UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF OKLAHOMA

(1) TAMMY THOMAS, as Next Friend of BENNY WATTS, Plaintiff, v. (2) CHRIS ELLIOTT, in his official capacity as Sheriff of Wagoner County, Oklahoma, (3) SAINT FRANCIS HOSPITAL MUSKOGEE, INC., Defendants.	Case No.: CIV-25-366-GLJ **JURY TRIAL DEMANDED** **ATTORNEY LIEN CLAIMED**

FIRST AMENDED COMPLAINT

Tammy Thomas, as Next Friend of Benny Watts, for this cause of action against the above-named Defendant, states as follows:

I.

PARTIES, JURISDICTION, VENUE

1. Tammy Thomas is the biological daughter and power of attorney for Benny Watts, an incapacitated person.

2. Chris Elliott (Elliott) is the elected sheriff of Wagoner County, Oklahoma. Under Oklahoma law, Elliott is a final policymaker over jail operations for the Wagoner County Detention Center (WCDC). Elliott is solely responsible for operation of the Wagoner County Sheriff's Office (WCSO), including, without limitation, promulgating, creating, implementing and possessing responsibility for all operations at the WCDC, supervision, policies, practices, staffing, and training. Elliott is sued in his official capacity for acts performed while Sheriff of Wagoner

County. Because his position is that of a final policymaker, Elliott's acts and omissions constitute the acts and omissions of the county and the taxpayers who elected him. At all times relevant herein, Elliott was acting under the color of state law.

3. Saint Francis Hospital Muskogee, Inc. (STFM) is a domestic not for profit entity located in Muskogee County, Oklahoma. Upon information and belief, STFM employed person(s) who encountered Benny in October 2025.

4. The events complained of occurred in Wagoner County, Oklahoma and Muskogee County, Oklahoma.

5. This is an action for the deprivation of rights secured by the Fourteenth Amendment to the United States Constitution, actionable pursuant to 42 U.S.C. §1983. Plaintiff also brings supplemental claims against STFM.

6. This Court has subject matter jurisdiction and venue is proper.

II.

STATEMENT OF FACTS

7. Plaintiff adopts and incorporates the preceding paragraphs as if fully set forth herein.

A. BENNY IS CONFINED AT THE WCDC

8. Benny was diagnosed with schizophrenia in 2001.

9. Since that time, Benny has managed his schizophrenia with physician prescribed medication.

10. Benny was suffering from delusions when he struck a nurse during an episode when he was not adherent to his medication.

11. On December 28, 2023, Benny was arrested and booked into the Wagoner County Detention Center (WCDC) on felony assault and battery on a medical provider.

12. A competent intake medical screening would reveal that Benny managed a serious mental health condition with physician prescribed medication.

13. At all times relevant to this Complaint, Benny was an incompetent person incapable of understanding the reason why is was being held in a pretrial detention facility.

14. Upon information and belief, Benny's unmanaged and untreated serious mental health condition would be obvious to anyone who encountered him.

15. Upon information and belief, Benny's unmanaged and untreated serious mental health condition was known to every person who encountered him at the WCDC.

16. WCSO staff failed to complete a receiving screening upon Benny's arrival at the jail on 12/28/23, failing to identify and ensure that his emergent and urgent health needs were met.

17. Upon Benny's arrival at the WCDC, his community-prescribed treatment plan was not continued.

18. WCSO staff failed to obtain Benny's community-prescribed plans of care for his schizophrenia and type 2 diabetes.

19. From 12/30/23 through 1/31/24, the WCSO nursing staff knew Benny had diabetes and that his blood glucose levels, on multiple readings, were dangerously elevated between 240-479 mg/dl. They observed he had physical symptoms, and he was unable to cooperate with the necessary care and treatment. The nursing staff failed to notify a physician or transfer Benny to a higher level of care.

20. From 12/30/23 through 1/31/24, the WCSO nursing staff knew Benny's blood pressure and heart rate were elevated, indicative of hypertension and tachycardia. The nursing staff failed to notify a physician or transfer Benny to a higher level of care.

21. Only after Nurse Longshore believed his symptoms may be "life-threatening" on 2/1/24, was Benny transferred to the local emergency department.

22. Benny was evaluated at the WCH emergency department. His significant past medical history was noted to include Factor 5 deficiency, Type 2 diabetes mellitus, schizophrenia, schizoaffective disorder, and suicidal thoughts. His previously prescribed medications included Perseris long-acting injectable every 4 weeks and Risperdal 2 mg by mouth daily. He was diagnosed with upper respiratory infection, leukocytosis sepsis, Type 2 diabetes, and tachycardia. He was treated with intravenous antibiotics and hydration; however, he refused to be admitted.

23. On 2/2/25, he was discharged to the care of the WCSO with orders to resume his home medications and was prescribed cefdinir 300 mg by mouth every twelve hours, and cephalexin 500 mg by mouth every 6 hours for 7 days.

24. On 2/2/24, Benny was seen at the jail by M. Ashton, LPN, who documented receipt of Benny's discharge plan, including prescribed medications.

25. LPN Ashton also documented that Benny's medications would be administered after arrival from the pharmacy; however, there is no record that they were administered as ordered.

26. M. Ashton, LPN, ordered that Benny did not need to be seen by the physician.

27. On 2/14/24, LPN M. Ashton completed a medical screening of Benny. The screening documentation indicates that Benny endorsed feeling suicidal or having a history of

multiple suicide attempts, had been hospitalized due to mental illness, and was prescribed and took psychotropic medications, the names and dosages of which are unknown.

28. Benny endorsed having a history of a blood clot in his leg and a urinary tract infection. He also endorsed not wanting to take his daily prescribed medication, including insulin.

29. LPN Ashton did not place Benny on suicide watch, per the protocol. LPN Ashton did not escalate Benny's need for care and treatment to a licensed mental health professional or physician.

30. No nursing or mental health monitoring or care was provided to Benny.

31. Between 3/22/24 and 5/26/24, Benny was evaluated only twice by S. Wilson, Medical Assistant, and R. Bebee, credentials unknown, and documented as having elevated blood pressure, heart rate, and blood glucose, and abnormal physical findings; however, a physician was not notified, nor was Benny transferred to a higher level of care for evaluation and treatment.

32. No nursing or mental health monitoring or care was provided to Benny between 5/26/24 and 8/29/24.

33. On 8/29/24, LPN M. Ashton documented that Benny was in his cell, unresponsive to verbal and pain stimuli. His blood glucose was 91 mg/dL, and his blood pressure was elevated at 160/82 mmHg.

34. Benny was transferred to the WCH Emergency Department and was diagnosed with lethargy. He was discharged to jail after Dr. James Wiley discussed the patient's case with Dr. Good, who agreed the patient could go back to jail. The discharge orders were that the patient needs continued routine care and then recheck if any problems developed. Stable to return to jail.

35. On 8/29/24 at 21:17, Benny was admitted to the Saint Francis Hospital for treatment of abdominal pain, Diabetes mellitus, and schizophrenia.

36. He was discharged on 8/31/24 with discharge orders that included: follow-up with the jail facility physician in 3-5 days, check blood glucose twice daily, seizure and fall precautions.

37. No nursing or mental health monitoring and care were provided to Benny after his return from the hospital on 8/31/24 until 9/21/24.

38. On 9/21/24, Benny was evaluated by LPN M. Ashton. During that encounter, his blood pressure and heart rate were elevated at 147/95 mmHg and 117 beats per minute, respectively.

39. LPN Ashton documented that his vital signs were within the normal range and that he did not appear to be in distress; however, she documented that he "appears to be shaking".

40. Again, she did not refer him to a physician or transfer him to a higher level of care.

41. No nursing or mental health monitoring or care was provided to Benny between 9/21/24 and 10/23/24.

42. On 10/23/24, LPN Ashton documented that Benny "appears to be shaking quite a bit and had difficulty standing up out of chair". His blood pressure and heart rate were elevated at 144/86 mmHg and 131 beats per minute, respectively. His blood glucose was also elevated at 164 mg/dL.

43. Again, LPN Ashton documented that his vital signs were within normal range, even though they were not.

44. A physician was not contacted, nor was Benny transferred to a higher level of care.

45. No nursing or mental health monitoring or care was provided to Benny between 10/23/24 and 10/29/24.

46. On 10/29/24, ten months after he arrived at the jail, Benny was referred for a mental health evaluation and treatment.

47. No nursing or mental health monitoring or care was provided to Benny between 10/29/24 and 11/21/24.

48. On 11/21/24, LPN Ashton evaluated Benny and documented his decompensation, specifically that he was very shaky while sitting and standing, appeared to need assistance from officers to stand, and had not eaten three meals in a row. His heart rate was elevated at 123 per minute.

49. Again, a physician was not called, nor was he transferred to a higher level of care.

50. No nursing or mental health monitoring or care was provided to Benny between 11/21/24 and 12/23/24.

51. On 12/23/25, Benny was observed smearing feces in his cell, and became combative with custody staff when they attempted to remove him from his cell.

52. Benny was placed in restraints.

53. R. Bebee, LPN, administered intramuscular Geodon 20 mg as ordered by Dr. Caldwell and documented that the patient was pending transfer for crisis stabilization.

54. There is no documented nursing follow-up to evaluate the effectiveness of the administered psychotropic medication.

55. Benny was admitted to CREOKS Behavioral Health Services facility on 12/23/24 and was discharged on 12/30/24.

56. On 12/30/24, Benny was booked into the WCDC.

57. R. Bebee, LPN, completed a medical screening.

58. Benny complained of body aches and shortness of breath.

59. No vital signs were obtained, and the nurse erroneously documented that Benny did not have diabetes and did not obtain a blood glucose reading.

60. Benny had languished at the WCDC for nearly a year without his medication or any mental health treatment.

61. During this time, Benny suffered the effects of untreated and unmedicated schizophrenia.

62. Untreated and unmedicated schizophrenia causes a worsening of symptoms, poorer functioning, higher relapse, and higher mortality. The longer psychosis goes untreated, the worse the outcomes.

63. Prolonged untreated psychosis also causes structural and cognitive changes and a worsening neuropsychological performance.

64. Upon information and belief, Benny suffered from one or more of these adverse outcomes or worsening conditions as a direct and proximate result of the prolonged separation from any mental health care at the WCDC.

65. No nursing or mental health monitoring or care was provided to Benny between 12/30/24 and 4/11/25.

66. Benny languished at the WCDC for nearly a year without his medication or any mental health treatment.

67. During this time, Benny suffered the effects of untreated and unmedicated schizophrenia.

68. Untreated and unmedicated schizophrenia causes a worsening of symptoms, poorer functioning, higher relapse, and higher mortality. The longer psychosis goes untreated, the worse the outcomes.

69. Prolonged untreated psychosis also causes structural and cognitive changes and a worsening neuropsychological performance.

70. Upon information and belief, Benny suffered from one or more of these adverse outcomes or worsening conditions as a direct and proximate result of the prolonged separation from any mental health care at the WCDC.

71. On 04/11/25, A. Watson, credentials not recorded, completed a lockdown assessment indicating that because Benny refused to go to the medical unit for evaluation, he was placed in isolation lockdown.

72. No nursing or mental health monitoring or care was provided to Benny between 4/11/25 and 6/7/25 in spite of multiple reports by the custody of his increasingly aggressive and self-harming behavior.

73. On 6/7/25, jail staff contacted Medical Assistant S. Wilson with concerns about Benny's skin color and the belief that he may be developing sepsis.

74. Benny became combative, and vital signs were not obtained.

75. Medical Assistant Wilson did not contact a physician nor transfer Benny to a higher level of care.

76. No nursing or mental health monitoring or care was provided to Benny between 6/7/25 and 6/11/25.

77. On 6/11/25, the court authorized involuntary medical intervention for Benny's emergent psychiatric condition and physical health deterioration.

78. On 6/11/25, Benny was admitted and discharged from the WCH Emergency Department back to the jail.

79. Benny was diagnosed with dementia with mild cognitive impairment, agitation, and hyperglycemia.

80. Discharge orders included: follow-up with his primary care physician within 1 to 3 days, continue his regular diet, and continue his regular medication.

81. No nursing or mental health monitoring or care was provided to Benny between 6/11/25 and 10/6/25.

82. During his detainment at the WCDC, Benny was never evaluated by a physician, and a care plan was never developed to treat his Type 2 diabetes, hypertension, and Factor 5 deficiency.

83. During his detainment at the WCDC, Benny was not routinely monitored by nursing staff for complications from his untreated Type 2 diabetes and hypertension.

84. During his detainment at the WCDC, Benny was never evaluated by a mental health professional or psychiatrist, and a care plan was never developed to treat his schizophrenia.

85. Benny was routinely restrained by custody staff without a physician being immediately notified, such that appropriate orders could be given.

86. WCDC medical and custody staff were aware of Benny's declining physical and mental condition and failed to notify a physician or transfer him to a higher level of care.

87. Hospital discharge plans and orders, including antibiotics to treat sepsis were not implemented and followed by WCDC nursing staff.

88. M. Ashton, LPN, E. Bebee, LPN, and S. Wilson, Medical Assistant, knew Benny was non-compliant with community-prescribed medications to treat his serious medical and mental health conditions and failed to refer him to a physician or transfer him to a higher level of care.

89. Benny was left at the WCDC in an unmedicated state and without treatment for a serious mental illness that was known to Elliott and the medical staff at the WCDC.

90. Upon information and belief, Benny developed numerous decubitus ulcers from his lack of voluntarily movement and because staff exhibited indifference to his serious medical needs.

91. Decubitus ulcers are preventable and result from prolonged disregard of a patient's welfare.

92. Upon information and belief, the development of decubitus ulcers was entirely preventable and a direct and proximate result of the inadequate care and treatment Benny received at the WCDC.

93. Upon information and belief, the decubitus ulcers continued to worsen and cause extreme and unnecessary pain.

94. The decubitus ulcers Benny developed caused him pain and unnecessary suffering.

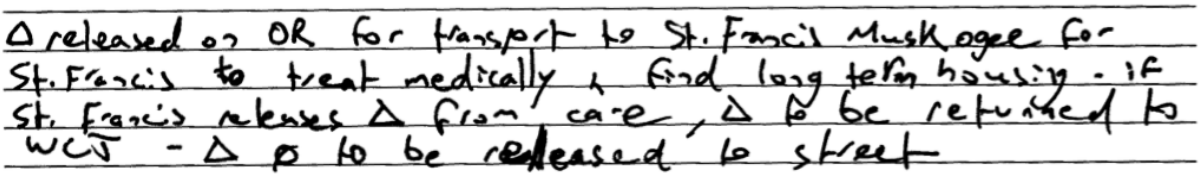
95. However, rather than transport Benny for the care he needed, the County subjected Benny to an official policy or unwritten practice adopted, enforced, ratified, and maintained with indifference to the pain and harm it inflicted upon him.

96. Specifically, the County's practice involved allowing Benny's condition to worsen so that it could justify contacting the district attorney's office to request Benny's release from custody on his "own recognizance" despite actual knowledge that Benny is legally incompetent.

97. Pursuant to this practice, the County relied on the district attorney to obtain an order from the court approving Benny's release on his " own recognizance," despite actual knowledge that Benny is legally incompetent.

98. Pursuant to this practice, and upon information and belief, the County did obtain an order on October 6, 2025 releasing Benny from custody on his "own recognizance."

99. The substance of that order is set forth below:



100. Plaintiff understands the order to read as follows: "[Benny] released on OR for transport to St. Francis Muskogee for St. Francis Muskogee to medically treat and find long term housing – if St. Francis releases [Benny] from care, [Benny] to be returned to WCJ – [Benny is not] to be released to street."

101. The County's practice involved having Benny released on his "own recognizance" to deny financial responsibility for the harm it caused.

102. Pursuant to this practice, Benny was subjected to the confusing and illogical duality of being a "free person" who can incur medical costs, while also not a "free person" who could leave the hospital on his "own recognizance".

103. On October 6, 2025, WCSO deputy Jay Tellez transported Benny to St. Francis-Muskogee.

104. Upon information and belief, either the substance of the October 6, 2025 was not adequately communicated to St. Francis-Muskogee, or it was adequately communicated but not adequately documented by St. Francis-Muskogee.

105. Regardless of whether the substance of the order was adequately communicated, the County owed a non-delegable duty to ensure Benny was not "released to the street."

106. Upon information and belief, the County expected Tellez to communicate the substance of the October 6, 2025 order to the hospital.

107. Upon information and belief, the County knew or should have known it could not expect the hospital to hold Benny once he was ready for discharge.

108. Upon information and belief, the County knew or should have known that Benny could be discharged without supervision if it did not station a deputy at the hospital.

109. Upon information and belief, the County did not station any deputy at St. Francis-Muskogee to ensure Benny was not "released to the street," and allowed Tellez to abandon Benny at the hospital despite knowledge of the order to ensure Benny was not "released to the street."

110. Upon information and belief, ODMHSA has a duty to attempt to restore the competency of people like Benny so they can obtain release from their confinement.

111. Upon information and belief, ODMHSA's duty is not discretionary, especially given the consequences of failure, e.g., forcing pretrial detainees who are presumed innocent to remain forcibly incarcerated.

112. Upon information and belief, ODMHSA breached its duty to attempt to restore Benny's competency.

113. ODMHSA's breach caused Benny to remain incarcerated at the WCDC unnecessarily and resulted in Benny suffering damages and injuries as a direct result of the breach.

B. BENNY IS TREATED AND DISCHARGED FROM ST. FRANCIS-MUSKOGEE

114. Plaintiff adopts and incorporates the preceding paragraphs as if fully set forth herein.

115. Upon information and belief, Tellez arrived at St. Francis-Muskogee with Benny on October 6, 2025.

116. Upon information and belief, Tellez remained with Benny until St. Francis-Muskogee admitted him at which time Tellez returned to duty.

117. Upon information and belief, case workers at St. Francis-Muskogee were in contact with administrative staff from the WCSO following Benny's admission.

118. Upon information and belief, one or more employees at St. Francis-Muskogee knew or should have known that Benny was subject to October 6, 2025 order from the Wagoner County District Court that prohibited Benny from being "released to the street."

119. Despite actual knowledge of the order, one or more employees of St. Francis failed to prevent Benny's "release[] to the street," or alternatively, failed to take reasonable measures to coordinate Benny's transfer back into the custody of the WCSO.

120. Before being "released to the streets," Benny received medical care at St. Francis-Muskogee for the worsening condition he developed over nearly two years of languishing at the WCDC.

121. Upon information and belief, once St. Francis-Muskogee completed its treatment of Benny, St. Francis-Muskogee staff released him to the streets.

122. Upon information and belief, no person at STFM contacted the WCSO to advise them of Benny's impending release.

123. Under no circumstances should Benny have been released to the streets given his condition.

C. BENNY IS ASSAULTED BY CITY POLICE

124. Plaintiff adopts and incorporates the preceding paragraphs as if fully set forth herein.

125. After being released to the streets, Benny was disorientated and still suffering from the effects of his serious mental health condition.

126. Upon information and belief, Benny began walking from Muskogee to Ft. Gibson on or about October 7, 2025.

127. Based on records from Muskogee, Benny stopped to sleep in a yard.

128. Based on records from Muskogee, Benny was observed "littering" near the intersection of Millis and Gibson.

129. Based on records from Muskogee, when officers approached Benny "he ignored multiple commands to stop and continued walking away."

130. Upon information and belief, Benny was not capable of understanding the officers or the reason why they were following him.

131. Upon information and belief Benny did not understand the officers due to his mental illness and because he was legally incompetent.

132. Upon information and belief, Benny was frightened of the officers.

133. Based on records from Muskogee, one officer attempted to "grab" Benny.

134. Based on records from Muskogee, Benny responded by "pull[ing] away" and "refused to comply."

135. Based on records from Muskogee, one or more officers had Benny "taken to the ground."

136. The phrase "taken to the ground" is an innocuous-sounding term commonly used throughout law enforcement in this area of Oklahoma to mask tactics that are that are excessive, unnecessary, and used for the purpose of causing the person to suffer pain or injury beyond what is necessary under the circumstances.

137. Upon information and belief, Benny suffered serious leg injuries as a direct and proximate result of the force used by the Muskogee officers.

138. Before transporting Benny to jail, responding EMS staff called STFM in regards to Benny after noticing a wristband from the hospital recently releasing him.

139. EMS staff spoke with the "Charge Nurse" who do not advise them of the order to send Benny back to the WCDC.

140. Upon information and belief, Benny was transported and booked into the Muskogee County Detention Center (MCDC) on municipal charges of littering, resisting, and disorderly conduct.

D. BENNY IS TAKEN TO THE MCDC

141. Plaintiff adopts and incorporates the preceding paragraphs as if fully set forth herein.

142. Upon information and belief, Benny was unable to walk at the time officers presented Benny for booking.

143. Upon information and belief, Benny was incoherent when presented for booking.

144. Upon information and belief, Benny was reporting substantial leg pain to booking staff when presented for booking at the MCDC.

145. Upon information and belief, Benny's serious and ongoing leg pain was known to booking officers at the MCDC.

146. Upon information and belief, Benny's serious and ongoing leg pain required the booking officers to exercise their gatekeeping authority to elevate Benny's care to an appropriate medical provider.

147. Upon information and belief, the booking officers either did not exercise their gatekeeping responsibility, or alternatively, they did refer Benny to a medical provider who failed to respond reasonably to Benny's serious medical needs.

148. Upon information and belief, the failure to respond reasonably to Benny's serious medical needs at the time of booking was motivated by the official policies or unwritten practices of Muskogee County.

149. Upon information and belief, Muskogee County has adopted, enforced, ratified and maintained a booking practice to disregard serious medical needs of arrestees by delaying care until the person is discharged.

150. Upon information and belief, application of this policy or practice results in the infliction of substantial pain on arrestees like Benny that is continuous and unnecessary.

151. Upon information and belief, Benny remained confined at the MCDC during his hearing on the municipal charges and required a wheelchair to appear by video.

152. Upon information and belief, a person unknown to Benny forged his signature on a document indicating that he was pleading guilty to the charges.

153. Benny was not competent to plead to any charges or understand the nature of the charges asserted against him.

154. Benny was held at the MCDC for "time served."

155. Upon information and belief, Benny never received any care or treatment for his mental health issues or his broken leg while confined at the MCDC.

156. Upon his release from the MCDC, Benny was transported back to St. Francis-Muskogee for injuries sustained when he was "taken to the ground" by the Muskogee police officers.

157. Once at St. Francis-Muskogee, medical staff appreciated that Benny required higher-level care.

158. Benny was then transported to St. Francis-Tulsa with a hip fracture.

III.

STATEMENT OF CLAIMS

159. Plaintiff adopts and incorporates the preceding paragraphs as if fully set forth herein, including all facts, information, and theories of recovery supported by the facts and reasonable inferences therefrom that Plaintiff identifies throughout discovery and respectfully requests the Court enter judgment against the Defendants on any theory of recovery supported by the facts and reasonable inferences set forth above including, without limitation, the following:

Claim 1
DELIBERATE INDIFFERENCE TO ADEQUATE MEDICAL CARE
42 U.S.C. § 1983
DEFENDANT ELLIOTT IN HIS OFFICIAL CAPACITY
SYSTEMIC DEFICIENCY

160. Plaintiff adopts and incorporates the preceding paragraphs as if fully set forth herein.

161. Benny suffered from multiple objectively serious medical conditions while at the WCDC, of which Elliott had actual knowledge, including, without limitation: incoherence, decubitus ulcers, and untreated schizophrenia. Despite this knowledge, Elliott failed or refused to implement an adequate staffing, facilities, equipment, or procedures to provide an adequate healthcare delivery system to respond to Benny's objectively serious medical conditions with deliberate indifference to the consequences for which the county is liable pursuant to 42 U.S.C. § 1983 and based on Elliott's status as a final policymaker in the realm of jail operations.

162. Upon information and belief, Elliott's actions or inactions were the moving force behind the injuries and damages suffered by Plaintiff for which the County is liable.

Claim 2
DELIBERATE INDIFFERENCE TO ADEQUATE MEDICAL CARE
42 U.S.C. § 1983
DEFENDANT ELLIOTT IN HIS OFFICIAL CAPACITY
FINAL POLICYMAKER LIABILITY

163. Plaintiff adopts and incorporates the preceding paragraphs as if fully set forth herein.

164. Sheriff Elliott knew of and disregarded Benny's objectively serious medical needs throughout Benny's detention at the WCDC, he was personally aware that no staff were stationed at STFM, and he knew his office could not rely on STFM to execute the order returning Benny to the custody of the WCSO, and despite that knowledge he evicted Benny from the WCDC with indifference to the consequences. He is also personally responsible for the policies and practices of the WCDC that served as the moving force behind the injuries and damages suffered by Benny for which the County is liable under 42 U.S.C. § 1983.

Claim 3
DELIBERATE INDIFFERENCE TO ADEQUATE MEDICAL CARE
42 U.S.C. § 1983
DEFENDANT ELLIOTT IN HIS OFFICIAL CAPACITY
DIRECT LIABILITY

165. Plaintiff adopts and incorporates the preceding paragraphs as if fully set forth herein.

166. The County adopted multiple affirmative policies or practices, including but not limited to: (a) the worsen-till-release practice; (b) the financial avoidance practice; and (c) the patient-dumping practice, the application of which served as the moving force behind injuries and damages suffered by Plaintiff for which the County is liable under 42 U.S.C. § 1983.

Claim 4
DELIBERATE INDIFFERENCE TO ADEQUATE MEDICAL CARE
42 U.S.C. § 1983
DEFENDANT ELLIOTT IN HIS OFFICIAL CAPACITY
INDIRECT LIABILITY

167. Plaintiff adopts and incorporates the preceding paragraphs as if fully set forth herein.

168. The County adopted multiple indirect policies or practices, including but not limited to: (a) inadequate training; (b) inadequate staffing; and (c) inadequate supervision, the application of which served as the moving force behind injuries and damages suffered by Plaintiff for which the County is liable under 42 U.S.C. § 1983.

Claim 5
NEGLIGENCE
COMMON LAW
DEFENDANT SAINT FRANCIS HOSPITAL MUSKOGEE, INC.
RESPONDEAT SUPERIOR

169. Plaintiff adopts and incorporates the preceding paragraphs as if fully set forth herein.

170. STFM owed Benny a duty of reasonable care in accepting him to the hospital under court orders not to release Benny to the streets, or alternatively, STFM assumed a duty by telling WCSO leadership that it would not discharge Benny without contacting WSCO first.

171. One or more agents or employees of STFM breached that duty by allowing Benny to be released to the streets, which serves as the direct and proximate cause of damages and injuries suffered by Benny for which Defendant STFM is liable.

IV.

RELIEF REQUESTED

172. Based on the foregoing, including additional facts, information, and claims developed though discovery, Plaintiff respectfully requests the Court enter judgment in its favor and against the Defendants, and award the following relief:

A. Compensatory damages against all Defendants;

B. Nominal damages against all Defendants;

C. Punitive damages against Defendant STFM;

D. Pre and post-judgment interest;

E. Reasonable costs and attorney's fees;

F. Any other relief to which Plaintiff may be entitled by law;

G. Any other relief the Court deems just and equitable.

Respectfully submitted,

BRYAN & TERRILL

By: s/*J. Spencer Bryan*

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