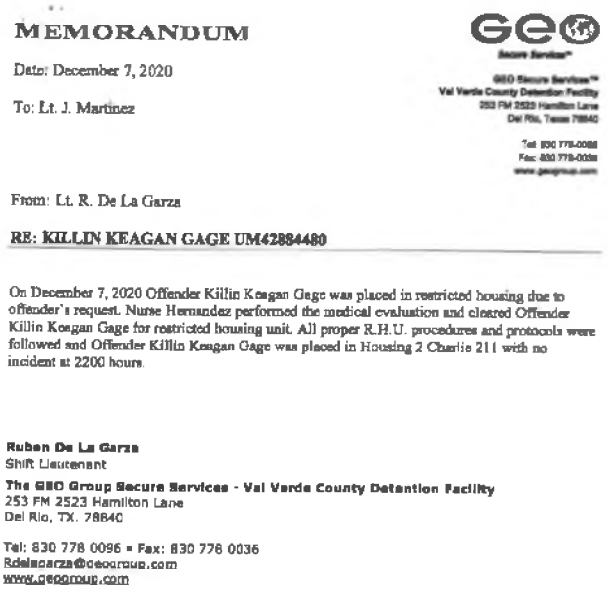
51. Between October 14, 2020, and March 2, 2021, Keegan was not on any psychiatric medications for his mental illnesses and was not receiving any psychotherapy, which is the first line of treatment for PTSD. Keegan was assigned to solitary confinement during this same period.

E. Keegan's Assignment to Solitary Confinement, December 7, 2020

52. The Texas Commission on Prison Standards (TCJS) requires that inmates be housed in the "least restrictive housing available without jeopardizing staff, inmates, or the public."[10] An inmate's housing assignment is usually in the general population absent an extenuating circumstance requiring restrictive or solitary confinement.

53. GEO's Restrictive Housing Unit (RHU) is the solitary confinement area of the prison where inmates not suitable for general population are housed for punitive, security, or safety reasons. The inmate is returned to general population when the behavior or security threat improves.

54. On December 7, 2020, Keegan was cleared for assignment to solitary confinement despite his ongoing and untreated mental conditions.



MEMORANDUM

Date: December 7, 2020

To: Lt. J. Martinez

GEO Secure Services™
Val Verde County Detention Facility
253 FM 2523 Hamilton Lane
Del Rio, Texas 78840

Tel: 830 778-0098
Fax: 830 778-0036
www.geogroup.com

From: Lt. R. De La Garza

RE: KILLIN KEAGAN GAGE UM42884480

On December 7, 2020 Offender Killin Keagan Gage was placed in restricted housing due to offender's request. Nurse Hernandez performed the medical evaluation and cleared Offender Killin Keagan Gage for restricted housing unit. All proper R.H.U. procedures and protocols were followed and Offender Killin Keagan Gage was placed in Housing 2 Charlie 211 with no incident at 2200 hours.

Ruben De La Garza
Shift Lieutenant
The GEO Group Secure Services - Val Verde County Detention Facility
253 FM 2523 Hamilton Lane
Del Rio, TX. 78840

Tel: 830 778 0098 • Fax: 830 778 0036
Rdelacarza@geogroup.com
www.geogroup.com

[10] Tex. Administrative Code § 271(a).

55. Keegan was not a behavior problem or a safety or security threat. He was assigned to the solitary confinement "by request" and with no reason or justification other than his own preference. This is not standard practice in a prison and violative of the prison standards. But, this was GEO's pattern, practice, and/or custom.

56. Due to the high risk of suicide and psychological harm to isolated inmates, TCJS requires that inmates be housed in the "least restrictive housing available without jeopardizing staff, inmates, or the public."[11] It is widely known and has been for many decades due the abundance of prison suicide studies, the risk of suicide is higher under social extremes of incarceration such as being subjected to solitary confinement. The TCJS standards of using the least restrictive means were written for this reason.

57. GEO and Warden Martinez disregarded the industry's knowledge and the TCJS's specific standard regarding Keegan. Indeed, GEO and Warden Martinez approved of and allowed the practice of permitting inmates to request solitary confinement to the extent it became an established custom and/or practice. According to GEO's RHU Logs, several inmates were in RHU "per request" and not for discipline, safety, or security reasons. GEO and Warden Martinez disregarded not only the TCJS's standards, but their own written policy requiring solitary confinement only when an inmate is a "serious threat to life, property, self, staff or other inmates." [12]

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[11] Tex. Administrative Code § 271(a).

[12] Geo Policy and Procedure Manual, Special Management at 1.

58. Two days after Keegan entered solitary confinement, Sandra Hernandez, RN, did a "medical evaluation" and cleared him for RHU. Ruben De La Garza, GEO's shift lieutenant, signed the evaluation confirming to GEO's Lt. Juan Martinez, Jr. that all "RHU protocols and procedures were followed."[13]

59. Keegan's move to solitary was not for mental health reasons so his clearance did not include a mental evaluation per GEO's policy. He was only to be medically cleared.[14] Keegan's history of psychiatric medication management while in prison was disregarded and his recent termination of psychiatric medication by Dr. Garza was never reviewed, approved, flagged, or questioned during Keegan's transition to solitary confinement. The last "telehealth" psychiatric appointment Keegan had was six months earlier on July 15, 2020, with psychiatrist Magdalene Garza, M.D. Keegan told Dr. Garza he was still having ongoing symptoms of PTDS including night terrors, nightmares, and insomnia. Despite active symptomology indicative of acute PTSD, Garza discontinued Keegan's PTSD medications without cause on October 14, 2020, knowing he would be with no treatment for his PTSD. This is a deviation from standard of psychiatric care and not supported by any medical studies on proper protocol.

60. Besides being without psychiatric medications, Keegan was put in solitary confinement with no special monitoring, psychotherapy, suicide preventive measures, or restrictions on what items he could and could not have in his cell.

[13] December 7, 2020, Memo to Lt. J. Martinez from Lt. R. De La Garza.
[14] Geo Policy and Procedure Manual, Special Management at 4.

Solitary confinement alone is a high-risk factor for suicide besides an inmate's other conditions.

61. The purpose of RHU according to GEO's Policy and Procedural Manual, is to provide effective supervision of inmates in RHU for protective custody and disciplinary detention.[15] There are 5 reasons to be assigned to RHU:

a. There is a threat to the safety/security of the facility.

b. Escape risk.

c. To preserve the integrity of an investigation.

d. At the request of the governing agency (USMS/ICE).

e. Other.[16]

62. Keegan was not classified as a safety or security risk and was not put in solitary for punishment. There were no reasons for Keegan's placement in solitary other than it was requested. In fact, Keegan was in the Val Verde prison for a year with no incident warranting assignment to an isolated cell. GEO's records portray Keegan as a docile young man, and first-time offender, that kept to himself. This is also characteristic of PTDS sufferers. They tend to isolate due to the level of distress.

63. GEO and Warden Martinez approved of and allowed the practice of permitting inmates to request solitary without justification to the extent it became an established custom and/or practice of the prison. This is further evidenced by the fact that other inmates were in solitary "by request" like Keegan and not due to

[15]Policy and Procedure Manual, Chapter Special Management, No. 1500.01 (effective 3/23/20) at 1.
[16] Restrictive Housing Unit Notification Letter to Keegan Killin, dated 12/7/20.

security or safety issues. GEO, Warden Martinez, Dr. Cadena and the Psychiatrist Defendants each knew putting Keegan in isolation and allowing him to remain in isolation increased his risk of death by strangulation. The suicide studies of prisons dating to the 1960s are widely known in the industry.

64. Keegan's placement in solitary was reviewed by Warden Martinez on December 11, 2020, who checked these boxes:

a. Does the initial reason for placement remains valid? – Yes.

b. Does the offender pose a threat to himself, others, or staff? – No.

c. Is the offender defiant toward authority? – No.

d. Is the offender unwilling to live in general population? – Yes.[17]

65. That only less than 5% of inmates are housed in solitary confinement in the United States underscores the seriousness and risk of death or psychological harm to the inmate.[18] Solitary confinement should never be used without clear and well documented justification. The risk of suicide is higher under social extremes of incarceration such as being subjected to solitary confinement. As it inherently reduces protective factors such as meaningful social contact and access to purposeful activity, exposure to solitary confinement negatively affects prisoners' mental health and confers an increase in risk of suicide. [19] Solitary confinement itself is an independent risk factor for suicidal behavior.

66. Knowing these suicide facts and statistics, GEO, its guards, medical

[17] December 11, 2020, 30 Day Segregation Review.
[18] *Id.*
[19] Brown, E. (2020). A systematic review of the effects of prison segregation. *Aggression and Violent Behavior*, 52, 101389. DOI: 10.1016/j.avb.2020.101389; see also Haney, C. (2018). Restricting the use of solitary confinement. *Annual Review of Criminology*, 1, 285–310. DOI: 10.1146/annurev-criminol-032317-092326.

staff, and Warden Martinez approved Keegan's placement in solitary knowing that to do so placed him at risk of harm, death, and violation of his constitutional rights to be protected from harm. GEO, its guards, medical staff, and Warden Martinez. had actual knowledge, through GEO's intake, medical, and mental documentation that Keegan: 1) was a pre-trial detainee with no history of federal detention; 2) had a history of mental illness; 3) had a confirmed and symptomatic diagnosis of PTSD documented by three GEO psychiatrists; 4) had a diagnosis of insomnia and slept only hours a night and with nightly night terrors; 5) had a history of drug and alcohol abuse, and 6) a previous suicide attempt of strangulation. GEO its guards, medical staff, and Warden Martinez learned these facts through Keegan's intake mental screening, mental and medical evaluations, and ongoing mental health issues, medications, and progress notes, speaking with the prison physicians and psychiatrists, nursing staff, and and/or through oral briefings with his officers and lieutenants. It is difficult to imagine a more extensive set of facts that would put a jail and its medical staff on notice a person should not be incarcerated in solitary but instead immediately placed under continuous monitoring where there is less opportunity to commit suicide.

67. Further, GEO its guards, medical staff, and Warden Martinez had actual knowledge that placing Keegan in solitary without justification was against the TCJS's policy to use the "least restrict housing available" due to the suicide risk.

68. GEO its guards, medical staff, and Warden Martinez also knew moving Keegan to solitary confinement meant he would be alone and only observed visually

for up to 5 seconds every 30 minutes – assuming it is done at all. The TCJS requires adequate supervision of mentally disabled prisons due to the high risk of suicide.[20] GEO did not adequately supervise Keegan.

69. Hanging is the most common method of suicide. Death from hanging/strangulation can be completed in just minutes. GEO, its guards, medical staff, and Warden Martinez knew this when they approved Keegan for solitary confinement without suicide preventative measures in place.

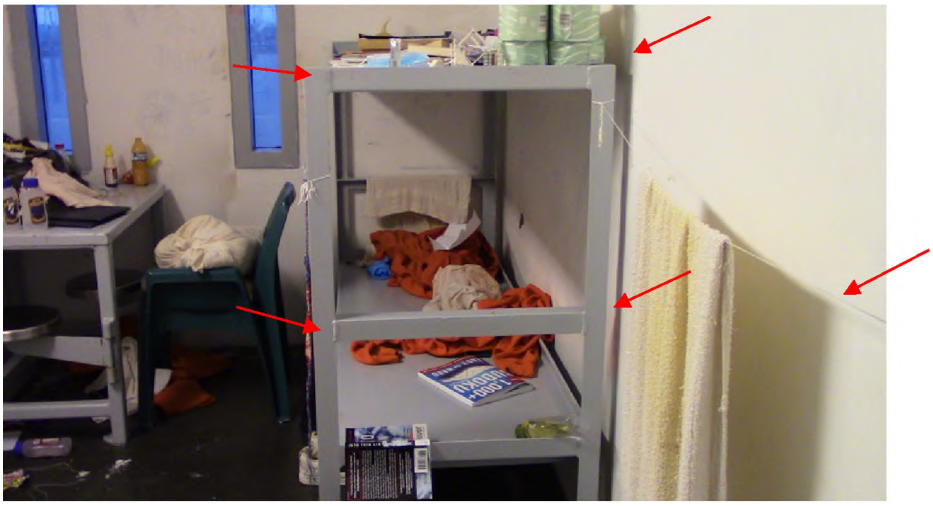
70. GEO's policy was to monitor inmates in solitary twice per hour, no more than 40 minutes apart, on an irregular schedule.[21] Irregular checks were not to be done sooner than 20 minutes from the last check.[22] This policy and custom in the jail's highest risk location could never prevent inmates from successful hanging and death from strangulation. 20-40 minutes, the guaranteed time inmates have twice an hour without observation is ample time to complete suicide by hanging. Death by suicide takes only minutes. Not only was this known to GEO, its guards, and medical staff, and Warden Martinez due to the proliferation of prison suicide studies conducted since the 1960s, but was known to the Psychiatric Defendants, who as medical doctors, knew the time it takes for death to ensure from asphyxiation. GEO and Warden Martinez disregarded the industry's knowledge and mental health advisories on increased risk of suicide in solitary confinement. GEO's monitoring policy was inadequate to prevent death by hanging. All Defendants, with this

[20] Tex. Administrative Code § 273(a).
[21] Geo Policy and Procedure Manual, Special Management at 4.
[22] *Id.*

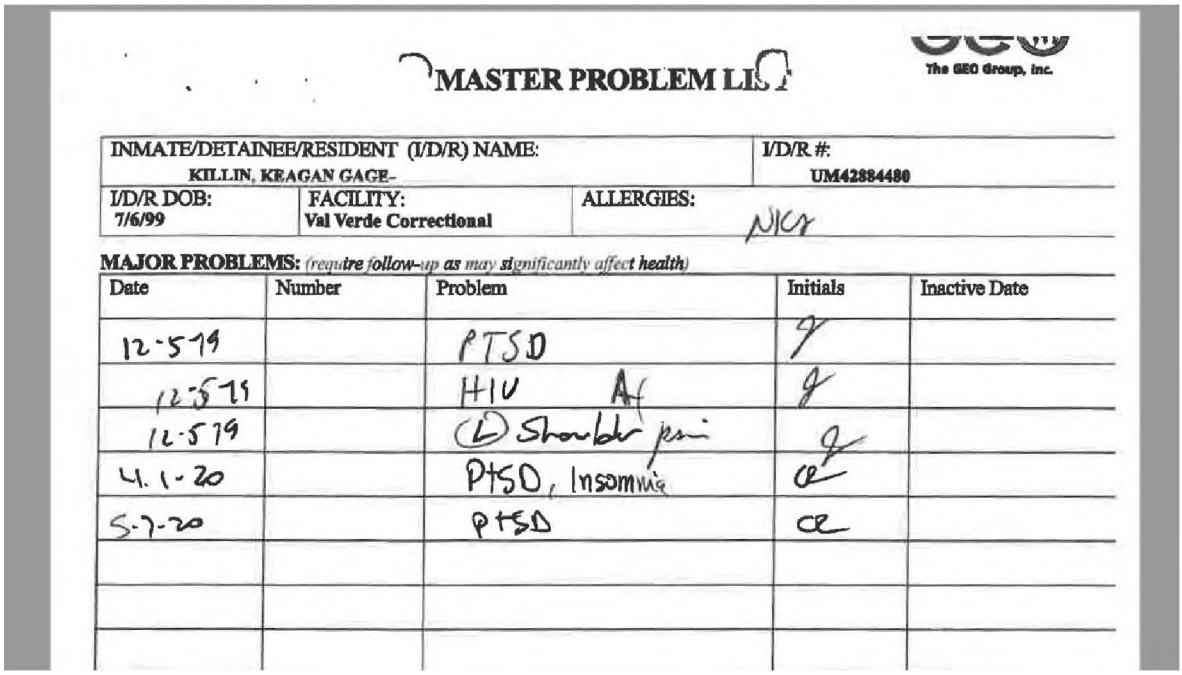
knowledge, were deliberately indifferent to, and acted unreasonably regarding Keegan's rights, health, and safety. Defendants knew their conduct involved an extreme degree of risk yet proceeded with deliberate and conscious indifference.

71. GEO and Warden Martinez also knew when Keegan was approved for solitary confinement, he would have free and unrestricted access to items from the commissary that can be used to make home-made wine in the privacy of his isolated cell. As evidenced by the photos on his day of death, it was the policy, practice, and/or custom for GEO to allow inmates to make wine regarding of their mental health status.

72. GEO and Warden Martinez also knew Keegan would have access to various tools and apparatuses he could use as a ligature to hang himself unless special precautionary instructions were made to make sure the cell was free of such items. Keegan's isolation cell was outfitted with hanging tie offs including the bed bunk and a variety of tools suitable for suicide including blankets, shoelaces, ropes used to string towels, and razor.



73. GEO's guards including Officer Ricardo Casarez observed the condition of Keegan's cell including the suicide tie offs, containers, and tools at least twice an hour every hour round the clock each day for the 96 days Keegan was in solitary. The GEO guards, including Officer Ricardo Casarez, neither removed such items nor instructed that such items be removed. The GEO guards, including Officer Ricardo Casarez, also contacted no supervisor regarding removal of such items and did not consult the medical and mental health staff about Keegan's possession of these items. GEO, its guards, medical staff, and Warden Martinez, knew about Keegan's serious mental conditions, which were conspicuously highlighted for everyone to see in the "Master Problem List."



MASTER PROBLEM LIST

The GEO Group, Inc.

INMATE/DETAINEE/RESIDENT (I/D/R) NAME: KILLIN, KEAGAN GAGE-			I/D/R #: UM42884480
I/D/R DOB: 7/6/99	FACILITY: Val Verde Correctional	ALLERGIES: NKA	

MAJOR PROBLEMS: *(require follow-up as may significantly affect health)*

Date	Number	Problem	Initials	Inactive Date
12-5-19		PTSD	J	
12-5-19		HIV Af	J	
12-5-19		(L) Shoulder pain	J	
4-1-20		PTSD, Insomnia	CR	
5-7-20		PTSD	CR	

74. That GEO, its guards, medical staff, and/or Warden Martinez, did not remove or instruct to be removed the items that could be used to commit suicide from Keegan's cell indicates a custom or practice of allowing such items to mentally ill inmates with a history of suicide. GEO, its guards, medical staff, and Warden Martinez were deliberately indifferent to, and acted unreasonably regarding, Keegan's needs to be protected. Defendants knew their conduct involved an extreme degree of risk, yet proceeded with conscious indifference to the rights, health, and safety of Keegan.

F. The Psychiatrist Defendants

75. The Psychiatrist Defendants (Farino, Garza and Beachkofsky) had actual knowledge of Keegan's high suicide risk. As of 2019 when Keegan entered the Val Verde prison where the Psychiatrist Defendants provided (or failed to provide) mental healthcare, it was widely known and documented in the scientific literature

that solitary confinement increases the risk of suicide. There are numerous empirical studies dating to the 1960s that report robust findings. With remarkably few exceptions, virtually every one of these studies found that isolated prisoners experience negative psychological effects and are at a significant risk of serious harm.[23] The pain, suffering, and psychic damage that can occur in solitary confinement are underscored by it being commonly used in so-called brainwashing and certain forms of torture and are analogous to the acute reactions suffered by torture and trauma victims, including PTSD. The research consistently documents and details the risk of psychological harm that social isolation creates, including mental pain and suffering and the increased incidence of self-harm and suicide. Solitary confinement is, in itself, a risk factor for suicide even among inmates not burdened with the plethora of other suicide risk factors Keegan had.

76. The Psychiatrist Defendants knew of the many of prison suicide studies relating to their practice area. As licensed medical doctors, the Psychiatrist Defendants are ethically bound to stay apprised of medical studies in their practice areas.

77. The Psychiatrist Defendants also actually knew of Keegan's specific risk factors for suicide. Psychiatrists are medical doctors focused on the diagnosis, treatment, and prevention of mental, emotional, and behavioral disorders. Psychiatrists are the experts in mental disorders and management of treatment. To become a psychiatrist, a person must complete college, then medical school, and then

[23] *Id.*

complete four years of psychiatry residency including at least three years learning the diagnosis and treatment of mental health, including various forms of psychotherapy and using psychiatric medications and other treatments. At least two of the GEO psychiatrists are board certified in psychiatry.

78. The Psychiatrist Defendants each were aware and informed of Keegan's mental health symptoms and each diagnosed Keegan with PTSD and insomnia according to the DSM-5. The Psychiatrist Defendants had actual knowledge, based on their training, expertise, and experience, that PTSD and insomnia, separately or collectively are risk factors for suicide. The Psychiatrist Defendants had actual awareness of Keegan's ongoing mental illness that – by definition of their own DSM-5 diagnosis – caused him to isolate, suffer night terrors with little sleep, and shut down from others.

79. The Psychiatrist Defendants also knew the prison setting of their patients, especially those in solitary confinement, was a risk factor for suicide that exacerbated the patient's underlying mental conditions.

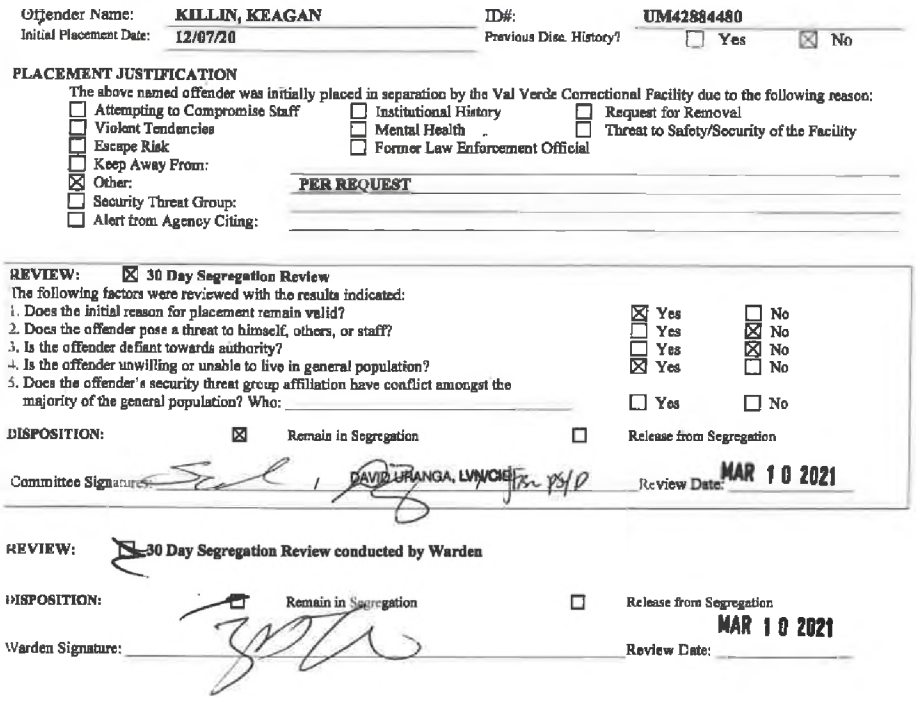
80. The Psychiatrist Defendants also knew their inmate patients' most common method of suicide was death by hanging. As medical doctors trained in life saving measures, the Psychiatrist Defendants knew death by hanging can be completed in minutes. The Psychiatrist Defendants knew, given Keegan's many risk factors for suicide, including diagnosis of PTSD, insomnia, solitary confinement, pre-trial detainee, night terrors, age, history of abuse, and previous suicide attempt, he had a substantial risk of death by hanging, and GEO's policy of only observing him

every 30 minutes would not prevent death.

81. The Psychiatrist Defendants went rogue abandoning all medical training, studies, data, ethics, knowledge, and expertise in favor of Defendants' pattern, policy, customs, and practice of denying mentally ill inmates urgent care putting Keegan at substantial risk of suicide. The Psychiatrist Defendants were deliberately indifferent to, and acted unreasonably regarding, Keegan's serious mental illness. The Psychiatrist Defendants knew their conduct involved an extreme degree of risk, yet they proceeded with conscious indifference to the rights, health, and safety of Keegan.

82. The Psychiatrist Defendants had actual awareness of Keegan's ongoing mental illness that, by definition of their own DSM-5 diagnosis, caused him to isolate, suffer night terrors with little sleep, and shut down from others. Keegan killed himself 4 months after being assigned to solitary confinement.

83. Keegan's placement in solitary confinement was reviewed on December 11, 2020, January 15, 2021, and March 10, 2021, and his continued isolation was approved each time by Warden Martinez. No justification such as safety or security threat, escape risk, mental health, or violence was noted except that the placement



Offender Name: KILLIN, KEAGAN ID#: UM42884480
Initial Placement Date: 12/07/20 Previous Disc. History? ☐ Yes ☒ No

PLACEMENT JUSTIFICATION
The above named offender was initially placed in separation by the Val Verde Correctional Facility due to the following reason:
☐ Attempting to Compromise Staff ☐ Institutional History ☐ Request for Removal
☐ Violent Tendencies ☐ Mental Health ☐ Threat to Safety/Security of the Facility
☐ Escape Risk ☐ Former Law Enforcement Official
☐ Keep Away From:
☒ Other: PER REQUEST
☐ Security Threat Group:
☐ Alert from Agency Citing:

REVIEW: ☒ 30 Day Segregation Review
The following factors were reviewed with the results indicated:
1. Does the initial reason for placement remain valid? ☒ Yes ☐ No
2. Does the offender pose a threat to himself, others, or staff? ☐ Yes ☒ No
3. Is the offender defiant towards authority? ☐ Yes ☒ No
4. Is the offender unwilling or unable to live in general population? ☒ Yes ☐ No
5. Does the offender's security threat group affiliation have conflict amongst the majority of the general population? Who: ☐ Yes ☐ No

DISPOSITION: ☒ Remain in Segregation ☐ Release from Segregation
Committee Signatures: DAVID URANGA, LVN/CIE Review Date: MAR 10 2021

REVIEW: ☒ 30 Day Segregation Review conducted by Warden
DISPOSITION: ☒ Remain in Segregation ☐ Release from Segregation
Warden Signature: Review Date: MAR 10 2021

was "per request."

84. On December 17, 2020, psychiatrist, Jessica Beachkofsky, M.D., met with Keegan via "telemental". This was 12 days into Keegan's solitary confinement. Dr. Beachkofsky noted Keegan's PTSD diagnosis, that he was only sleeping 5-6 hours, and had worsening anxiety. The only treatment recommended by Dr. Beachkofsky was Benadryl, an over-the-counter antihistamine. Dr. Beachkofsky did not prescribe any psychiatric medications for Keegan's worsening PTSD and anxiety, did not recommend psychotherapy, and did not recommend that he be removed from solitary confinement given his worsening mental symptoms. Keegan's PTSD was acute and he needed urgent mental health care.

85. On January 15, 2021, Keegan raised issue with his mental health treatment plan. A note written on a GEO document, "Refusal of Health Services," and stamped by Antonio Cadena, M.D. stated "on meds – not working." Dr. Cadena, as the medical director, was on notice that Keegan was not being treated for his

serious mental condition and took no action to make sure he did.

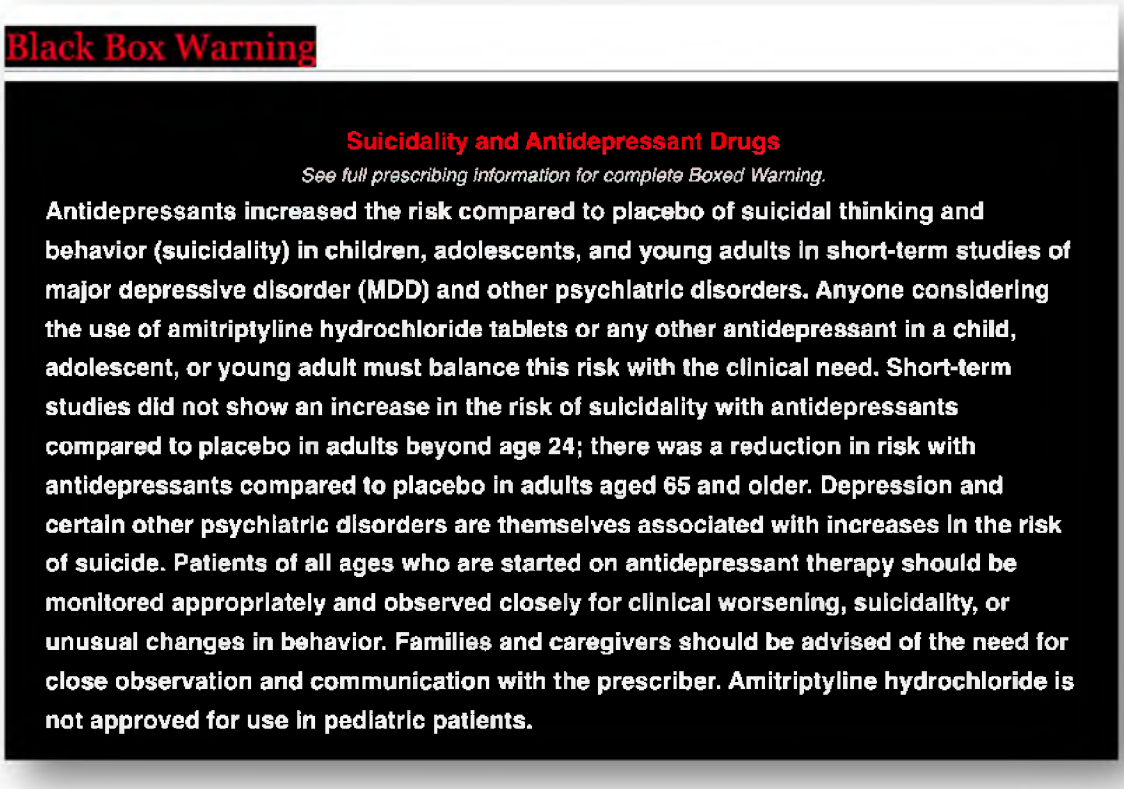
86. On February 5, 2021, Keegan was seen by a psychologist for the first time. A "Mental Health Initial Segregation Evaluation" was done by Y. Fisher, Psy.D. She documented Keegan's history of a suicide attempt, PTSD diagnosis, night terrors, and anxiety. Dr. Fisher recommended a follow up assessment in one week due to Keegan's reported mental health concerns, which were the same concerns he reported repeatedly to various GEO staff, including the Psychiatrist Defendants, since 2019.

87. Dr. Fisher did not recommend Keegan's removal from solitary. Dr. Fisher did not recommend to GEO or anyone that any suicide prevention measures be implemented such as increased monitoring or an inspection of Keegan's cell to remove items that could be used to commit suicide, such as tie offs, razors, strings, or shoelaces. Dr. Fisher did not recommend a referral to a psychiatrist for psychotropic medication.

88. On February 10, 2021, Keegan saw Dr. Fisher for a "weekly segregation contact and PREA evaluation." Dr. Fisher recommended weekly counseling if Keegan was in solitary. Dr. Fisher raised no concern with Keegan being in solitary without increased protective measures. It is unclear if Dr. Fisher could see the horrific condition of Keegan's cell and the stacks of contraband. She did not request a sweep or inspection of his cell.

89. On February 24, 2021, Dr. Beachkofsky saw Keegan in follow up to her previous "telemental" appointment on December 17, 2020. Keegan reported worsening mental symptoms including increased anxiety, worsening mood, and

sleeping only 4-5 hours. Dr. Beachkofsky prescribed amitriptyline, an older class of antidepressants (a tricyclic antidepressant) Keegan had never taken before. Importantly, amitriptyline carries a "black box warning" regarding its use in adolescents and young adults (ages less than 24 years) because it can increase the risk of suicidal ideation and behaviors. A black box warning is the highest safety rating available due high risk of extreme and adverse effects. Doctors proscribing medications with a black box warning must use extreme caution. Dr. Beachkofsky did not.


Black Box Warning

Suicidality and Antidepressant Drugs

See full prescribing information for complete Boxed Warning.

Antidepressants increased the risk compared to placebo of suicidal thinking and behavior (suicidality) in children, adolescents, and young adults in short-term studies of major depressive disorder (MDD) and other psychiatric disorders. Anyone considering the use of amitriptyline hydrochloride tablets or any other antidepressant in a child, adolescent, or young adult must balance this risk with the clinical need. Short-term studies did not show an increase in the risk of suicidality with antidepressants compared to placebo in adults beyond age 24; there was a reduction in risk with antidepressants compared to placebo in adults aged 65 and older. Depression and certain other psychiatric disorders are themselves associated with increases in the risk of suicide. Patients of all ages who are started on antidepressant therapy should be monitored appropriately and observed closely for clinical worsening, suicidality, or unusual changes in behavior. Families and caregivers should be advised of the need for close observation and communication with the prescriber. Amitriptyline hydrochloride is not approved for use in pediatric patients.

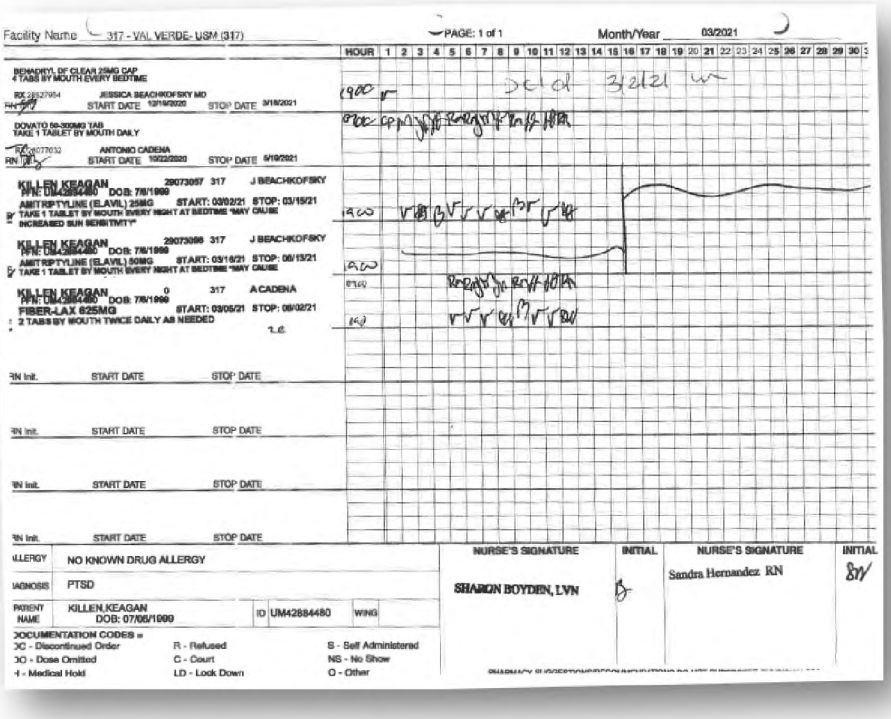
90. The increased risk of suicide in young adults taking amitriptyline was known to Dr. Beachkofsky, whose specialty is the management and treatment of mental health disorders, including prescribing medications. In October of 2004, the

Federal Drug Administration (FDA) issued the "black-box" label warning for certain antidepressants, including amitriptyline. The black box warning means adolescents and young adults such as Keegan being treated with amitriptyline should be monitored appropriately and observed closely for clinical worsening, suicidality, and unusual changes in behavior, especially during the initiation of therapy.

91. Keegan had never taken amitriptyline. Any potential adverse effects were unknown. No one, including the 4 GEO doctors tried in medication management, monitored him.

92. Dr. Beachkofsky did not recommend that any suicide prevention measures be implemented during the drug initiation period such as increased monitoring or an inspection of Keegan's cell to remove any items that could be used to commit suicide. Dr. Beachkofsky leaving Keegan to fend for his own in solitary confinement, PTSD, night terrors, and a new psychiatric drug with unknown consequences scheduled Keegan's follow up 4-6 weeks later.

93. Keegan started amitriptyline on March 2, 2021 and took it nightly for ten days until he hung himself on March 13, 2021.


Facility Name 317 - VAL VERDE- USM (317) PAGE: 1 of 1 Month/Year 03/2021

HOUR 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30

BENADRYL DF CLEAR 25MG CAP
4 TABS BY MOUTH EVERY BEDTIME
RX 28327954 JESSICA BEACHKOFSKY MD
START DATE 12/14/2020 STOP DATE 3/19/2021

DOVATO 50-300MG TAB
TAKE 1 TABLET BY MOUTH DAILY
RX 28277032 ANTONIO CADENA
START DATE 10/22/2020 STOP DATE 5/19/2021

KILLEN KEAGAN 29073057 317 J BEACHKOFSKY
PFN: DM42884480 DOB: 7/6/1999 START: 03/02/21 STOP: 03/15/21
AMITRIPTYLINE (ELAVIL) 25MG
TAKE 1 TABLET BY MOUTH EVERY NIGHT AT BEDTIME *MAY CAUSE INCREASED SUN SENSITIVITY*

KILLEN KEAGAN 29073098 317 J BEACHKOFSKY
PFN: DM42884480 DOB: 7/6/1999 START: 03/16/21 STOP: 06/13/21
AMITRIPTYLINE (ELAVIL) 50MG
TAKE 1 TABLET BY MOUTH EVERY NIGHT AT BEDTIME *MAY CAUSE

KILLEN KEAGAN 0 317 A CADENA
PFN: DM42884480 DOB: 7/6/1999 START: 03/05/21 STOP: 06/02/21
FIBER-LAX 625MG
2 TABS BY MOUTH TWICE DAILY AS NEEDED

RN Init. START DATE STOP DATE

RN Init. START DATE STOP DATE

RN Init. START DATE STOP DATE

RN Init. START DATE STOP DATE

ALLERGY NO KNOWN DRUG ALLERGY
DIAGNOSIS PTSD
PATIENT NAME KILLEN,KEAGAN DOB: 07/06/1999 ID UM42884480 WING

DOCUMENTATION CODES =
DC - Discontinued Order R - Refused S - Self Administered
DO - Dose Omitted C - Court NS - No Show
H - Medical Hold LD - Lock Down O - Other

NURSE'S SIGNATURE	INITIAL	NURSE'S SIGNATURE	INITIAL
SHARON BOYDEN, LVN	B	Sandra Hernandez RN	SH

G. March 13, 2021, Timeline of Events Recorded by GEO CCTV

94. GEO had video monitoring of the walkway in front of Keegan's cell which recorded:

a. At 2:06 am Officer Ricardo Casarez is seen via video conducting rounds using his flashlight and standing at Keegan's cell (H2C208). The lights were off in Keegan's cell.

b. At 2:12 am the lights in Keegan's cell turned on.

c. At 2:34 am Officer Ricardo Casarez calls out a code blue in Keegan's cell stating he was hanging. He asked for 911 and cut down tools.

d. At 2:36 am other officers and nursing staff arrive at the cell to cut Keegan down and start chest compressions until the paramedics arrived at 2:48 am. The resuscitating efforts were recorded via hand-held video

camera.

e. At 3:04 am the paramedic's supervising doctor called the time of death.[24]

H. Statements of GEO Guards and Nurses

95. Officer Ricardo Casarez wrote in his statement he was returning from his break after 2:30 a.m. and found Keegan hanging in his cell, # 208. When Keegan didn't respond, Officer Casarez ran to the service table to call a Code Blue at approximately 2:35 am. He went back to Keegan's cell and cut him down so the medical staff could start chest compressions.

96. Sandra Hernandez, RN wrote when she arrived on the scene, she checked for a pulse, but Keegan did not have one. Nurse Hernandez did CPR and AED for 10 minutes until EMS arrived. EMS took over and continued CPR for another 30 minutes including three rounds of intravenous epinephrine. Keegan never responded. He was pronounced dead at 3:04 a.m. on March 13, 2021. Dr. Y. Fisher was notified of Keegan's death.

97. Elizabeth Moynihan, the facility nurse practitioner, wrote Keegan started Elavil, 25, mg on March 2, 2021, and last saw the psychologist, Dr. Y. Fisher, on March 10, 2021. She wrote that Keegan has a history of suicide attempt at age 10 but was not on suicide watch.

98. None of the statements mention the condition of Keegan's cell, contraband, the empty containers used for alcohol, or that he was intoxicated.

[24] Death Incident at Val Verde Correctional Facility dated March 13, 2021; see also Fwd: Code Blue H2C208 Offender Killen, Kegan Gage UM42884480, dated March 15, 2021.

I. GEO Death Report Summary

99. Bertha Villanueva, GEO Director Health Services, and Dr. Antonio Cadena, the prison's Medical Director, wrote the "Death Summary" for GEO. Ms. Villanueva wrote that Keegan was found hanging with a pant leg tied around his neck. She noted Keegan's medical history of HIV, PTSD, and left shoulder pain and that he was referred to Chronic Care and Mental Health.

100. Dr. Antonio Cadena, the prison's Medical Director, wrote he saw Keegan four times for management of his HIV. He noted Keegan told intake he had PTSD and was also the victim of childhood sexual abuse. He said Keegan was pleasant, engaging, and showed no signs of depression or irritability, and that Keegan was on antidepressants Zoloft and Trazodone discontinued several months back. Dr. Cadena echoed the statements of the other witnesses that Keegan was found hanging in his cell with a cloth ligature around his neck at approximately 2:36 am and was cut down and placed on the floor for resuscitation efforts by GEO medical staff. He noted Keegan was found in asystole when the AED was initially applied and there was no shockable rhythm detected through the resuscitation effort. The paramedics supervising physician gave the CPR termination order at 3:04 a.m. Dr. Cadena wrote the cause of death was asphyxiation and suicide.

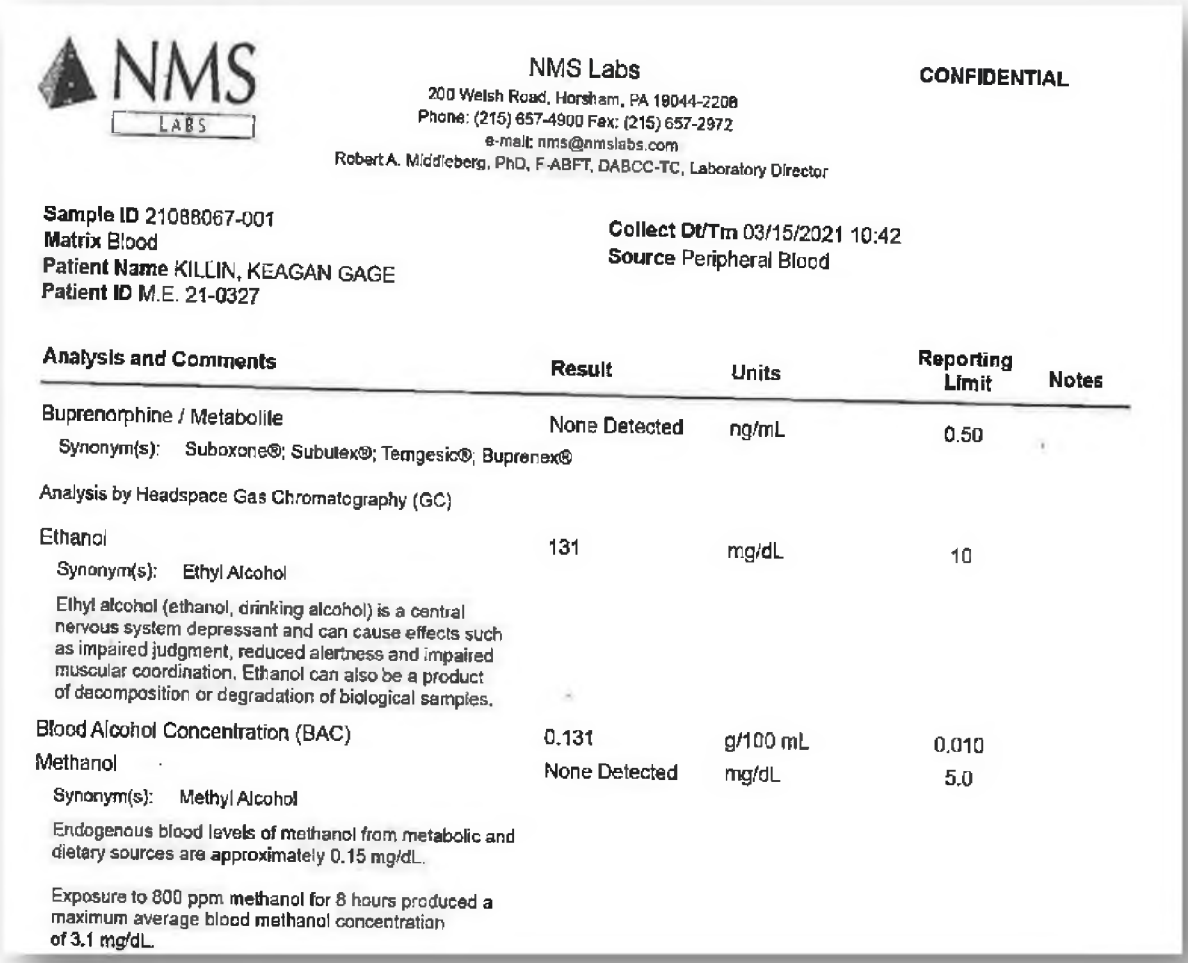
101. According to GEO's timeline recorded by CCTV and hand-held video, the AED was attached to Keegan at 2:36 a.m. Keegan was already in asystole (or flatlined). Thus, he completed suicide between 2:12 a.m. (when his cell light turned on) and 2:34 am (when he was discovered by Officer Casarez). GEO's and Warden Martinez's policy and custom of only visually checking inmates in the RHU every 30

minutes was inadequate and was a moving force in causing Keegan's death.

102. Neither Dr. Cadena nor Ms. Villanueva, both in positions of leadership at the prison, mentioned in their statements the condition of Keegan's cell, the alcohol containers, suicide tools and tie offs, or that he was intoxicated during his death.

J. Autopsy Report

103. The Webb County Medical Examiner conducted an autopsy. The cause of death was listed as hanging, and the manner of death was suicide. Keegan's blood alcohol concentration (BAC) was 0.131. None of GEO's records or death investigation reports reference Keegan's intoxication, where Keegan obtained the alcohol, how he stored it, and how he was able to drink to this level of intoxication in a secure prison without being detected. A BAC of .131 in a 160 lb. man is approximately 5-6 drinks per hour.



NMS LABS

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e-mail: nms@nmslabs.com
Robert A. Middleberg, PhD, F-ABFT, DABCC-TC, Laboratory Director

CONFIDENTIAL

Sample ID 21088067-001
Matrix Blood
Patient Name KILLIN, KEAGAN GAGE
Patient ID M.E. 21-0327

Collect Dt/Tm 03/15/2021 10:42
Source Peripheral Blood

Analysis and Comments	Result	Units	Reporting Limit	Notes
Buprenorphine / Metabolite	None Detected	ng/mL	0.50	
Synonym(s): Suboxone®; Subutex®; Temgesic®; Buprenex®				
Analysis by Headspace Gas Chromatography (GC)				
Ethanol	131	mg/dL	10	
Synonym(s): Ethyl Alcohol				
Ethyl alcohol (ethanol, drinking alcohol) is a central nervous system depressant and can cause effects such as impaired judgment, reduced alertness and impaired muscular coordination. Ethanol can also be a product of decomposition or degradation of biological samples.				
Blood Alcohol Concentration (BAC)	0.131	g/100 mL	0.010	
Methanol	None Detected	mg/dL	5.0	
Synonym(s): Methyl Alcohol				
Endogenous blood levels of methanol from metabolic and dietary sources are approximately 0.15 mg/dL.				
Exposure to 800 ppm methanol for 8 hours produced a maximum average blood methanol concentration of 3.1 mg/dL.				

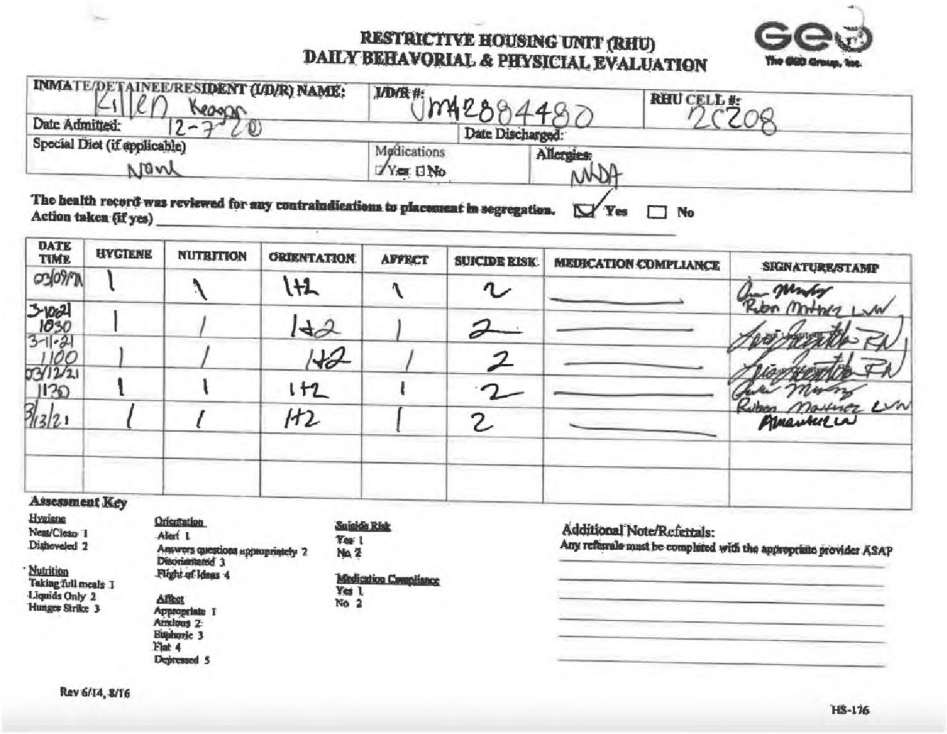
104. That Keegan made, stored, and drank that amount of alcohol while in a solitary confinement indicates a policy or custom of allowing inmates to have sufficient containers in their cell at one time to make and/or store at least 5-6 servings of alcohol.

105. Home-made wine or "hooch" is made with any food substance containing natural or added sugar. At least ten of the containers found in Keegan's cell on the day he died were empty grape jelly containers scattered all over the desk and floor. Keegan's ability to make and store home-made wine in plain sight and in sufficient amounts to lead to a BAC of .131 indicates a policy or custom of allowing inmates to make and consume alcohol without consequence. Keegan's cell was supposedly checked every 30 minutes and the above photos show his ability to make, store, and consume large amounts of alcohol right under the nose of the GEO guards.

106. In the 24 hours before he hung himself, Keegan's cell was supposedly

checked 48 times based on prison policy of cell checks every 30 minutes. In addition, Keegan was given his medication every evening, meals during the day, and was seen by nurses for the RHU Daily Behavioral & Physical Evaluation.

107. In the days before his death, GEO nurses Annick Martell LVN, Ruben Martinez LVN, and Lois Quintela RN all evaluated Keegan for suicide risk, affect, orientation, nutrition, and hygiene. No nurses indicated anything was wrong. Keegan consistently received perfect ratings each time. The photos of Keegan's cell showing empty containers, bags of trash, and a make-shift alcohol production area at his toilet paired with a BAC of .131 tell a different story of how he was doing. A story much different than what GEO staff recorded its form documents. The discrepancy between what GEO guards and nurses were recording and what the photos and blood data reflect demonstrate a policy, custom, and/or practice of not doing the daily cell checks and/or daily behavioral & physical evaluations required in the solitary unit. The GEO records indicate a policy, custom, and/or practice of recording the ratings because it was required but not because it was done.



RESTRICTIVE HOUSING UNIT (RHU)
DAILY BEHAVORIAL & PHYSICIAL EVALUATION

The GEO Group, Inc.

INMATE/DETAINEE/RESIDENT (I/D/R) NAME: Killen Keegan	I/D/R #: 08884480	RHU CELL #: 2C208
Date Admitted: 12-7-20	Date Discharged:	
Special Diet (if applicable): NONE	Medications: ☑ Yes ☐ No	Allergies: NKDA

The health record was reviewed for any contraindications to placement in segregation. ☑ Yes ☐ No
Action taken (if yes) _____

DATE TIME	HYGIENE	NUTRITION	ORIENTATION	AFFECT	SUICIDE RISK	MEDICATION COMPLIANCE	SIGNATURE/STAMP
03/09/21	1	1	1+2	1	2		Ruben Martinez LVN
3-10-21 1030	1	1	1+2	1	2		RN
3-11-21 1100	1	1	1+2	1	2		RN
03/12/21 1130	1	1	1+2	1	2		Ruben Martinez LVN
3/13/21	1	1	1+2	1	2		Ruben Martinez LVN

Assessment Key

Hygiene
Neat/Clean 1
Disheveled 2

Nutrition
Taking full meals 1
Liquids Only 2
Hunger Strike 3

Orientation
Alert 1
Answers questions appropriately 2
Disorientated 3
Flight of Ideas 4

Affect
Appropriate 1
Anxious 2
Euphoric 3
Flat 4
Depressed 5

Suicide Risk
Yes 1
No 2

Medication Compliance
Yes 1
No 2

Additional Note/Referrals:
Any referrals must be completed with the appropriate provider ASAP

Rev 6/14, 8/16

HS-176

IV. FIRST CAUSE OF ACTION 42 U.S.C. § 1983 VIOLATION OF FOURTEENTH AMENDMENT RIGHT TO DUE PROCESS OF LAW (Against all Defendants)

108. Plaintiff realleges and incorporates each of the preceding paragraphs, and all subsequent paragraphs.

109. Keegan was a pre-trial detainee and was never convicted of any crime while detained in the Val Verde prison for 15 months. Under the laws of the United States, pretrial detainees have a constitutional right, under the Due Process Clause of the Fourteenth Amendment, to adequate medical care and protection from harm during the length of their confinement. *See Thompson v. Upshur Cnty., Tex.*, 245 F.3d 447, 457 (5th Cir. 2001); *Jacobs v. West Feliciana Sheriff's Dep't*, 228 F.3d 388, 393 (5th Cir. 2000). Because the suicide of a pretrial detainee implicates both the state's duty to provide medical care and its duty to provide protection from harm, *Jones v.*

Throckmorton Cnty., Tex., 1:02-CV-l 82-C, 2004 U.S. Dist. LEXIS 3499, 2004 WL 419811, at *4 (N.D. Tex. March 8, 2004), failing to provide pretrial detainees with medical care and adequate protection from their known suicidal impulses violates the Fourteenth Amendment, *Nunez v. Deviney*, 4:06-CV-0579-BE, 2007 U.S. Dist. LEXIS 51683, 2007 WL 2059726, at *2 (N.D. Tex. July 17, 2007) (citing *Hare v. City of Corinth, Miss.*, 74 F.3d 633, 639 (5th Cir. 1996)). And further violates the Texas Constitution, Art. I, §§ 13 & 19 guarantees to be free from unusual punishment and deprivation of life, liberty or property.

A. The Fifth Circuit Mandates Continuous Monitoring of Detainees with Suicidal Tendencies

110. Defendants were put on notice long ago that anything short of continuous monitoring of inmates with a high risk of suicide was insufficient and violated the United States Constitution. The law was established in the Fifth Circuit with exacting specificity, and Defendants are charged with knowledge of it.

111. Circuit Judge Goldberg, writing a concurring opinion on behalf of the United States Court of Appeals for the Fifth Circuit nearly 30 years ago – in 1992 – unambiguously wrote that the right to continual monitoring of prisoners with suicidal tendencies was established. In *Rhyne vs. Henderson Val Verde County*, 973 F.2d 386 (5th Cir. 1992), the mother of a pre-trial detainee sued for the death of her child. Judge Goldberg warned and put on notice all policymakers within the jurisdiction of the United States Court of Appeals for the Fifth Circuit regarding pre-trial detainees in need of mental health care (and specifically those with suicidal tendencies):

> Fortunately, the policymakers in charge can learn from their mistakes and take the necessary additional steps to ensure the safety of pretrial detainees in need of mental health care. Other municipalities should also take heed of the tragic consequences which are likely to ensue in the absence of adequate safety measures to deal with detainees displaying suicidal tendencies. What we learn from the experiences of Henderson Val Verde County [Texas] is that when prisoners know a detainee is prone to committing suicide, a policy of observing such a detainee on a periodic, rather than on a continuous, basis, will not suffice; that vesting discretion in untrained prison personnel to assess the need for, and administer, mental health care, will not be responsive to the medical needs of mentally ill detainees; and that delegating the task of providing mental health care to an agency that is incapable of dispensing it on the weekends will endanger the well-being of its emotionally disturbed detainees.
>
> We need not remind prisoners and municipalities that the Constitution works day and night, weekends, and holidays—it takes no coffee breaks, no winter recess, and no summer vacation
>
> So the plaintiff in this case did not prove that Henderson Val Verde County adopted its policy of handling suicidal detainees with deliberate indifference to their medical needs. But that does not insulate Henderson Val Verde County, or any other municipality, from liability in future cases. Prisoners and municipalities beware! Suicide is a real threat in the custodial environment. Showing some concern for those in custody, by taking limited steps to protect them, will not pass muster unless the strides taken to deal with the risk are calculated to work: Employing only "meager measures that [prisoners and municipalities] know or should know to be ineffectual" amounts to deliberate indifference. To sit idly by now and await another, or even the first, fatality, in the face of the Henderson Val Verde County tragedy, would surely amount to *deliberate* indifference. *Id.*, 27.

112. Keegan was never monitored any more than anyone else in the Val Verde prison despite his history of suicide, serious mental health conditions, and

multitude of other risk factors of suicide well known to Defendants and even posted on Keegan's "master problem list" for everyone to read. Frequent periodic checks were obviously inadequate with someone like Keegan with a risk of suicide and history of attempt suicide by strangulation. Keegan was even put in solitary confinement by his own request where he could complete death by suicide, undetected, and with all the tools needed that was displayed in plain sight of all GEO guards, nurses and the Individual Defendants and Psychiatrist Defendants that came to his cell. Keegan's suicide should be no surprise to any Defendant. Defendants created the conditions and opportunity for death to occur. More frequent checks or continuous observation was necessary to protect Keegan's life.

B. *Monell* Liability of GEO and Val Verde County

113. Plaintiff realleges and incorporates each of the preceding paragraphs, and all subsequent paragraphs.

114. Plaintiff sets forth in this section additional facts and allegations supporting liability claims against GEO and Val Verde County under *Monell v. Department of Soc. Svcs.*, 436 U.S. 658 (1978). It is Plaintiff's intent that all facts asserted in this pleading relating to policies, practices, and/or customs of GEO and the Val Verde County support *Monell* liability claims, and not just facts and allegations in this section. Such policies, practices, and/or customs alleged in this pleading, individually and/or working together, were moving forces behind and caused the constitutional violations, and damages and death of Keegan. These policies, practices, and/or customs are pled individually and alternatively.

115. GEO and Val Verde County knew, when it incarcerated Keegan, that its personnel, policies, practices, and/or customs were such that it could not meet its constitutional obligations to provide appropriate mental health treatment to, and protect, Keegan from further mental decompensation and suicide.

116. Val Verde County made decisions about policy and practice which it implemented through its official policymakers, including its commissioner's court, its sheriff, county judges, and/or through such widespread practice and/or custom that such practice and/or custom became the policy of Val Verde County.

117. Likewise, GEO made decisions about policy and practice which it implemented through its wardens, including Warden Martinez, facility, compliance, safety, and medical administrators, physicians, safety manager and/or through such widespread practice and/or custom that such practice and/or custom became the policy of GEO as it related to its prisons. The Fifth Circuit Court of Appeals has clarified that Plaintiff need not allege at the pleading stage the identity of the chief policymaker.

118. There were several policies, practices, and/or customs of Val Verde County and GEO which were moving forces behind, caused, were producing causes of, and/or proximately caused Keegan's suffering and death, and other damages referenced in this pleading. Val Verde County and GEO made deliberate decisions, acting in a deliberately indifferent and/or objectively unreasonable manner, when implementing and/or allowing such policies, practices, and/or customs to exist. Further, when Val Verde County and GEO implemented and/or consciously allowed

such policies, practices, and/or customs to exist, it knew with certainty that the result would be serious injury, suffering, physical illness, and/or death.

C. Val Verde County and GEO's Policies, Practices, and Customs Were Moving Forces Behind And Caused the Constitutional Violations, And Damages And Death Of Keegan

119. Plaintiff realleges and incorporates each of the preceding paragraphs, and all subsequent paragraphs.

120. Suicides were not a novel occurrence and/or unknown issue to Val Verde County and GEO. Defendants were well-aware of the risk – and in Keegan's case the certainty – of suicide. Upon information and belief, Val Verde County and GEO were aware of the significant risk of suicide in prisons, and they learned that information both from their education, training, work in and/or related to the industry, prisons, prison suicide studies and/or in the news media.

121. Val Verde County and GEO, besides knowing of the high risk of prison suicides, were put on notice well before Keegan's incarceration they needed the appropriate policies, practices, and/or customs in place to fulfill its constitutional obligations to provide medical and mental health care and protect inmates. Defendants were deliberately indifferent to the certainty of Keegan's suicide. Individual Defendants and the Psychiatrist Defendants acted in an objectively unreasonable manner, and the Val Verde County's and GEO's policies, practices, and/or customs were moving forces behind and caused Keegan's death.

122. Val Verde County and GEO had a policy, practice, and/or custom of allowing inmates to be classified and housed in solitary confinement by the inmate's

request with no justification. This practice was common as evidenced by several other inmates in RHU who, like Keegan, were in RHU for no reason other than the inmate's own preference. Determining where to house an inmate, based upon the inmate's specific needs, is designed not only to protect that inmate but also other inmates that may encounter that inmate. Val Verde County and GEO should never allow inmates, much less inmates suffering from mental illness, to make decisions about their housing. Val Verde County and GEO had a practice and custom of allowing inmates to choose isolation without justification or protective measures. Val Verde County and GEO allowed this practice knowing Keegan had the type of mental illness that worsened in isolation, and according to the available scientific literature, would be exponentially exacerbated by isolation causing further harm and even death.

123. Val Verde County and GEO had a policy, custom, and/or practice for guards to only perform visual checks every 30 minutes in the solitary unit and not any more frequently absent other instructions. No other instructions were given for Keegan's safety. GEO and Warden Martinez's 30-minute checks were obviously inadequate for someone like Keegan with a risk of suicide and history of attempt suicide by strangulation.

124. Val Verde County and GEO had a policy, custom, and/or practice for guards and nursing staff not to perform required periodic observations of inmates, not appropriately documenting any observations made, and/or falsifying observation records. In the days before his death, GEO nurses Annick Martell LVN, Ruben Martinez LVN, and Lois Quintela RN all evaluated Keegan for suicide risk, affect,

orientation, nutrition, and hygiene. Keegan consistently received perfect ratings on these factors each time. The photos of Keegan's cell showing empty containers, bags of trash, grape jelly containers used to make alcohol, a make-shift alcohol production area at his toilet and a BAC of .131 tell a different story of how Keegan was doing. The discrepancy between what GEO guards and nurses were recording and what the photos and blood data reflect demonstrate a policy, custom, and/or practice of not doing the daily cell checks and/or daily behavioral & physical evaluations required in the solitary unit.

125. Val Verde County and GEO had a policy, custom, or practice of not treating inmates with PTSD. PTSD is a severe and chronic anxiety disorder, with impairment in daily functioning, frequent suicidal behavior, and high rates of comorbidity. Psychotherapy in the form of cognitive behavioral therapy (CBT) and its related forms are the first line of treatment for PTSD.[25] Pharmacological treatment is not the first line of treatment for PTSD but if used, selective serotonin reuptake inhibitors (SSRIs) are considered best due to the results of numerous clinical trials.[26] Sertraline and paroxetine are the only antidepressants approved by the FDA to treat PTSD and are the most extensively studied SSRIs for this indication. Keegan was not given any psychotherapy or cognitive behavioral therapy (CBT) despite GEO's actual knowledge of his PTSD during intake and throughout his 15-month incarceration.

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[25] American Psychological Association. "Clinical Practice Guidelines for the Treatment of PTSD in Adults." (2017) (developed to provide recommendations on psychological and pharmacological treatments for posttraumatic stress disorder (PTSD) in adults).

[26] Alexander, Walter. "Pharmacotherapy for Post-traumatic Stress Disorder in Combat Veterans: Focus on Antidepressants and Atypical Antipsychotic Agents." P & T : a peer-reviewed journal for formulary management vol. 37,1 (2012): 32-8.

He was taking Sertraline when he arrived at GEO but was taken off it, without cause, two months before moving to solitary confinement. Keegan's PTSD had not changed but was getting worse. GEO's complete failure to treat Keegan's PTSD demonstrates a policy, custom, and/or practice of not following the guidelines, recommendations, or medical studies and protocols about the proper treatment of PTSD.

126. Val Verde County and GEO had a policy, custom, or practice of understaffing its prison even in critical areas such as the solitary unit. There was only one guard monitoring Keegan the night he hung himself and that guard only saw him for seconds every 30 minutes. Val Verde County's and GEO's policy, custom, and/practice to understaff the prison with only one guard at night in the solitary unit allowed Keegan ample time to complete suicide by hanging without detection in under 30 minutes.

127. Val Verde County and GEO had a policy, practice, and/or custom of allowing inmates to have multiple containers and items in their cell to make alcohol. All GEO guards and nurses recording cell or behavioral checks saw the many containers scattered across the cell and the make-shift alcohol production area by the toilet. Many containers were empty grape jelly containers. Grape jelly is a high sugar food that can be used to make alcohol. None of the GEO guards and/or nurses removed these nor instructed that such items be removed. The GEO guards and/or nurses also contacted no supervisor regarding removal of such items.

128. Val Verde County and GEO had a policy, practice, and/or custom of not conducting cell checks for contraband. GEO guards and/or nurses knew Keegan was

making alcohol in his cell. That knowledge is confirmed by photos reflecting the number of jelly containers and items in Keegan's cell on the day of his death, and the make-shift alcohol production area set up by his toilet. That the GEO guards and/or nurses did not remove these items or instruct that the items be removed indicates a custom or practice at the prison of not checking cells for contraband and/or falsifying records that the cells were checked for contraband. Keegan's cell passed inspection every time even with alcohol and empty containers all over his cell.

129. GEO had a policy, practice, and/or custom of enabling pretrial detainees to commit suicide, and failing to protect suicidal inmates, by providing them with jail-issued bed sheets, shoestrings, laundry lines, and metal bunks with holes used to facilitate suicide. Keegan was able to tie a cloth around the bunk and hang himself – all tools provided by the prison.

D. Liability of Warden Martinez, in his Official and Individual Capacity, Under 42 U.S.C. § 1983, for Violation of Keegan Killin's 14th Amendment Due Process Rights to Reasonable Medical and Mental Health Care, to be Protected, and Not to Be Punished as a Pretrial Detainee

130. Plaintiff realleges and incorporates each of the preceding paragraphs, and all subsequent paragraphs.

131. Warden Martinez, Dr. Cadena, and the Psychiatrist Defendants, as employees of GEO, contracted to perform the public functions of Val Verde County, i.e., to provide medical and mental health services in prisons, and thus they are state actors standing in the shoes of Val Verde County.

132. Warden Martinez was the prison administrator and chief policy maker during the relevant time. As such, Warden Martinez was informed of Keegan's mental illnesses, mental health treatment (and lack thereof) and was the decision maker who put Keegan in solitary confinement despite his awareness of these issues and Keegan's high risk of suicide.

133. As described throughout, Warden Martinez failed to take measures to prevent Keegan from committing suicide, despite his knowledge of a substantial risk of suicide and the prison's lack policies to prevent suicide. Warden Martinez acted with deliberate indifference to the health, safety, and welfare of Keegan when he deliberately and intentionally placed him in a solitary cell, without justification and with all the tools and apparatuses to hang himself. Warden Martinez further had a policy, practice, and custom of allowing guards to not perform required cell checks and sweeps of those in solitary, and log false inmate and cell check entries. Thus, Warden Martinez is liable to Plaintiff pursuant to 42 U.S.C. § 1983, for violating Keegan's rights to reasonable medical and mental health care, to be protected from himself and others, and not to be punished as a pretrial detainee, such rights guaranteed by the 14th Amendment to the United States Constitution. Pre-trial detainees are entitled to a greater degree of medical care than convicted inmates, according to the Fifth Circuit Court of Appeals. Pre-trial detainees are also entitled to protection from themselves and others, and not to be punished at all since they have not been convicted of any crime resulting in their incarceration.

134. Warden Martinez acted and failed to act under color of state law at all

times referenced in this Complaint. Warden Martinez wholly or substantially ignored Keegan's suicidal and self-harm tendencies and his obvious serious mental health needs, and he was deliberately indifferent to those needs. Warden Martinez chose to allow Keegan to harm himself, and thus failed to protect him, and further punished Keegan by, among potentially other things, by placing him into isolation without treatment or suicide-preventive measures for continuous observation, thereby allowing him to kill himself. Warden Martinez was well informed of Keegan's mental health conditions and lack of treatment and had subjective knowledge of the substantial risk of suicide and responded with deliberant indifference to that risk. Warden Martinez was aware of the excessive risk to Keegan's health or safety and was aware of facts from which an inference could be drawn of serious harm (and he in fact drew that inference). In fact, based on what occurred, it was more than an inference to Warden Martinez. It was blatantly apparent to Warden Martinez, unless heprotected Keegan and provided him needed medical and/or psychological care, he would kill himself.

135. Warden Martinez violated clearly established constitutional rights, and his conduct was objectively unreasonable in light of clearly established law at the time of the relevant incidents. Keegan, as a pretrial detainee, had a clearly established right to receive reasonable medical and mental health care, to be protected from himself and others, and not to be punished. These rights included the right to be continuously and appropriately monitored. These rights also included the right to have removed from Keegan's cell items commonly known to be used by suicidal

inmates to kill themselves such as lines and tie-ffs from bunks.

E. Individual Liability of Dr. Cadena and the Psychiatrist Defendants Under 42 U.S.C. § 1983 for Violation of Keegan Killin's 14th Amendment Due Process Rights to Reasonable Medical and Mental Health Care, to be Protected, and Not to Be Punished as a Pretrial Detainee

136. Plaintiff realleges and incorporates each of the preceding paragraphs, and all subsequent paragraphs.

137. Dr. Cadena and the Psychiatrist Defendants were employees and/or contractors of GEO hired to perform the public functions of Val Verde County, i.e., to provide medical services in jails, and thus they are state actors standing in the shoes of Val Verde County.

138. Dr. Cadena, was the medical director for the prison who was responsible for implementing, managing, and directing medical and mental health care of the inmates. On information and belief, as medical director of the prison, Dr. Cadena had a supervisory role over the other Psychiatrist Defendants.

139. As the medical director of the prison, Dr. Cadena was aware of Keegan's mental illnesses, mental health treatment (and lack thereof) and the prison's decision to put Keegan in solitary confinement despite his awareness of these issues and Keegan's high risk of suicide. Dr. Cadena knew on the day Keegan entered the prison he has serious mental health needs and concerns because he personally examined Keegan. He also knew that Keegan's mental health issues were not treated, and as a medical doctor, the risk of an inmate in solitary confinement not being treated for serious mental health issues.

140. On December 5, 2019, Dr. Cadena, Jr. noted during on Keegan's transfer papers that he had PTSD and should be referred to "psych." On January 15, 2021, Keegan raised issue with his mental health treatment plan. A note written on a GEO document, "Refusal of Health Services," and stamped by Antonio Cadena, M.D. stated "on meds – not working." Dr. Cadena, was on notice that Keegan was not being treated for his serious mental condition and took no action to make sure he did. Keegan died less than two months later due to lack of mental health care and the pattern and abuses by Defendants.

141. Psychiatrist Defendants, as pled elsewhere in this Complaint, all knew of Keegan's many risk factors for suicide, yet they never provided mental health treatment for his acute symptoms. Keegan received no psychotherapy until the week before his death and by this time, Dr. Beachkofsky gave him a black box warning psychiatric drug without monitoring or suicide prevention measures. It should be no surprise to the Psychiatrist Defendants that Keegan, who was suffering deeply and in grave distress and in isolation, hung himself. Indeed, Psychiatrist Defendants, as jail doctors, know that strangulation is the most common method of suicide in a jail and did nothing to ensure their patient's cell was safe, especially during initiation of a new drug that carries the highest danger rating for young adults.

F. Bystander Liability of Warden Martinez, Dr. Cadena, and the Psychiatrist Defendants

142. Plaintiff realleges and incorporates each of the preceding paragraphs, and all subsequent paragraphs.

143. Warden Martinez and the Psychiatrist Defendants are also liable under the theory of bystander liability. Bystander liability applies when the bystander (1) knows that a fellow officer/nurse is violating person's constitutional rights; (2) has a reasonable opportunity to prevent the harm; and (3) chooses not to act. As described above and throughout this Complaint, the actions and inaction of Warden Martinez, Dr. Cadena, and the Psychiatrist Defendants meet all three elements.

G. Warden Martinez, Dr. Cadena, and the Psychiatrist Defendants Are Not Entitled to Immunity

144. Defendants Warden Martinez, Dr. Cadena, and the Psychiatrist Defendants are not entitled to immunity. In March 2021, the law was clearly established that, under the Fourteenth Amendment Due Process Clause of the United States Constitution, pre-trial detainees are entitled to to adequate medical care and protection from harm during the length of their confinement, that state actors have a duty to provide such medical care, and a duty to provide protection from harm. Further, Defendants had a policy and practice of delaying and denying medical and mental health care to prisoners. Their duty to provide care is not discretionary. Defendants Warden Martinez, Dr. Cadena, and the Psychiatrist Defendants acted with deliberate indifference and conscious disregard outside of their official capacities, and objectively knew that the law required them to act otherwise. Defendants did not act in good faith and are therefore not entitled to immunity.

- GEO was systematically organized to perform the major administrative task of providing medical care in Texas prisons.

- GEO was at the time relevant to this case in the business of administering correctional healthcare services.

- GEO has made millions of dollars each year from its contracts with governments for prison medical care, including Val Verde County.

- Warden Martinez, Dr. Cadena, and the Psychiatrist Defendants were employees of GEO at all relevant times, GEO at the time being a systematically organized entity to assume a major administrative task with limited direct supervision by Val Verde County, undertaking that task for profit and while in competition with other for-profit firms providing similar services.

- Market forces existed at all relevant times that were likely to provide GEO with strong incentives to avoid overly timid or insufficiently vigorous employee job performance.

- Ordinary marketplace pressures were present at all relevant times regarding GEO's provision of services to Val Verde County.

- Based on information and belief, GEO had a multi- year contract with Val Verde County with renewal periods, such that its performance was disciplined by pressure from potentially competing firms who could try to take its place in providing services to Val Verde County.

- GEO operated with relatively little ongoing Val Verde County supervision.

- GEO, as opposed to Val Verde County, took the lead in developing relevant policy regarding medical and mental health care provision in the Val Verde County prison.

- GEO, Warden Martinez, Dr. Cadena, and the Psychiatrist Defendants had discretion to take certain actions which Val Verde County employees lacked the authority to do.

- Warden Martinez, Dr. Cadena, and the Psychiatrist Defendants knew, based on information and belief, that they could ꝭsubject to liability without the benefit of qualified immunity; even so GEO attracted qualified employees.

145. The above factors, under controlling authority, demonstrate that Warden Martinez, Dr. Cadena, and the Psychiatrist Defendants cannot assert qualified immunity.

H. Municipal Liability

146. Plaintiff realleges and incorporates each of the preceding paragraphs, and all subsequent paragraphs.

147. GEO and Val Verde County are liable to Plaintiff because they maintained policies at the prison that were the moving force behind Keegan's suffering and death.

148. The Fifth Circuit Court of Appeals has clarified that Plaintiff need not specifically identify a policymaker at the Complaint stage. But out of an abundance of caution, the sheriff of Val Verde County, County Judges Mike Fernandez and Lauren Allen, and the Val Verde County Commissioner's Court were the Val Verde County's relevant chief policymakers over matters at issue in this case and contracted with GEO to manage and administer health and mental health care to Val Verde County prisoners.

149. GEO's chief executive officers and/or other executives, such as a regional director, medical director Antonio Cadena, Jr. and Warden Martinez were their policymakers regarding the policies maintained at the Val Verde prison.

I. Liability of Val Verde County Under the Non-Delegable Duty Doctrine

150. Val Verde County cannot escape liability under 42 U.S.C. § 1983 because it contracted out its governmental duty to provide medical services to inmates. In *West*, the Supreme Court discusses the non-delegable duty doctrine of liability: "Contracting out prison medical care does not relieve the State of its constitutional duty to provide adequate medical treatment to those in its custody, and it does not deprive the State's prisoners of the means to vindicate their Eighth Amendment rights. The State bore an affirmative obligation to provide adequate medical care to West; the State delegated that function to respondent Atkins; and respondent voluntarily assumed that obligation by contract. *West v. Atkins,* 108 S. Ct. 2250, 101 L. Ed. 2d 40, 1988 U.S. LEXIS 2744, 56 U.S.L.W. 4664.

151. Applying *West* here, GEO, Warden Martinez, Dr. Cadena, and the Psychiatrist Defendants' delivery of mental healthcare to Keegan was state action attributable to Val Verde County and GEO, Warden Martinez, Dr. Cadena, and Psychiatrist Defendants therefore acted under color of state law for§ 1983.

152. Further, as plead elsewhere in this Complaint, Val Verde County is liable for the policies, practices, and/or customs of GEO, its guards, medical staff, and Warden Martinez, and doctors and nurses hired to care for prisons. These defendants individually and/or working together, were moving forces behind and caused the constitutional violations, suffering, damages and death of Keegan and Plaintiff. Val Verde County cannot contract away its liability and remains liable for any constitutional deprivations caused by the policies or customs of GEO. Val Verde

County's duty to provide medical services is non-delegable.

153. Val Verde County and GEO were deliberately indifferent regarding policies, practices, and/or customs developed and/or used regarding issuesaddressed by allegations set forth above. They also acted in an objectively unreasonable manner. Policies, practices, and/or customs referenced above were moving forces behind and violated Keegan's rights and showed deliberate indifference to the known or obvious consequences of suffering and death that constitutional violations would occur.

154. Val Verde County's and GEO' relevant policies, practices, and/or customs, whether written or not, were also objectively unreasonable as applied to Keegan. Their failure to provide mental healthcare and protect Keegan, and other actions and/or inaction referenced in this Complaint, caused, proximately caused, and/or were producing causes of Keegan's suffering and death and other damages mentioned and/or referenced in this pleading, including but not limited to those suffered by Plaintiff and his heirs at law.

155. Therefore, Plaintiff, on behalf of Keegan's estate and/or his heirs at law suffered these damages, for which she seeks recovery from defendants. But for defendants' acts and/or omissions, Keegan would not have died. Defendants' specific acts and/or omissions were the proximate cause of Plaintiffs' injuries and damages including:

a. Keegan's conscious physical pain, suffering, and mental anguish;

b. Keegan's loss of income;

c. Keegan's loss of life and/or loss of enjoyment of life;

d. Keegan's medical expenses;

e. Keegan's funeral/cremation expenses; and

f. exemplary/punitive damages.

156. Plaintiff also individually seeks and is entitled to all damages available to her individually for 42 U.S.C. § 1983 claims. Plaintiff seeks such damages as a result of the wrongful death of her son caused and/or proximately caused by defendants. Their actions caused, were a proximate cause of, and/or were a producing cause of these damages suffered by Plaintiff for which she individually seeks compensation:

a. loss of services Plaintiff would have received from Keegan;

b. expenses for Keegan's funeral;

c. past mental anguish and emotional distress suffered by Plaintiff resulting from and caused by Keegan's death;

d. future mental anguish and emotional distress suffered by Plaintiff resulting from and caused by Keegan's death;

e. loss of companionship and/or society that Plaintiff would have received from Keegan;

f. exemplary/punitive damages; and

g. reasonable and necessary attorneys' fees available under 42 U.S.C. §§ 1983 and 1988.

V. SECOND CAUSE OF ACTION VIOLATION OF 42 U.S.C. § 12101 et seq. TITLE II OF THE AMERICANS WITH DISABILITIES ACT (ADA)

(Against Val Verde County and GEO)

157. Plaintiff realleges and incorporates each of the preceding paragraphs, and all subsequent paragraphs.

158. Title II of the ADA provides in pertinent part: "[N]o qualified individual with a disability shall, by reason of such disability, be … denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." 42 U.S.C. § 12132.

159. At all times relevant to this action, Val Verde County and GEO, including its employees and agents, were public entities within the meaning of Title II of the ADA and provided programs, services, or activity to individuals at the prison.

160. At all times relevant to this action, Keegan was a qualified individual with one or more medical and/or mental disabilities within the meaning of Title II of the ADA and met the essential eligibility requirements under Title II. Specifically, as alleged throughout this complaint, Keegan had a history of PTSD and abuse which substantially limited major life activities.

161. Val Verde County and/or GEO are liable to Plaintiff (and Keegan's heirs-at-law) for violation of Title II of the ADA. Val Verde County is liable whether it was Val Verde County employees and/or agents who violated the ADA in the alternative, GEO employees and/or agents who violated the ADA.

162. Despite Val Verde County's and/or GEO's knowledge that Keegan had

a history of PTSD and abuse, he was placed in solitary confinement without justification, monitoring, or treatment, and was given psychotropic drugs, known to cause suicide, in a manner that did not reasonably accommodate his disability. By failing to reasonably accommodate Keegan's mental disability while in custody, and instead placing him in solitary confinement, Val Verde County and/or GEO violated the ADA. Such failure and refusal was intentional, and caused, proximately caused, and was a producing cause of Keegan's death and Plaintiff's damages.

163. Because Keegan's death resulted from Val Verde's and/or GEO's intentional discrimination against him, Plaintiff is entitled to the maximum amount of compensatory damages allowed by law. Plaintiff seeks all such damages itemized in the prayer and or body in this pleading (including sections above giving appropriate and fair notice of Plaintiff's 42 U.S.C. § 1983 claims and resulting damages) to the extent allowed by the ADA. Plaintiff also seek reasonable and necessary attorneys' fees and other remedies afforded by those laws.

VI. THIRD CAUSE OF ACTION VIOLATION OF 29 U.S.C. § 794 SECTION 504 OF THE REHABILITATION ACTOF 1973

(Against Val Verde County and GEO)

164. Plaintiff realleges and incorporates each of the preceding paragraphs, and all subsequent paragraphs.

165. Section 504 of the Rehabilitation Act of 1973 provides in pertinent part: "[N]o qualified individual with a disability … shall, solely by reason of his or her disability, … be subjected to discrimination under any program or activity receiving federal financial assistance …." 29 U.S.C. § 794.

166. At all times relevant to this action, Keegan was a qualified individual with the meaning of the Rehabilitation Act because he had a mental and/or medical impairment that substantially limits one or more of his major life activities. 29 U.S.C. § 705(20)(B). Specifically, as alleged throughout this complaint, Keegan had a history of PTSD and abuse which substantially limited major life activities.

167. At all times relevant to this action, Val Verde County and GEO were recipients of federal funding within meaning of the Rehabilitation Act.

168. Val Verde County and/or GEO are liable to Plaintiff (and Keegan's heirs-at-law) for violation of the Rehabilitation Act. Val Verde County is liable whether it was Val Verde County employees and/or agents who violated the Rehabilitation Act, or in the alternative, GEO employees and/or agents who violated the ADA.

169. Despite Val Verde County's and/or GEO's knowledge that Keegan had a history of PTSD and abuse, he was placed in solitary confinement without justification, monitoring, or treatment, and was given psychotropic drugs, known to cause suicide. By doing so, Val Verde County and/or GEO intentionally discriminated against Keegan on the basis of his disability, and/or acted with a reckless disregard for the rights of Keegan, in violation of the Rehabilitation Act.

170. Val Verde's and/or GEO's intentional discrimination of Keegan on the basis of his disability proximately caused, and was a producing cause of Keegan's death and Plaintiff's damages.

171. Because Keegan's death resulted from Val Verde's and/or GEO's intentional discrimination against him, Plaintiff is entitled to the maximum amount

of compensatory damages allowed by law. Plaintiff seeks all such damages itemized in the prayer and or body in this pleading (including sections above giving appropriate and fair notice of Plaintiff's 42 U.S.C. § 1983 claims and resulting damages) to the extent allowed by the Rehabilitation Act. Plaintiff also seek reasonable and necessary attorneys' fees and other remedies afforded by those laws.

VII. FOURTH CAUSE OF ACTION NEGLIGENCE

(Against GEO, Dr. Cadena, and the Psychiatrist Defendants)

172. Plaintiff realleges and incorporates each of the preceding paragraphs, and all subsequent paragraphs.

173. Plaintiff asserts claims of negligence against GEO Group, Dr. Cadena, and the Psychiatrist Defendants.

A. Negligence of GEO Group

174. GEO had a duty to ensure Plaintiff's safety while in GEO's custody and had a duty to provide competent medical and mental healthcare to Keegan while in GEO's custody. GEO accepted this duty of caring for mentally ill detainees at the prison when it contracted with Val Verde County. GEO did so knowing of Val Verde County's policies, practices, and/or customs of deliberate indifference to and conscious disregard of the mental healthcare needs of detainees, and in turn, GEO maintained its own policies, practices, and/or customs of deliberate indifference to and conscious disregard of the mental healthcare needs of detainees.

175. GEO, either directly or through its employees, agents, officers, supervisors, and representatives, committed one or more of these acts or omissions,

each of which amounted to an act and/or omission which a reasonable person or entity would not have done in the same or similar circumstances, proximately causing the occurrences, injuries, and damages of Keegan and Plaintiff, individually, and on behalf of Keegan's estate:

a. Failed to properly determine whether solitary confinement was an appropriate placement for Keegan.

b. Failed to implement special monitoring or suicide preventive measures for Keegan while in solitary confinement;

c. Failed to treat and accommodate Keegan's serious mental illness, in line with the current protocols for mentally ill detainees;

d. Failed to adequately hire, train, and supervise its employees and health care workers to monitor individuals with serious mental illness, in line with the current protocols for mentally ill detainees;

e. Failed to adequately staff the RHU with enough employees to provide routine monitoring of solitary confinement cells;

f. Failed to enforce required behavioral and cell checks for mental health screening;

g. Failed to flag dangers present in Keegan's cell given his mental condition;

h. Falsified observation records during periodic cell checks of Keegan's cell;

i. Failed to implement restrictions on what items Keegan could have in his cell while in solitary confinement;

j. Failed to enforce rules against contraband and/or alcohol;

k. Failed to protect suicidal inmates by providing them with jail-issued bed sheets, shoestrings, laundry lines, and metal bunks with holes used to facilitate suicide; and

l. Failed to provide the least restrictive means available for Keegan in line with the TCJS and suicide studies.

176. GEO's actions and/or inactions were the cause-in-fact of Keegan's injuries, suffering and death, including pain and suffering, and the damages of Plaintiff, individually and on behalf of Keegan's estate.

177. Had GEO upheld its duty to ensure Keegan, a pre-trial detainee within its custody and control, was getting medical and mental healthcare that met the standard of care, Keegan would not have died.

178. Keegan's and Plaintiff's damages were the foreseeable consequence of failing to provide adequate mental health care and failing to protect Keegan, despite numerous signs, exhibited over 15 months that Keegan seriously mentally ill and needed urgent care, safety, and protection from death.

B. Negligence of Dr. Cadena and the Psychiatrist Defendants

179. Dr. Cadena and the Psychiatrist Defendants, as contracted medical providers for Val Verde County had a duty to provide competent medical and mental health care to Keegan while he was detained at the prison. Dr. Cadena and the Psychiatrist Defendants accepted the duty of caring for mentally ill detainees at the prison when they agreed to work for GEO as the jail's medical director and/or psychiatrists. Dr. Cadena and the Psychiatrist Defendants did so knowing of Val Verde County's and Geo's policies, practices, and/or customs of deliberate

indifference to and conscious disregard of the mental healthcare needs of detainees.

180. Dr. Cadena and the Psychiatrist Defendants knew that Val Verde County's and Geo's policies, practices, and/or customs of deliberate indifference and conscious disregard of the mental healthcare needs of prisons was contra to the evidence-based treatment techniques, required care taught in medical school, and established as the standard of care in the medical literature, and in common practices of psychiatrists.

181. Dr. Cadena and the Psychiatrist Defendants knew Val Verde County's and Geo's policies, practices, and/or customs were violative of the reasonable standards of psychiatric care, yet they did nothing to remedy or report the violations in their own treatments, or lack thereof, provided to Keegan. Despite their knowledge of Val Verde's and Geo's grossly inadequate system of medical and mental healthcare care, they accepted the positions at Geo for compensation.

182. Dr. Cadena and the Psychiatrist Defendants committed one or more of these acts or omissions, either directly or through their employees, agents, officers, supervisors, and representatives, each of which amounted to an act and/or omission which a reasonable person orentity would not have done in the same or similar circumstances, proximately causing the occurrences, injuries, and damages of Keegan and Plaintiff, individually, and on behalf of Keegan's estate:

a. Failed to monitor Keegan's serious mental illness;

b. Failed to recognize and/or diagnose Keegan's serious mental illness and symptoms as strong indicators of an immediate danger and risk of death by suicide;

c. Failed to act and take measures to prevent Keegan from committing

suicide. Keegan was put in solitary confinement without psychiatric medications, any special monitoring, psychotherapy, suicide preventive measures, or restrictions on what items he could have in his cell all while under their care. Keegan was already high risk;

d. Failed to monitor Keegan, a young adult, starting an unknown antidepressant;

e. Failed to recognize Keegan's serious mental illness and symptoms as strong indicators of an immediate danger and risk of death by suicide;

f. Failed to treat Keegan's serious mental illness in line with the current protocols and evidence-based treatments;

g. Failed to adequately train employees and health care workers to detect and diagnose serious mental conditions or illnesses;

h. Failed to supervise the staff providing mental health care and services to inmates, including Keegan;

i. Failed to enforce required behavioral and cell checks for mental health screening;

j. Failed to flag dangers present in Keegan's cell given his mental condition;

k. Failed to provide the least restrictive means available for Keegan in line with the TCJS and suicide studies; and

l. Failed to enforce rules against contraband and/or alcohol.

183. Dr. Cadena and the Psychiatrist Defendants actions and/or inactions were the cause-in-fact of Keegan's injuries, suffering and death, including pain and suffering, and the damages of Plaintiff, individually and on behalf of Keegan's estate.

184. Had Dr. Cadena and the Psychiatrist Defendants upheld their duty to ensure their patient, Keegan, was getting medical and mental healthcare that met the standard of care, Keegan would not have died.

185. Keegan's and Plaintiff's damages were the foreseeable consequence of failing

to provide adequate mental health care, despite numerous signs, exhibited over 15 months that Keegan seriously mentally ill and needed urgent care, safety, and protection from death.

VIII. EXEMPLARY DAMAGES

(*Against GEO, Dr. Cadena, and the Psychiatrist Defendants*)

186. Exemplary/punitive damages are appropriate against the defendants to deter and punish clear and unabashed violation of Keegan's constitutional rights.

187. Instituting a system of mental health care at the Val Verde County prison as described above involved an extreme degree of risk, considering the probability and magnitude ofthe potential harm to inmates at the prison and the high risk of suicide at prisons.

188. Defendants had actual, subjective awareness of this precise risk from its experience with hundreds and hundreds of lawsuits brought against it for subpar medical care, as well as more than one investigation by federal authorities of their facilities, which found that the medical care provided was dangerously inadequate. The GEO chose to consciously ignore this risk, and instituted a system of medical care and inadequate staffing almost identical to what they had implemented at the facilities deemed inadequate by the federal government.

189. Defendants' actions, omissions, and inaction showed a reckless or callous disregard of, or to, Keegan's rights, health, and safety; therefore, Plaintiff is entitled to exemplary damages. Moreover, Plaintiff seeks reasonable and necessary attorneys' fees available under 42 U.S.C. §§ 1983 and 1988.

IX. CONCLUDING ALLEGATIONS AND PRAYER

A. Use of Documents or at Trial or Pretrial Proceedings

190. Plaintiff intends to use at one or more pretrial proceedings and/or all documents produced by Defendants in response to written discovery requests, with initial disclosures (and any supplements or amendments to same), and in response to Public Information Act request(s).

B. Jury Demand

191. Plaintiff demands a jury trial on all issues which may be tried to a jury.

C. Prayer for Relief

192. For these reasons, Plaintiff asks that defendants be cited to appear and answer,and that Plaintiff, Jennifer Guadarrama, Individually and on behalf of the Estate of Keegan Killn, have judgment for damages within the jurisdictional limits of the court and against all defendants, jointly and severally, as legally available, and applicable, for all damages referenced above and below in this Complaint including:

a. Loss of services Plaintiff would have received from Keegan;
b. expenses for Keegan's cremation and funeral;
c. past mental anguish and emotional distress suffered by Plaintiff resulting from and caused by Keegan's death;
d. future mental anguish and emotional distress suffered by Plaintiff resulting from and caused by Keegan's death;
e. loss of companionship and/or society that Plaintiff would have received from Keegan;
f. exemplary/punitive damages;
g. reasonable and necessary attorneys' fees available under 42 U.S.C. §§

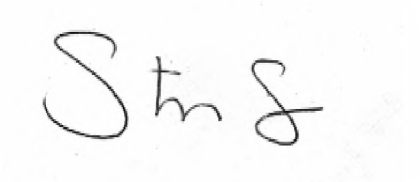
1983 and 1988 and the Americans with Disabilities Act;

h. Costs and all other recoverable costs;

i. Prejudgment and post judgment interest at the highest allowable rates; and

j. All other relief, legal and equitable, general, and special, to which Plaintiff isentitled.

Respectfully Submitted,



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