

**UNITED STATES DISTRICT COURT  
EASTERN DISTRICT OF OKLAHOMA**

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(1) TAMMY THOMAS, as Guardian  
of BENNY WATTS,

Plaintiff,

v.

Case No.: CIV-25-366-GLJ

(1) CHRIS ELLIOTT, in his official capacity as  
Sheriff of Wagoner County, Oklahoma,

**JURY TRIAL DEMANDED  
ATTORNEY LIEN CLAIMED**

(2) SAINT FRANCIS HOSPITAL MUSKOGEE, INC.,

(3) OKLAHOMA DEPARTMENT OF MENTAL  
HEALTH AND SUBSTANCE ABUSE SERVICES,

(4) CITY OF MUSKOGEE,

(5) WAGONER HOSPITAL AUTHORITY  
d/b/a WAGONER COMMUNITY HOSPITAL,

(6) ANDY SIMMONS, in his official capacity  
as Sheriff of Muskogee County, Oklahoma,

Defendants.

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**SECOND AMENDED COMPLAINT**

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Tammy Thomas, as Guardian of Benny Watts, for this cause of action against the above-named Defendants, states as follows:

**I.**

**PARTIES, JURISDICTION, VENUE**

1. Tammy Thomas is the biological daughter and court appointed guardian 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 Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) is a state agency of the State of Oklahoma charged by statute with providing competency evaluation and restoration services to pretrial detainees declared incompetent to stand trial. Under Oklahoma law, when a court determines that a defendant is incompetent to stand trial and capable of restoration, ODMHSAS is obligated to provide court-ordered restoration services within a reasonable time. ODMHSAS is subject to suit under the Oklahoma Governmental Tort Claims Act (OGTCA), 51 O.S. § 151 et seq., for acts and omissions of its employees and agents acting within the scope of their employment.

5. The City of Muskogee is a municipal corporation and political subdivision of the State of Oklahoma, subject to liability under the Oklahoma Governmental Tort Claims Act, 51 O.S. § 151 et seq., for acts and omissions of its employees acting within the scope of their

employment. The City is also subject to suit under 42 U.S.C. § 1983. At all times relevant herein, the City's police officers were acting under color of state law and within the scope of their employment.

6. Wagoner Hospital Authority d/b/a Wagoner Community Hospital (WCH) is a public trust organized and existing under the laws of the State of Oklahoma and is a governmental entity subject to liability under the OGTCAs, 51 O.S. § 151 et seq., for acts and omissions of its employees and agents acting within the scope of their employment. Upon information and belief, WCH employed or contracted with persons who provided emergency care to Benny Watts on February 2, 2024, August 29, 2024, and June 11, 2025.

7. Andy Simmons (Simmons) is the elected Sheriff of Muskogee County, Oklahoma. Under Oklahoma law, Simmons is a final policymaker over the operations of the Muskogee County Detention Center (MCDC), including without limitation the staffing, policies, practices, training, and supervision of MCDC personnel with respect to the receipt, booking, and medical care of pretrial detainees. Simmons is sued in his official capacity for acts performed while Sheriff of Muskogee County. Because his position is that of a final policymaker, Simmons's acts and omissions, and those of his deputies, constitute the acts and omissions of Muskogee County under 42 U.S.C. § 1983. At all times relevant herein, Simmons was acting under color of state law.

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

9. 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 state law claims against Elliott, STFM, WCH, ODMHSAS, and the City of Muskogee, with all OGTCAs notices served on November 11, 2025 and denied by operation of law.

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

## II.

### STATEMENT OF FACTS

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

#### A. BENNY IS CONFINED AT THE WCDC

12. Benny was diagnosed with schizophrenia in 2001.

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

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

15. 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.

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

17. 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.

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

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

20. 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.

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

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

23. 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.

24. 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.

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

26. 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.

27. 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.

28. 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.

29. 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.

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

31. 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.

32. 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.

33. 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.

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

35. 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.

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

37. 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.

38. 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.

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

40. 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.

41. 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.

42. 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.

43. 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".

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

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

46. 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.

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

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

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

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

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

52. 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.

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

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

55. 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.

56. Benny was placed in restraints.

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

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

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

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

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

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

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

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

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

66. 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.

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

68. 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.

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

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

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

72. 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.

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

74. 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.

75. 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.

76. 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.

77. 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.

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

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

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

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

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

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

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

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

86. 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.

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

88. 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.

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

90. 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.

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

92. 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.

93. 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.

94. 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.

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

96. 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.

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

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

99. 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.

100. 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.

101. 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.

102. 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."

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

Δ released on OR for transport to St. Francis Muskogee for  
St. Francis to treat medically & find long term housing - if  
St. Francis releases Δ from care, Δ to be returned to  
WCJ - Δ is to be released to street

104. 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."

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

106. 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".

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

108. 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.

109. 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.”

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

111. 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.

112. 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.

113. 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.”

114. 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.

115. 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.

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

117. 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**

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

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

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

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

122. 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."

123. 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.

124. 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.

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

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

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

**C. BENNY IS ASSAULTED BY CITY POLICE**

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

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

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

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

132. Based on records from Muskogee, Benny was observed “littering” near the intersection of Millis and Gibson.

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

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

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

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

137. Based on records from Muskogee, one officer attempted to “grab” Benny.

138. Based on records from Muskogee, Benny responded by “pull[ing] away” and “refused to comply.”

139. Based on records from Muskogee, one or more officers had Benny “taken to the ground.”

140. 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.

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

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

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

144. 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**

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

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

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

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

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

150. 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.

151. 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.

152. 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.

153. 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.

154. 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.

155. 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.

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

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

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

159. 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.

160. 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.

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

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

### **III.**

#### **STATEMENT OF CLAIMS**

163. 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**

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

165. 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.

166. 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**

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

168. 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**

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

170. 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**

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

172. 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**

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

174. 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 WCSO first.

175. 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.

**Claim 6**

**NEGLIGENCE – NEGLIGENT PERFORMANCE OF A POLICE FUNCTION / EXCESSIVE FORCE  
OKLAHOMA GOVERNMENTAL TORT CLAIMS ACT, 51 O.S. § 151 ET SEQ.  
DEFENDANT CITY OF MUSKOGEE**

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

177. The City of Muskogee is liable under the Oklahoma Governmental Tort Claims Act, 51 O.S. § 151 et seq., for the negligent performance of a police function by its officers, who used objectively unreasonable force against Benny — an unarmed, legally incompetent person exhibiting obvious signs of serious, untreated mental illness who posed no threat — causing him serious physical injury including a hip fracture. The City’s officers were acting within the scope of their employment at all times relevant herein.

**Claim 7**

**EXCESSIVE FORCE / FAILURE TO TRAIN  
42 U.S.C. § 1983 – FOURTH AND FOURTEENTH AMENDMENTS  
DEFENDANT CITY OF MUSKOGEE – MONELL LIABILITY / FAILURE TO TRAIN**

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

179. One or more City of Muskogee police officers, acting under color of state law, subjected Benny to objectively unreasonable force in violation of the Fourth Amendment as incorporated through the Fourteenth Amendment. The officers knew or should have known that Benny was mentally ill, legally incompetent, and incapable of processing commands; no crime was in progress; Benny was unarmed; and his failure to comply with commands was a product of

his serious mental illness, not willful resistance. The force used — taking him to the ground and causing a hip fracture — was constitutionally unreasonable under clearly established law. *See Allen v. Muskogee*, 119 F.3d 837, 840–41 (10th Cir. 1997); *Estate of Ceballos v. Husk*, 919 F.3d 1204, 1214–15 (10th Cir. 2019).

180. The City of Muskogee is liable under 42 U.S.C. § 1983 on a failure-to-train theory. Encounters with mentally ill or emotionally disturbed persons who pose no criminal threat constitute a usual and recurring situation that City officers must confront. The City’s policymakers knew to a moral certainty that officers would encounter such situations and that the absence of adequate training in crisis intervention and de-escalation would plainly result in constitutional violations. The City’s deliberate indifference to this need for training was the moving force behind the constitutional violation suffered by Benny. *See City of Canton v. Harris*, 489 U.S. 378 (1989); *Lance v. Morris*, 985 F.3d 787, 800 (10th Cir. 2021).

### **Claim 8**

#### **NEGLIGENCE – NEGLIGENT MEDICAL CARE / HOSPITAL DISCHARGE**

#### **OKLAHOMA GOVERNMENTAL TORT CLAIMS ACT, 51 O.S. § 151 ET SEQ.**

#### **DEFENDANT WAGONER HOSPITAL AUTHORITY D/B/A WAGONER COMMUNITY HOSPITAL**

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

182. WCH owed Benny a duty of reasonable care, including the duty to provide emergency treatment consistent with the applicable standard of care, to formulate discharge plans that adequately addressed the known risks of returning a legally incompetent patient with serious, complex, and untreated medical and psychiatric conditions to a custodial setting that had demonstrably failed to implement prior discharge orders, and to take reasonable measures to ensure that its discharge plans and orders would actually be implemented.

183. WCH breached the standard of care by: (a) on February 2, 2024, discharging Benny back to the WCDC following a diagnosis of leukocytosis sepsis, uncontrolled Type 2 diabetes, and tachycardia, without ensuring his prescribed antipsychotic medications would be administered and without a discharge plan adequate for a legally incompetent patient with untreated schizophrenia and serious comorbidities; (b) on August 29, 2024, discharging Benny back to the WCDC with orders requiring physician follow-up within three to five days and twice-daily glucose monitoring, without reasonable measures to ensure those orders would be implemented; and (c) on June 11, 2025, discharging Benny back to the WCDC with orders requiring physician follow-up within one to three days following a court-authorized emergency intervention, without reasonable measures to ensure implementation. These breaches were a direct and proximate cause of the progressive worsening of Benny's conditions and the damages he suffered, for which WCH is liable under the OGTC.

### **Claim 9**

#### **NEGLIGENCE – BREACH OF STATUTORY AND COMMON LAW DUTY TO PROVIDE COMPETENCY RESTORATION SERVICES**

#### **OKLAHOMA GOVERNMENTAL TORT CLAIMS ACT, 51 O.S. § 151 ET SEQ.**

#### **DEFENDANT OKLAHOMA DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES**

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

185. ODMHSAS's duty to provide timely competency restoration services was confirmed and given federal constitutional dimension in *Briggs v. Friesen*, No. 4:23-cv-00081 (N.D. Okla.), in which the parties, including the State of Oklahoma, acknowledged that ODMHSAS's chronic delays in providing court-ordered restoration services violated the Due Process Clause of the Fourteenth Amendment. The court entered final approval of a consent decree on March 10, 2025, imposing a binding 21-day deadline for restoration treatment and establishing

compliance monitoring and contempt fines for violations. Post-judgment enforcement proceedings remain ongoing.

186. ODMHSAS breached its statutory and common law duty by failing to timely provide competency restoration services to Benny, causing him to remain confined at the WCDC for an unreasonable period without the treatment necessary to restore his competency. This breach directly and proximately caused Benny's unnecessary continued incarceration and his exposure to the deprivations and failures of care described herein, for which ODMHSAS is liable under the OGTC, 51 O.S. § 151 et seq.

**Claim 10**

**DELIBERATE INDIFFERENCE TO SERIOUS MEDICAL NEEDS**

**42 U.S.C. § 1983 – FOURTEENTH AMENDMENT**

**DEFENDANT ANDY SIMMONS IN HIS OFFICIAL CAPACITY AS SHERIFF OF MUSKOGEE COUNTY  
FINAL POLICYMAKER / SYSTEMIC DEFICIENCY / AFFIRMATIVE POLICY**

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

188. Upon information and belief, the failure to respond reasonably to Benny's objectively serious medical needs at the MCDC was the product of an official policy or unofficial but well-settled custom of delaying or deferring care for arrestees presenting with serious medical needs at booking until discharge, thereby shifting financial responsibility to others. This policy or custom reflects deliberate indifference to the constitutional rights of pretrial detainees and was the moving force behind the injuries and damages suffered by Benny during his confinement at the MCDC, for which Defendant Simmons and Muskogee County are liable under 42 U.S.C. § 1983.

**Claim 11**

**NEGLIGENCE – NEGLIGENT PERFORMANCE OF A LAW ENFORCEMENT FUNCTION  
OKLAHOMA GOVERNMENTAL TORT CLAIMS ACT, 51 O.S. § 151 ET SEQ.  
DEFENDANT ELLIOTT IN HIS OFFICIAL CAPACITY  
PLEADING IN THE ALTERNATIVE TO CLAIM 5**

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

190. Elliott, in his official capacity as Sheriff of Wagoner County, is liable under the Oklahoma Governmental Tort Claims Act, 51 O.S. § 151 et seq., for the acts and omissions of his deputies acting within the scope of their employment. Deputy Tellez, acting within the scope of his employment with the WCSO, owed Benny a duty of reasonable care in connection with his transport and delivery to St. Francis-Muskogee pursuant to the October 6, 2025 court order directing that Benny receive medical treatment and not be “released to the street.”

191. Pleading in the alternative to Claim 5, Deputy Tellez breached that duty by failing to adequately communicate to St. Francis-Muskogee the substance and binding effect of the October 6, 2025 court order specifically, that Benny was not to be released to the street and was to be returned to WCSO custody upon discharge, and by abandoning Benny at the hospital after his admission without stationing a deputy to ensure compliance with the order. Alternatively, if the substance of the order was adequately communicated to St. Francis-Muskogee, WCSO’s failure to station a deputy or otherwise take reasonable measures to ensure Benny was not “released to the street” independently constitutes a breach of the duty of reasonable care owed to Benny.

192. Tellez’s negligence in failing to adequately communicate the court order and in abandoning Benny at the hospital was a direct and proximate cause of Benny’s release to the street, his subsequent encounter with Muskogee police officers, and the serious physical injuries,

including a hip fracture, and other damages Benny suffered as a result, for which Defendant Elliott and Wagoner County are liable under the OGTC.

**IV.**

**RELIEF REQUESTED**

193. Based on the foregoing, including additional facts, information, and claims developed through 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

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