UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF LOUISIANA

MARIA OLGA ZAVALA,	*	
	*	
Plaintiff,	*	
	*	
VERSUS	*	
	*	
CITY OF BATON ROUGE/PARISH OF EAST BATON ROUGE; SHERIFF SID J. GAUTREAUX, III, SHERIFF OF EAST BATON ROUGE PARISH; LIEUTENANT COLONEL DENNIS GRIMES, WARDEN OF EAST BATON ROUGE PARISH PRISON; PRISON MEDICAL SERVICES; RINTHA SIMPSON, INTERIM DIRECTOR, PRISON MEDICAL SERVICES; DR. CHARLES BRIDGES, M.D.; DR. ROBERT BLANCHE, M.D.; CORRECTHEALTH, LLC,	*	Docket No.
Defendants.	*	
**********	*	

COMPLAINT

Maria Olga Zavala files this Complaint based on the Defendants failure to protect her son, Louis Jonathan Fano (hereinafter, "Mr. Fano"), from harm and for deliberate indifference to his serious medical needs. Mr. Fano died as a result of both explicit and *de facto* policies and practices by the Defendants with responsibility for the East Baton Rouge Parish Prison (hereinafter, "EBRPP"). EBRPP is managed and operated in an unconstitutionally dangerous manner. In addition, the Defendants are deliberately indifferent to the serious medical and mental health needs of all prisoners in EBRPP, including individually towards Mr. Fano, which resulted in Mr. Fano's unnecessary suffering and ultimately his death. The Defendants' explicit and *de facto* policies and

practices and deliberate indifference violated Mr. Fano's right to be free from punishment without the due process of law under the Fourteenth Amendment to the U.S. Constitution.

In support of these claims, Maria Olga Zavala shows as follows:

I. JURISDICTION

1.

This action is brought through 42 U.S.C. § 1983, pursuant to the Fourteenth Amendment to the United States Constitution. Jurisdiction is founded on 28 U.S.C. §§ 1331 and 1343, and the aforementioned statutory and constitutional provisions. In addition, Plaintiff invokes supplemental jurisdiction over claims under state constitutional and statutory law pursuant to 28 U.S.C. §1367.

II. PARTIES

2.

MARIA OLGA ZAVALA (hereinafter, "Plaintiff") is a person of full age of majority and a resident of California. Plaintiff is the mother of Mr. Fano (deceased), who was never married, had no children, and suffered and ultimately died as a result of treatment endured as a pretrial detainee at EBRPP.

Named Defendants herein are:

3.

CITY OF BATON ROUGE/PARISH OF EAST BATON ROUGE (hereinafter, "CITY-PARISH") is a political entity capable of suing and being sued. The CITY-PARISH is the entity responsible for funding operations and maintenance, including necessary improvements, repairs, routine daily maintenance, purchase of equipment, supplies, and materials needed for such purposes, and for utility services, of EBRPP. In addition, the CITY-PARISH is responsible for

the food, clothing, medical treatment, and related expenses for prisoners housed in EBRPP, including mental health services. The East Baton Rouge Parish Metropolitan Council (hereinafter, "Metro Council") is responsible for setting the policy of the CITY-PARISH.

4.

SHERIFF SID J. GAUTREAUX, III (hereinafter, "GAUTREAUX") a person of full age of majority and a resident of Louisiana, in his individual and official capacity. At all times described herein, GAUTREAUX was the Sheriff of the East Baton Rouge Parish Sheriff's Office and was responsible for the hiring, training, supervision, discipline and control of appropriate staff to maintain the care, custody, and control of prisoners in the custody of the East Baton Rouge Parish Sheriff's Office. He was responsible for all staffing levels of EBRPP. He was also responsible for the supervision, administration, policies, practices, customs, and operations of EBRPP. GAUTREAUX was and is a final policy maker who at times delegated policy making authority to other Defendants named in this lawsuit. At all pertinent times, GAUTREAUX was acting under color of law. He is liable both directly for the unconstitutional actions and vicariously for the state law actions complained of herein.

5.

LIEUTENANT COLONEL DENNIS GRIMES (hereinafter, "GRIMES") a person of the full age of majority and a resident of Louisiana, in his individual and official capacity as warden of EBRPP. At all times described herein, GRIMES was the Warden of EBRPP, and as such was responsible for supervision, administration, policies, practices, customs, operations, training of staff, and operation of EBRPP. GRIMES was and is a final policy maker who at times delegated policy making authority to other Defendants named in this lawsuit. At all pertinent times, GRIMES

was acting under color of law. He is liable both directly for the unconstitutional actions and vicariously for the state law actions complained of herein.

6.

PRISON MEDICAL SERVICES, a department of Emergency Medical Services, a Division of the City of Baton Rouge/Parish of East Baton Rouge (hereinafter, "PMS"), was until December 31, 2016 the entity with which the East Baton Rouge Sheriff's Office and the CITY-PARISH contracted to provide medical and mental health services to prisoners at EBRPP. During the time until December 31, 2016 PMS was responsible for the provision of all staffing, training, policies and procedures for medical and mental health personnel at EBRPP and all health care provided to prisoners in EBRPP, including Mr. Fano.

7.

RINTHA SIMPSON (hereinafter, "SIMPSON"), a person of the full age of majority and a resident of Louisiana, in her individual and official capacity as the interim director of PMS. Until December 31, 2016, SIMPSON was the interim director of PMS, and as such was responsible for supervision, administration, policies, practices, customs, operations, training of staff, and operation of the infirmary and provision of health care at EBRPP in execution of the contract for services made with the East Baton Rouge Sheriff's Office and CITY-PARISH. SIMPSON was and is a final policy maker who at times delegated policy making authority to other Defendants named in this lawsuit. SIMPSON is liable both directly for the unconstitutional actions and vicariously for the state law actions complained of herein.

8.

DR. CHARLES BRIDGES, M.D. (hereinafter, "BRIDGES"), a person of the full age of majority and a resident of Louisiana, in his individual and official capacity as the designated

medical director of EBRPP. At all times described herein, as Medical Director, BRIDGES was responsible for final clinical judgments related to the treatment of prisoners and supervision, administration, policies, practices, customs, operations, training of staff, and operation of the infirmary and provision of health care at EBRPP. BRIDGES was and is a final policy maker who at times delegated policy making authority to other medical staff at EBRPP. BRIDGES is liable both directly for the unconstitutional actions and vicariously for the state law actions complained of herein.

9.

DR. ROBERT BLANCHE, M.D. (hereinafter, "BLANCHE"), a person of the full age of majority and a resident of Louisiana, in his individual and official capacity as the psychiatrist for the mental health program at EBRPP. At all times described herein, BLANCHE was responsible for final clinical judgments related to the treatment of prisoners and supervision, administration, policies, practices, customs, operations, training of staff, and operation of the mental health care program and provision of mental health care at EBRPP. BLANCHE was and is a final policy maker who at times delegated policy making authority to other mental health care staff at EBRPP. BLANCHE is liable both directly for the unconstitutional actions and vicariously for the state law actions complained of herein.

10.

CORRECTHEALTH, LLC, a private, for-profit company based in Atlanta, Georgia, (hereinafter, "CorrectHealth"), is, as of January 1, 2017, the entity with which the East Baton Rouge Sheriff's Office and the CITY-PARISH contract to provide medical and mental health services to prisoners at EBRPP. Since January 1, 2017, CorrectHealth has been responsible for

the provision of all staffing, training, policies and procedures for medical and mental health personnel and all health care provided to prisoners in EBRPP, including Mr. Fano.

11.

COLUMBIA CASUALTY COMPANY, CNA INSURANCE COMPANY is a domestic or foreign insurance corporation authorized to do and doing business in the State of Louisiana, which at all times mentioned herein provided Defendant Sheriff GAUTREAUX and the East Baton Rouge Sheriff's Office with a policy of liability insurance for the acts complained of herein.

III. FACTUAL ALLEGATIONS

12.

Mr. Fano was a twenty-seven (27) year old man who suffered from mental illness. Since 2013, he was prescribed powerful antipsychotic drugs such as risperidone and olanzapine for bi-polar disorder and trazadone for depression. In the days before he was arrested, Mr. Fano was hearing voices.

13.

On October 30, 2016, while on a Greyhound bus from Miami to his home in Southern California, Mr. Fano disembarked in Baton Rouge, Louisiana. He did so, as his family recollects, because "the voices told him to."

14.

On October 31, 2016, at approximately 9:30 a.m. at 930 N. 7th Street in downtown Baton Rouge, Mr. Fano was arrested by Baton Rouge Police Department officers for 6 misdemeanors: obscenity, criminal trespass, disturbing the peace, resisting arrest, misdemeanor battery on an officer, and simple criminal damage to property.

15.

Mr. Fano's mental decompensation led to his arrest. When officers arrived at the scene, Mr. Fano "was naked and running around swinging his penis . . . hollering and cussing at imaginary people." When the officers approached Mr. Fano, "he kept saying him and Titianna (Fake Imaginary person) was cross dressers and trying to find a show to make money." The reporting officer wrote: "At one point during our conversation Fano lifted his shirt (only piece of clothing on his body) and began twirling around hollering he was beautiful and there was no law against anything he or Titianna were doing." Mr. Fano resisted arrest, with no injuries to the officers, and the officers took Mr. Fano "straight to" EBRPP "due to his horribly bad behavior."

16.

On January 1, 2016, Defendant CITY-PARISH contracted with Health Management Associates (hereinafter, "HMA") "to provide an assessment of the clinical operations and medical services being provided by the City Parish at the East Baton Rouge Parish Prison." The contract between the Defendant CITY-PARISH and HMA noted that the final product would be a PowerPoint presentation to the Metro Council that "will summarize findings and make recommendations around the current health care delivery within the prison."

17.

The authors of the HMA study interviewed various Baton Rouge officials, including the Mayor's Chief Administrative Officer William Daniel, and Defendants SIMPSON, GRIMES, BLANCHE, and BRIDGES. A site visit and tour of EBRPP and interviews took place in February of 2016. The findings and recommendations were presented publicly to the Metro Council on June 8, 2016.

18.

On information and belief, draft reports of HMA's findings were presented to SIMPSON, GRIMES, BLANCHE, and BRIDGES, and staff of members of the Metro Council, including but not limited to the Mayor's Chief Administrative Officer William Daniel.

19.

According to HMA, prisoners brought to EBRPP "appearing ill are turned away at Central Booking and the transporting officers must take the individual to a hospital for evaluation," treatment, and medical clearance before admission into EBRPP.

20.

EBRPP staff, including Defendants PMS and CorrectHealth staff, were inadequately trained and supervised to recognize and treat Mr. Fano's mental illness.

21.

On October 31, 2016, EBRPP officials admitted an obviously hallucinatory and mentally ill Mr. Fano into EBRPP.

22.

According to HMA, "10% of newly admitted men/women do not have intake health screening performed on a timely basis. Some never receive the screening. This is a major risk to the institution and the individual patient."

23.

According to HMA, Licensed Practical Nurses (LPN) who provide screenings of newly admitted prisoners vary in their adherence to screening policy and procedures. During a site visit by HMA's experts at least one LPN "meticulously read the questions to the patient, the other shortened many of the questions and even skipped some."

24.

PMS staffer Sharon Allen failed to adequately screen Mr. Fano for his serious mental health condition.

25.

No EBRPP staff, including Defendants PMS and CorrectHealth staff, sought any medical records from Mr. Fano's extensive medical history.

26.

EBRPP staff, including Defendants PMS and CorrectHealth staff, made no effort and took no steps to discover details about Mr. Fano's mental health history from medical professionals who had treated him.

27.

EBRPP logbooks indicate on November 1, 2016, at 12:15 p.m., Mr. Fano was placed in a small dorm on EBRPP's "West End" named E2. Within hours Mr. Fano attempted suicide by cutting his wrists. EBRPP Deputy Troy McGee issued a disciplinary report for "self mutilation" to Mr. Fano and 6 days later, on November 7, 2016, an EBRPP disciplinary committee imposed 13 days isolation due to the "seriousness of the offense."

28.

On November 2, 2016, at 1 a.m., EBRPP logbooks indicate Mr. Fano was removed from the E2 dorm and taken to the hospital.

29.

HMA found that chart reviews "showed no evidence of [EBRPP] health staff following-up upon return [from the local hospital] other than noting inmate was back at" EBRPP.

30.

On an "Emergency Medical Request Form" completed on November 1, 2016, a PMS staff person inaccurately noted that Mr. Fano had no mental health history. The same notation accurately noted "suicidal cut to [left] wrist [complains of] hearing voices."

31.

EBRPP documents indicate that on November 2, 2016, Mr. Fano was placed on suicide watch in a single person cell. PMS staff reported that Mr. Fano had a "depressed mood" and "bizarre thoughts or behavior."

32.

According to HMA, prisoners placed on suicide watch were housed in Unit II's M01 and N01 wings. M01 and N01 were single man cells, and prisoners housed there receive no recreation or personal visits. In addition, M01 and N01 prisoners were locked in their cell for at least twenty-three and a half (23½) hours a day.

33.

Log books from Unit II's M01 and N01 control area indicate that on November 2, 2016, at 3:10 a.m., Mr. Fano was placed in N01, cell #4, and on "suicide watch."

34.

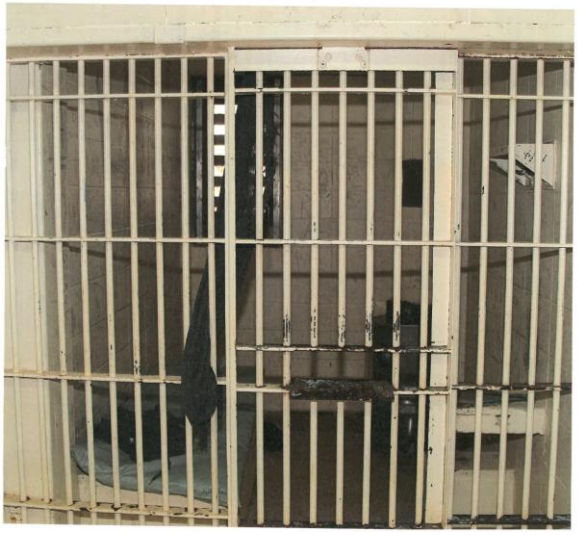
According to HMA, there was not a mental health housing unit at EBRPP. Unit II's M01 and N01 served as a "defacto male inpatient mental health unit –single bed cells open barred doors, loud (other patient-yelling during tour), no group rooms, no dayroom, no private interview area." M01 and N01 "are [a] woefully inadequate physical environment for the most unstable mentally ill at EBR prison."

35.

On information and belief, the individual cell configuration and conditions in Unit II's M01, N01, and N02 were identical. All three cellblocks housed a single male prisoner in each cell. Available photos of the cells on Unit II's M01 and N02 show filthy, decrepit, inhumane, and dangerous physical conditions with clear suicide hazards.

EBRPP, Unit II N01, Cell 21

EBRPP, Unit II M01, Cell 17



36.

According to HMA, "mental health staffing is not adequate to address the [mental health] needs of" EBRPP prisoners identified as mentally ill and "additional . . . specialist staff is needed to provide daily monitoring of high risk individuals and regular [mental health] programing."

37.

According to HMA, "[t]he barred cells that house mentally [ill] males and females create a suicide risk for this high risk population."

38.

According to HMA, "[t]here is no [mental health] programing done at" EBRPP "due to inadequate staffing and lack of suitable group rooms."

39.

On November 2, 2016, an appointment was made for Mr. Fano to see a social worker "for suicide precautions." The appointment was classified as the highest level of priority. The appointment was never kept and on January 6, 2017, Defendant CorrectHealth staff person Yolanda James deleted it from the system, correctly noting it was an "[o]verdue task prior to CorrectHealth Transition of health services effective 1/1/17."

40.

One day after being placed on suicide watch, on November 3, 2016, Defendant BLANCHE assessed Mr. Fano through the bars of his cell. Defendant BLANCHE determined that Mr. Fano was "NOT SUICIDAL," discontinued suicide watch, and prescribed Seroquel for sleep and olanzapine for Mr. Fano's bi-polar disorder.

41.

Defendant BLANCHE did rounds and interviews patients, including Mr. Fano, while the prisoner is locked in their cell and through the open bars due to the difficulty of moving such patients; not for any valid medical reason.

42.

On November 4, 2016, an appointment was made for Mr. Fano to see a psychiatrist for a one (1) month "RTC [return to clinic]" on December 15, 2016. The appointment was classified as the highest level of priority. The appointment was never kept and on December 27, 2016, Defendant PMS staff person Ricky Guillory correctly noted that Mr. Fano was "[n]ot seen on 12/15/16."

43.

On November 25, 2016, Mr. Fano completed a "Medical Request Form" and informed EBRPP officials "my meds don't work anymore still [sic] have a lot of anxiety and can't sleep." The medical staff disposition was "Appt. Psyc 12/15/16." No record exists of Mr. Fano seeing Defendant BLANCHE or any other psychiatrist on December 15, 2016.

44.

On December 18, 2016, Mr. Fano completed a "Medical Request Form" and claimed "I'm having really bad anxiety and depression. Feels as if the walls are closing in, also having really bad thoughts of my time here." The medical staff disposition was "seen on 1/3/17."

45.

On December 20, 2016, Mr. Fano was moved from a cell in EBRPP's Unit II N01 cellblock to another bleak, filthy isolation cell in Unit II's N02 cellblock.

46.

On December 22, 2016, an appointment was made for Mr. Fano to see an unidentified category of medical or mental health care staff for sick call for "Anxiety; Depression" on that same day—December 22, 2016. The appointment was classified as the highest level of priority. The appointment was never kept, and on December 23, 2016, Defendant PMS staff person Ricky Guillory noted that the appointment was not completed.

47.

On December 22, 2016, an appointment was made for Mr. Fano to see an unidentified category of medical or mental health care staff for sick call for "Anxiety; Depression" on December 23, 2016. The appointment was classified as the highest level of priority. The appointment was never kept and on January 6, 2017, Defendant CorrectHealth staff person

Yolanda James deleted it from the system, correctly noting it was an "[o]verdue task prior to CorrectHealth Transition [sic] of health services effective 1/1/17."

48.

On December 26, 2016, an appointment was made for Mr. Fano for a sick call. Defendant PMS staff person Ricky Guillory noted "NEED TO SEE PSYCH." Although EBRPP documents indicate the appointment was completed, Defendant BLANCHE made no notes whatsoever in Mr. Fano's file regarding the alleged interaction.

49.

On November 4, 2016, an appointment was made for Mr. Fano to see a psychiatrist for a one (1) month "RTC [return to clinic]" on January 3, 2017. The appointment was classified as the highest level of priority. The appointment was never kept and on January 7, 2017, Defendant CorrectHealth staff person Yolanda James correctly noted it was not completed and classified the appointment as "[r]escheduled." No new date was noted.

50.

In the alternative, Mr. Fano was seen on January 3, 2017 by a medical staff person with Defendant CorrectHealth. The exam sheet noted that Mr. Fano complained of anxiety, problems with depression, and hearing voices. The unknown medical staff person prescribed hydroxyzine for anxiety.

51.

On January 11, 2017, Mr. Fano was seen on a mental health sick call by Defendant CorrectHealth staff person Louise Leonard due to a report that Mr. Fano was "not taking medication and not eating." Mr. Fano was referred to Defendant BLANCHE and prescribed hydroxyzine for anxiety.

52.

On January 11, 2017, Mr. Fano was seen by Defendant CorrectHealth staff person Cathy Schley, who suspected Mr. Fano was "faking bad or exaggerating his condition" and wrote "presents as stable overall."

53.

On January 18 or 19, 2016, Defendant BLANCHE assessed Mr. Fano through the bars of his cell. Defendant BLANCHE noted that he doubted "serious mental illness, will begin tapering meds." Defendant BLANCHE ordered that Mr. Fano's antipsychotic medicine Zyprexa be reduced to 5 mg and discontinued after a week.

54.

On February 2, 2017, Mr. Fano was found hanging from the bars of cell #21 in Unit II's N02 cellblock, and was transported to Our Lady of the Lake Hospital in critical condition. He died 3 days later, on February 5, 2017.

55.

During the ensuing investigation into Mr. Fano's death, Sargent Henning from the East Baton Rouge Sheriff's Office interviewed a number of prisoners and EBRPP deputies. Prisoners Alex McKneely and Bobby Earl were in Unit II's N02 cells #22 and #23, respectively, and told Henning they could hear Mr. Fano crying "often." Another prisoner, James Hughes in cell #24, "only stared and would not communicate verbally" with Henning when asked about Mr. Fano.

56.

No EBRPP staffer, including Defendants PMS and CorrectHealth staff, documented that Mr. Fano was crying often.

57.

Along with two (2) Christian books, Henning found scrapes of paper. Included were two notes indicating that Mr. Fano was the target of other prisoners for his food and sex.

58.

Mr. Fano's mother and sister visited him once, flying from California for a court appearance. In addition, they called EBRPP two to three times per week. When at the jail, Mr. Fano's family informed EBRPP officials of Mr. Fano's mental health issues and begged for treatment. They were assured Mr. Fano was receiving the medication and treatment he needed.

59.

Not counting his last day—February 2, 2017—Mr. Fano was in EBRPP for 94 days. Of those, he spent 92 days in solitary confinement.

60.

Between November 2 and December 16, 2016, Mr. Fano received an average of eleven (11) minutes a day out of his cell on the hall of Unit II's N01 wing. Almost all, if not all, of the remainder of his time during that period was spent locked in his cell.

61.

According to HMA, the medication delivery system at EBRPP had a "missed med passage" rate of 22%, which is "high" compared to other jails.

62.

According to HMA, health care staff failed to document why prisoners were "not present" for their medication delivery.

63.

According to Defendant PMS and CorrectHealth documents, between Nov. 5, 2016 and February 1, 2017, Mr. Fano "refused", was "not present" or did not receive his medication due to "other" a total of 57 times. Documentation why occurred only 6 times.

MEDICAL AND MENTAL HEALTH CARE AT EBRPP

64.

HMA found that Defendant CITY-PARISH underfunds the medical, mental health, and dental care program at EBRPP. HMA recommended that, given the average daily population of prisoners in EBRPP, the budget should be doubled—from the current $5 million a year to almost $10 million.

65.

The lack of adequate funding results in insufficient health care staff to care for the approximately 1500 men and woman detained at EBRPP, including Mr. Fano. HMA found that EBRPP "is not adequately staffed by health care providers to address the health care needs of the population detained at the facility."

66.

In spite of HMA's recommendation that the health care budget be doubled to $10 million a year, Defendants CITY-PARISH, GAUTREAUX, and CorrectHealth agreed to a contract that increases the budget less than 6%—a little more than $5.2 million a year for an identical average daily population.

67.

According to interviews of Defendant CITY-PARISH leadership by HMA, medical doctors "get paid $100,000" to work 4 to 6 hours a week—scheduled for 3 clinics a week—for a

total of between 12 to 18 hours a week. The next highest "level of care" provided by Defendant CITY-PARISH is one registered nurse, leaving Licensed Practical Nurses to provide the majority of care. This means that "so much of what needs to be done is out of their scope of practice."

68.

HMA found EBRPP's Medical Unit with two infirmary rooms that only house males to be "'infirmaries' in name only." "The areas are not within sight of the nursing or correctional personnel. Patients can bang the doors/yell out for attention in case of emergency . . . [t]here were no hospital beds just metal cots."

69.

HMA found that "patient-inmates must ask the [correctional] officers for a form to submit a request for health services" and "[s]ick call slips are not readily available to inmates and require correctional officer [sic] to provide upon request."

70.

HMA found that the "result of limited access to sick call slips" and insufficient staffing noted in ¶65 are "barriers to care and inmates [are] required to make multiple requests for health care [and] subsequently care is delayed."

71.

HMA found that acutely mentally ill and suicidal patients like Mr. Fano are housed on Unit II's M01 and N01.

72.

HMA found that M01 and N01 provide a "woefully inadequate physical environment for the most unstable mentally ill at" EBRPP. EBRPP deputies reported to HMA that M01, N01 and "other lockdown areas are frequently loud with inmates who are shaking bars, throwing feces etc."

73.

HMA found that Defendant BLANCHE had not provided health care staff "suicide training" in over a year and "has not provided suicide training to the correctional staff in a # of years."

74.

Data from the Defendants and United States Department of Justice indicate that the death rate among individuals detained in EBRPP is disproportionately high compared to national data. For example, the mortality rate per 100,000 local jail prisoners in the United States was 129 per 100,000 in 2012. With a reported average daily population of 1,505 at EBRPP, in 2012 the mortality rate at EBRPP was 532 per 100,000.

75.

In 2013, the mortality rate among individuals detained in EBRPP was 34% higher than the national average. That is, the mortality rate per 100,000 local jail prisoners in the United States was 136 per 100,000, and with a reported average daily population of 1,650 at EBRPP, the mortality rate at EBRPP was 182 per 100,000.

76.

In 2014, the mortality rate among individuals detained in EBRPP was 90% higher than the national average. That is, the mortality rate per 100,000 local jail prisoners in the United States was 140 per 100,000 in 2014, and with a reported average daily population of 1,504 at EBRPP, the mortality rate at EBRPP was 266 per 100,000.

77.

No national data is available for the mortality rate among individuals detained in local jails for 2015 and 2016. EBRPP reported, however, an average daily population of 1,514 in 2015,

indicating a mortality rate of 198 per 100,000 in 2015. EBRPP reported an average daily population of 1,427 in 2016, indicating a mortality rate of 420 per 100,000 in 2016.

78.

In spite of mortality rates substantially above the national average, Defendants BRIDGES and BLANCHE did not prepare mortality reports for the deaths of prisoners at EBRPP.

79.

EBRPP had no mortality committee to review deaths of prisoners at EBRPP.

80.

EBRPP's mental health program had no quality improvement committee nor were any mental health quality metrics measured, tracked, or monitored.

81.

HMA found that the "mental health staffing is not adequate to address the [mental health] needs of" the mental health caseload.

82.

An August 27, 2015 media report quoted a contractor with Defendant PMS noting a "significant decline in the quality of care . . . over the past six or seven years," critical health conditions at the prison, and chronic understaffing.

83.

HMA found the health care provided to prisoners at EBRPP "episodic and inconsistent."

84.

Sheriff Gautreaux and Warden Grimes both have a policy of delegating all health care responsibilities to HMA and its successor, Correct Health.

OTHER SYSTEMIC FAILURES AT EBRPP

85.

Security staff fail to sufficiently monitor the living areas that house prisoners, including the units that housed Mr. Fano. Defects in physical design and manner of operation, including inadequate staffing, inadequate supervision techniques, and poor sightlines, create conditions of confinement where larger, stronger, and more violent prisoners are able to prey on smaller, weaker, and more docile prisoners. These conditions produce frequent violence and a continuous pattern of constitutional deprivations for the prisoners detained in EBRPP, including Mr. Fano.

86.

The overuse of solitary confinement, including on Mr. Fano, the failure of EBRPP security staff to monitor detainee living areas, and the failure of EBRPP security staff to intervene timely to protect prisoners from threats are the result of explicit policies to detain prisoners in a dilapidated and understaffed facility and *de facto* policies and practices that leave prisoners unmonitored and unprotected. Both the explicit and *de facto* policies and practices were developed by or resulted in unconstitutional conditions and treatment so extended and pervasive that Defendants GAUTREAUX and GRIMES should have known of them.

87.

Defendants GAUTREAUX and GRIMES have a policy of using solitary confinement as punishment *and* a warehouse for those with serious mental illness, including suicidal prisoners.

88.

Defendants GAUTREAUX and GRIMES do not have a consistent monitoring or rating system to standardize the delivery of mental health care to prisoners on suicide watch.

89.

EBRPP deputies, as the result of *de facto* policies and practices permitted by Defendants GAUTREAUX and GRIMES, falsely document that EBRPP staff make regular monitoring rounds to supervise prisoners.

90.

Defendants CITY-PARISH, GAUTREAUX, and GRIMES failed to provide sufficient staff to monitor and protect prisoners at EBRPP, including Mr. Fano.

91.

Defendants CITY-PARISH, GAUTREAUX, and GRIMES have a policy, practice, and custom of not monitoring the health care system at EBRPP to ensure that basic medical and mental health care services are delivered to prisoners. Defendants CITY-PARISH, GAUTREAUX, and GRIMES have abdicated their responsibility to deliver health care to prisoners in EBRPP.

92.

Defendants CITY-PARISH, GAUTREAUX, GRIMES, PMS, SIMPSON, BRIDGES, BLANCHE, and CorrectHealth failed to provide Mr. Fano sufficient access to qualified medical and mental health care.

93.

Defendants GAUTREAUX, GRIMES, PMS, SIMPSON, BRIDGES, BLANCHE, and CorrectHealth, as the result of the both explicit and *de facto* policies and practices, house suicidal and mentally ill prisoners in solitary confinement. Such a practice not only denies necessary treatment, it exacerbates the prisoners' condition and causes unnecessary pain and suffering. This is especially true for individuals with known, serious mental health conditions, including Mr. Fano.

94.

Defendants CITY-PARISH, GAUTREAUX, GRIMES, PMS, SIMPSON, BRIDGES, BLANCHE, and CorrectHealth, failed to adequately staff, train, and supervise employees and contractors responsible for providing constitutionally adequate medical and mental health care at EBRPP. As the result of *de facto* policies and practices permitted by Defendants CITY-PARISH, GAUTREAUX, GRIMES, PMS, SIMPSON, BRIDGES, BLANCHE, and CorrectHealth, EBRPP staff are not trained and supervised to address prisoners' serious medical and mental health care needs, including those exhibited by Mr. Fano, resulting in deliberate indifference to prisoners' serious medical and mental health care needs.

95.

Defendants GAUTREAUX, GRIMES, SIMPSON, BRIDGES, BLANCHE, and CorrectHealth, failed to adequately supervise employees and contractors to insure the proper screening of prisoners with serious medical and mental health conditions, provide access to sick call, identify suicidal prisoners, keep track of the location of prisoners and insure prisoners had access to their medications and other health care, conduct mortality reviews, institute a quality improvement committee, measure, track and monitor mental health quality metrics, and protect weaker, smaller, and more vulnerable prisoners from predatory prisoners.

96.

Defendants CITY-PARISH, GAUTREAUX, GRIMES, PMS, SIMPSON, BRIDGES, BLANCHE, and CorrectHealth's deliberate indifference to Mr. Fano's serious medical and mental health care needs began with his initial contact with Defendant PMS staff, and continued through Defendant CorrectHealth's assumption of the responsibility for health care during Mr. Fano's

detention in EBRPP. Defendants named in this paragraph ultimately failed to provide necessary medical and mental health care to Mr. Fano.

97.

Defendants CITY-PARISH failed to provide sufficient funding and oversight to all Defendants, resulting in unconstitutional conditions of confinement at EBRPP. The CITY-PARISH's explicit policy of not sufficiently funding and overseeing EBRPP caused defects in physical design and manner of operation, including inadequate staffing, inadequate supervision techniques, and/or poor sightlines at EBRPP, resulting in a continuous pattern of constitutional deprivations for all prisoners in EBRPP, including Mr. Fano.

98.

The failures of all Defendants are well known and consistent with a pattern and practice resulting in a decrepit physical plant, rampant violence, and deliberate indifference to the basic human needs, including medical and mental health care, of prisoners at EBRPP, including the following examples:

a. Since 2013, at least four people died at the jail due to inadequate medical and mental health care;

b. In February of 2015, Defendant GRIMES publicly acknowledged that cell doors in EBRPP do not open and shut due to rust, the layout of the prison makes it difficult to monitor prisoners, and overpopulation requires sending hundreds of prisoners to other parishes;

c. In May of 2015, Lamar Johnson ("Mr. Johnson") entered EBRPP after being detained during a routine traffic stop for tinted windows. Within a day of his booking his mental health deteriorated to the point that he was openly stating he wanted to end his life. Four days after entering EBRPP healthy and well-adjusted, Mr. Johnson left EBRPP on a stretcher after he was found hanging from his cell bars. He died a few days later at a local hospital;

d. In October of 2015, a Baton Rouge elected official complained of a study into the medical care at EBRPP, noting that "the council already knows about

numerous problems" including understaffing, medical equipment shortages, and insufficient compensation for medical professionals;

e. Also in October of 2015, Defendant GAUTREAUX was cited as requesting a new jail "for years" and that "officials long ago identified the problem: a dilapidated facility that is ill-equipped to hold . . . mentally ill who are booked";

f. In February 2016, seventeen (17) year old Tyrin Colbert died at the hands of his cellmate. Even though witnesses could hear the victim cry "I give up," EBRPP staff did not intervene in time to stop the murder. Defendant GAUTREAUX's spokesperson was reported to acknowledge that Tyrin's death proves that EBRPP is not safe for either EBRPP deputies or prisoners. Casey Rayborn Hicks noted that Defendant GAUTREAUX "proposed in a new facility . . . a layout that has more visibility for deputies [and] surveillance cameras."

99.

The failures of all Defendants are well known and consistent with a pattern and practice resulting in a decrepit physical plant, rampant violence, and deliberate indifference to the basic human needs, including medical and mental health care, of prisoners at EBRPP.

100.

Since at least 2014, Defendants GAUTREAUX and GRIMES, as well as former Mayor Kip Holden and some members of the Baton Rouge Metro Council, have advocated for a new jail to address what they recognize are widespread problems with the current jail including that the layout of the jail makes it difficult to monitor prisoners, substandard medical and mental health care, and understaffing.

101.

At all times relevant to this complaint, Defendants acted under color of state law.

102.

All Defendants are liable to Plaintiff for compensatory damages, and Defendants CorrectHealth and those sued in their individual capacity are liable to Plaintiff for punitive damages.

103.

All Defendants are liable jointly, severally, and in solido for Plaintiff's injuries.

104.

Defendants' actions were reckless, willful, wanton, and malicious, and constituted deliberate indifference to the rights of Mr. Fano. Defendants' actions were the proximate cause of the injuries and death of Mr. Fano and the damages of Plaintiff.

IV. CAUSES OF ACTION

COUNT 1 – § 1983 Violation Based on Establishment of a System in which Prisoners with Serious Health Issues are Denied Access to Appropriate Medical Care — Defendants GAUTREAUX, CITY-PARISH, PMS, SIMPSON, BRIDGES, BLANCHE, and CorrectHealth (Official Capacities)

105.

Plaintiff repeats and re-alleges each and every allegation of the Complaint.

106.

Defendants named in this Count, acting individually and together, under color of law, violated Mr. Fano's right to be free from punishment without due process as protected by the Fourteenth Amendment to the United States Constitution and 42 USC § 1983. They did so by establishing and maintaining policies, patterns or practices that provide inadequate and insufficient services for medical and mental health care that they knew would result in the deprivation of such services for prisoners with serious medical conditions, including serious mental health conditions. Plaintiff was individually harmed by the unconstitutionally inadequate and insufficient services for medical and mental health care because they resulted in the death of Mr. Fano, who was deprived of appropriate mental health and medical treatment after he was booked into EBRPP and continued until his suicide 3 months later.

107.

At all pertinent times, Defendants named in this Count, individually and collectively, acted unreasonably, recklessly, and with deliberate indifference and disregard for the safety, constitutional, and civil rights of Mr. Fano by failing to provide appropriate medical and mental health services.

COUNT 2 – *Monell* Violation of § 1983 Based on Establishment of Policies, Patterns or Practices pursuant to which Prisoners with Serious Mental Health Conditions are Denied Access to Appropriate Medical Care— Defendants GAUTREAUX, PMS, SIMPSON, CorrectHealth, and CITY-PARISH (Official Capacities)

108.

Plaintiff repeats and re-alleges each and every allegation of the Complaint.

109.

Defendants named in this Count, acting individually and together, under color of law, violated Mr. Fano's right to be free from punishment without due process as protected by the Fourteenth Amendment to the United States Constitution and 42 USC § 1983. They did so by establishing and maintaining policies, patterns or practices that they knew would deprive prisoners with serious medical conditions, namely, serious mental health disorders, of treatment for those conditions. There was furthermore a policy, pattern, and practice of staff members at EBRPP use of solitary confinement to punish and warehouse seriously mentally ill prisoners, and failing to monitor prisoner living areas, putting individuals with mental illness, including Mr. Fano, at risk for their personal safety.

110.

Plaintiff was individually harmed by these policies, patterns, or practices because they resulted in the pain, suffering, and death of Mr. Fano, who was deprived of appropriate mental health and medical treatment after he was booked into EBRPP, and did not receive adequate

treatment for his acute and severe emotional and mental distress following his booking into EBRPP and continued until his suicide over 3 months later.

111.

At all pertinent times, Defendants named in this Count, individually and collectively, acted unreasonably, recklessly, and with deliberate indifference and disregard for the safety, constitutional, and civil rights of Mr. Fano by establishing the above-described policies, patterns, or practices.

112.

The above-named Defendants are therefore liable to Plaintiff for the violation of constitutional rights described above pursuant to Monell v. Dept. of Soc. Servs., 436 U.S. 658 (1978).

COUNT 3 — § 1983 Violation Based on the De Facto Policy, as Evidenced by Extended, Pervasive Misconduct by EBRPP Staff, That Create Conditions and Treatment That Constitutes Impermissible Punishment of Prisoners Under the Due Process Clause— Defendants GAUTREAUX, GRIMES, and CITY-PARISH (Official Capacities)

113.

Plaintiff repeats and re-alleges each and every allegation of the Complaint.

114.

Defendants named in this Count, acting individually and together, under color of law, acted to violate Mr. Fano's right to be free from punishment without due process as protected by the Fourteenth Amendment to the United States Constitution and 42 USC § 1983. They did so by exposing prisoners at EBRPP, including Mr. Fano, to violent and dangerous conditions of confinement so extensive and pervasive that they reflect a *de facto* policy approved by Defendants named in this Count.

115.

Such policies and practices include, but are not limited to, inadequate classification of prisoners, use of solitary confinement to punish and warehouse seriously mentally ill prisoners, defects in physical design and manner of operation, including inadequate staffing, inadequate supervision techniques, poor sightlines, and inadequate monitoring of prisoner living areas that combined to result in frequent violence and a continuous pattern of constitutional deprivations for the prisoners in EBRPP, including Mr. Fano.

116.

In addition, Defendants GAUTREAUX and GRIMES knew or should have known that guards engage in illegal conduct including the falsifying of EBRPP monitoring logs. Finally, all Defendants named in this count failed to provide access to appropriate medical and mental health services to EBRPP prisoners, including Mr. Fano, who was individually harmed by the *de facto* policies and practices described above.

COUNT 4 – *Monell* Violation of § 1983 Based on Unconstitutional Conditions of Confinement That Constitutes Impermissible Punishment of Prisoners Under the Due Process Clause— Defendants GAUTREAUX, GRIMES, and CITY-PARISH (Official Capacities)

117.

Plaintiff repeats and re-alleges each and every allegation of the Complaint.

118.

Defendants named in this Count, GAUTREAUX, GRIMES, and CITY-PARISH, acting individually and together, under color of law, acted to violate Mr. Fano's right to be free from punishment without due process as protected by the Fourteenth Amendment to the United States Constitution and 42 USC § 1983. They did so by maintaining policies, patterns or practices that

created unconstitutional conditions of confinement that deprived prisoners, including Mr. Fano, of basic human needs, including physical safety and health care.

119.

Mr. Fano and Plaintiff were individually harmed by these policies, patterns, or practices because they resulted in the death of Mr. Fano, who was exposed to a continuous pattern of deprivations which clearly violated the United States Constitution. The policies and practices adopted by Defendants in this Count, whether explicit or *de facto* as evidenced by the extended and pervasive misconduct by EBRPP and CITY-PARISH officials, include but are not limited to: inadequate classification of prisoners, use of solitary confinement to punish and warehouse seriously mentally ill prisoners, defects in physical design and manner of operation, including inadequate staffing, inadequate supervision techniques, poor sightlines, and inadequate monitoring of prisoner living areas that combined to result in frequent violence and a continuous pattern of constitutional deprivations for the prisoners in EBRPP, including Mr. Fano. In addition, Defendants GAUTREAUX and GRIMES knew or should have known that guards engage in illegal conduct including the falsifying of EBRPP monitoring logs. Finally, all Defendants named in this count failed to provide appropriate medical and mental health services to EBRPP prisoners, including Mr. Fano, who was individually harmed by the *de facto* policies and practices described above and resulted in Mr. Fano's death.

120.

At all pertinent times, Defendants named in this Count, individually and collectively, acted unreasonably, recklessly, and with deliberate indifference and disregard for the safety, constitutional, and civil rights of Plaintiff's son Mr. Fano by establishing the above-described policies, patterns, or practices. The above-named Defendants are therefore liable to Plaintiff for

the violation of constitutional rights described above pursuant to *Monell v. Dept. of Soc. Servs*., 436 U.S. 658 (1978).

COUNT 5 –§ 1983 Violation Based on Failure to Supervise Other Defendants to Ensure Prisoners Received Appropriate Care for Serious Medical Needs— Defendants GAUTREAUX and GRIMES (Individual and Official Capacities)

121.

Plaintiff repeats and re-alleges each and every allegation of the Complaint.

122.

Defendants GAUTREAUX and GRIMES, in their individual and official capacities, failed to supervise their subordinates to ensure that these subordinates adequately screen prisoners with serious medical and mental health conditions, provide access to sick call, identify suicidal prisoners, keep track of the location of prisoners and insure prisoners had access to their medications and other health care, conduct mortality reviews, institute a quality improvement committee, measure, track and monitor mental health quality metrics, and protect weaker, smaller, and more vulnerable prisoners from predatory prisoners. Plaintiff was directly harmed by this failure to supervise because it caused the death of her son Mr. Fano, who was at times left untreated and when treated received patently insufficient treatment for his serious medical and mental health needs. At all pertinent times herein, Defendants GAUTREAUX and GRIMES were aware of the need to supervise their subordinates in order to ensure that they did not violate prisoners' rights. These Defendants ignored that need and acted unreasonably and with deliberate indifference and disregard for the safety of Mr. Fano, as described above.

COUNT 6 – § 1983 Violation Based on Deliberate Indifference to Mr. Fano's Constitutional Right to Appropriate Medical and Mental Health Care— Defendants GAUTREAUX, GRIMES, SIMPSON, BRIDGES, BLANCHE, and CorrectHealth (Individual and Official Capacities)

123.

Plaintiff repeats and re-alleges each and every allegation of the Complaint.

124.

The above-named Defendants, acting individually and together, and under color of law, engaged in a course of conduct and conspired to engage in a course of conduct that acted to deprive Mr. Fano of his constitutional rights and did deprive him of said rights, specifically, the right to reasonable and adequate medical and mental health care, and the right to be free from punishment without due process as protected by the Fourteenth Amendment to the United States Constitution and 42 U.S.C. § 1983.

125.

At all times pertinent herein, these Defendants, acting individually and collectively, acted unreasonably, recklessly, maliciously, and/or with deliberate indifference and disregard for the constitutional and civil rights and life and serious medical needs of the deceased, Mr. Fano.

126.

Furthermore, these Defendants, individually and collectively, had the duty and ability to intervene to prevent the violations of the rights of Mr. Fano, as described herein, but failed to do so. All of these Defendants knew EBRPP had inadequate mental health staffing to address the mental health needs of EBRPP prisoners, including Mr. Fano, had barred cells that house mentally ill prisoners that created an inappropriate suicide risk, and had no mental health programing due to inadequate staffing and lack of suitable group rooms.

127.

Finally, Defendants SIMPSON, BRIDGES, BLANCHE, and CorrectHealth acted as a final policy maker when they deprived Mr. Fano of reasonable and adequate medical and mental health care, having been delegated the authority to do so by Defendants GAUTREAUX and GRIMES.

COUNT 7 – § 1983 Violation Based on Specific Act or Omission Resulting in Unconstitutional Injury and Death— Defendant BLANCHE (Individual Capacity)

128.

Plaintiff repeats and re-alleges each and every allegation of the Complaint.

129.

Defendant named in this Count, BLANCHE, acting individually and together with other PMS and CorrectHealth staff and contractors, under color of law, acted to violate Mr. Fano's right to be free from punishment without due process as protected by the Fourteenth Amendment to the United States Constitution and 42 USC § 1983. He did so by providing grossly inadequate mental health care, including failing to properly diagnose and treat Mr. Fano's serious mental illness, including removing Mr. Fano from suicide watch, failing to monitor access to his medication, and failing to provide a semblance of mental health care. This Defendant was acting upon the custom within EBRPP of ignoring the basic human needs of prisoners, including Mr. Fano, in EBRPP. Finally, this Defendant knew EBRPP had inadequate mental health staffing to address the mental health needs of EBRPP prisoners, including Mr. Fano, had barred cells that house mentally ill prisoners that created an inappropriate suicide risk, and EBRPP had no mental health programing due to inadequate staffing and lack of suitable group rooms.

130.

Mr. Fano and Plaintiff were individually harmed by these policies, patterns, or practices because they resulted in the death of Mr. Fano, who was deprived of his constitutional right to

have his basic human needs met and to protection from harm from other prisoners. These deprivations resulted in his death, as described above.

131.

At all pertinent times, Defendant named in this Count, individually and collectively with other PMS and CorrectHealth staff and contractors, acted unreasonably, recklessly, and with deliberate indifference and disregard for the safety, constitutional, and civil rights of Mr. Fano and Plaintiff.

COUNT 8 – State Claim of Negligent and/or Intentional Conduct Resulting in Injury and Death— Defendants BRIDGES and BLANCHE (Individual Capacities)

132.

Plaintiff repeats and re-alleges each and every allegation of the Complaint.

133.

The above-named Defendants, acting individually and together, and under color of law, engaged in a course of conduct and conspired to engage in a course of conduct that caused injury and harm to Mr. Fano and ultimately led to his death. At all times pertinent herein, these Defendants, individually and collectively, acted intentionally, maliciously, recklessly, and/or negligently towards the deceased, Mr. Fano. Furthermore, these Defendants, individually and collectively, had the duty and ability to intervene to prevent the tortious conduct of co-Defendants toward Mr. Fano, as described herein, but failed to do so. They are therefore liable to Plaintiff, as described herein.

COUNT 9 – State Claim of Respondeat Superior Liability of Sheriff GAUTREAUX

134.

Plaintiff repeats and re-alleges each and every allegation of the Complaint.

135.

At all relevant times, the individually named Defendants were acting in the course and scope of their employment with Defendants GAUTREAUX and the East Baton Rouge Sheriff's Office. GAUTREAUX is therefore liable under the doctrine of *respondeat superior* for the actions and inactions of the individual Defendants, as described herein.

COUNT 10 – Loss of Consortium ALL DEFENDANTS

136.

Plaintiff repeats and re-alleges each and every allegation of the Complaint.

137.

Defendants are liable to MARIA ZAVALA, pursuant to La. C.C. 2315 (B) through 42 U.S.C. § 1983, for loss of service, society, support, love and affection arising out of the injuries occasioned by the acts and/or omissions of Defendants herein.

COUNT 11 – Wrongful Death Claim of MARIA ZAVALA

138.

Plaintiff repeats and re-alleges each and every allegation of the complaint.

139.

MARIA ZAVALA, who is the surviving mother of Mr. Fano, seeks to recover for the damages which she sustained as a result of the death of her son due to the fault of Defendants in that they had a very close, loving supportive relationship with her son.

140.

The deceased left no surviving wife or children.

COUNT 12 – Survival Action Claim of MARIA ZAVALA

141.

Plaintiff repeats and re-alleges each and every allegation of the Complaint.

142.

Plaintiff seeks relief under La. C.C. art 2315.2, for the pain and suffering occurring before and during Mr. Fano's death occasioned by the intentional and/or grossly negligent acts and/or omissions of Defendants herein, and for all other relief as set forth herein.

COUNT 13 – State Claim of Direct Action Against an Insurer, Pursuant to LA R.S. §22:1269

143.

Plaintiff repeats and re-alleges each and every allegation of the Complaint.

144.

At all applicable times, Defendant COLUMBIA CASUALTY COMPANY, CNA INSURANCE COMPANY afforded liability insurance coverage to Defendants GAUTREAUX and/or other Defendants. Accordingly, COLUMBIA CASUALTY COMPANY, CNA INSURANCE COMPANY is liable to the Plaintiff for the intentional and/or negligent acts of the other Defendants.

COUNT 14 – State Claim for Breach of Duty to Provide Medical Treatment (GAUTREAUX)

145.

Plaintiff repeats and re-alleges each and every allegation of the Complaint.

146.

Under Louisiana law, Defendant GAUTREAUX, as Sheriff and the confining authority, has a legal duty to provide medical treatment for prisoners.

147.

GAUTREAUX failed to provide medical and mental health treatment within EBRPP that was adequate and reasonable as required by law.

148.

Mr. Fano's death was a direct result of GAUTREAUX's failure to provide adequate and reasonable medical and mental health care.

V. INJURIES

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

a. Louis J. Fano, the decedent, suffered conscious and severe physical, mental, and emotional distress, pain and suffering prior to his death, and lost his life.

b. MARIA ZAVALA, who is the mother of Mr. Fano, suffered emotional pain and suffering, past, present, and future; loss of support; and has suffered the loss of love, affection, and companionship of her son, Louis Fano, and has incurred funeral and burial expenses.

VI. PRAYER FOR RELIEF

WHEREFORE, Plaintiff prays that after due proceedings there be judgment rendered herein in Plaintiff's favor and against all Defendants individually and jointly, as follows:

1. Compensatory and punitive damages as prayed for herein;

2. Reasonable attorneys' fees, as provided in 42 U.S.C. § 1988, 42 U.S.C. § 12205, and 29 U.S.C. § 794(b) and all costs of these proceedings and legal interest;

3. Punitive damages pursuant to 42 U.S.C. § 1983 and any other applicable statute;

4. Relief under La. C.C. arts. 2315 and 2321 from the intentional and/or negligent acts and/or omissions of Defendants herein; and

5. All other relief as appears just and proper to this Honorable Court.

RESPECTFULLY SUBMITTED, this 20th day of September, 2017.

THE CLAIBORNE FIRM, P.C.

/s/ David J. Utter
DAVID J. UTTER
Louisiana Bar Number: 23236
Lead Attorney for Plaintiff
410 East Bay Street
Savannah, Georgia 31401
(912) 236-9559 Telephone
(912) 236-1884 Facsimile
david@claibornefirm.com

THE CLAIBORNE FIRM, P.C.

/s/ William R. Claiborne
WILLIAM R. CLAIBORNE
Georgia Bar Number: 126363
Appearing Pro Hac Vice
Attorney for Plaintiff
410 East Bay Street
Savannah, Georgia 31401
(912) 236-9559 Telephone
(912) 236-1884 Facsimile
will@claibornefirm.com

/s/ John Adcock
JOHN ADCOCK
Louisiana Bar No. 30372
Attorney for Plaintiff
3110 Canal Street, 2d Floor
New Orleans, LA 70119
(504) 233-3125 Telephone
(504) 308-1266 Facsimile
jnadcock@gmail.com