Andrew G. Deiss (7184)
Corey D. Riley (16935)
Deiss Law PC
10 West 100 South, Suite 700
Salt Lake City, Utah 84101
(801) 433-0226
deiss@deisslaw.com
criley@deisslaw.com

Attorneys for Plaintiff

IN THE THIRD JUDICIAL DISTRICT COURT
SALT LAKE COUNTY, STATE OF UTAH

AMY BAKER, individually and for and on behalf of LELAND CROPPER, deceased, Plaintiff, v. SALT LAKE COUNTY, ROSIE RIVERA, TODD WILCOX, VIRGINIA TERRY, ERIN BANDLEY, NELLIE JOHNSON, JESSICA QUEZADA, ANGELA RIVERA, MARIA MONTOYA, RACHEL HOLM, MATSON NORMAN, Defendants.	**COMPLAINT** (Tier 3) Jury Demanded Case No. Judge:

Plaintiff, by and through undersigned counsel, alleges as follows:

Introduction

This action arises from the untimely death of Leland Cropper while in custody of the Salt Lake County Metro Jail. Prior to his death, the jail kept him locked in a cell even as he suffered excruciating and obvious pain for days. He was severely and visibly underweight and was bleeding internally. Guards and medical staff watched him in this clear medical distress. Leland died after suffering for five days in their custody. In addition to violating Leland's constitutional rights, Salt Lake County's misfeasance and nonfeasance constituted health care malpractice.

Jurisdiction, Venue, and Parties

1. This Court has jurisdiction to hear this matter under Utah Code § 78A-5-102.

2. Venue is proper under Utah Code § 78B-3-307 because the conduct giving rise to this lawsuit occurred in Salt Lake County, Utah.

3. Plaintiff, Amy Baker, is the surviving spouse of Leland Cropper (Leland). Ms. Baker is the personal representative of the Estate of Leland Cropper, and she is the mother of Cropper's four surviving children. She is a resident of Utah.

4. Defendant Salt Lake County (including the Salt Lake County Sheriff and the Salt Lake Department of Health) is and was at all relevant times a governmental entity as defined by Utah Code § 63G-7-102(4) with its principal place of business in Salt Lake County, State of Utah, where it resides.

5. Defendant Salt Lake County employs physicians, nurse practitioners, nurses, and other medical professionals (health care providers) who provide medical care and treatment to inmates in the Salt Lake County jail system.

6. Defendant Rosie Rivera was at all relevant times the Salt Lake County Sherriff and an employee and/or agent of Salt Lake County.

7. During all relevant times, Defendant Todd Wilcox was employed in and by Salt Lake County as a physician, including Medical Director of the Salt Lake County Jail System.

8. During all relevant times, Defendant Virginia Terry was employed in and by Salt Lake County as a Jail Nurse.

9. During all relevant times, Defendant Erin Bandley was employed in and by Salt Lake County as a Jail Nurse.

10. During all relevant times, Defendant Jessica Quezada was employed in and by Salt Lake County as a Jail Nurse.

11. During all relevant times, Defendant Nellie Johnson was employed in and by Salt Lake County as a Jail Nurse.

12. During all relevant times, Defendant Angela Rivera was employed in and by Salt Lake County as a Caseworker.

13. During all relevant times, Defendant Rachel Holm was employed in and by Salt Lake County as a Jail Nurse.

14. During all relevant times, Defendant Maria Montoya was employed in and by Salt Lake County as MAT Program Manager.

15. Defendant Matson Norman was at all relevant times deputy of the Salt Lake County Sheriff and an employee and/or agent of Salt Lake County.

16. At all times relevant, Defendants were acting under color of law, including the statutes, ordinances, regulations, polices, customs, practices, and usages of, and under the authority of, Defendant Salt Lake County, and the individual offices of Defendants, as officers, agents, contractors, and/or employees of Defendant Salt Lake County.

17. Jurisdiction for violations of the Utah Constitution is founded upon supplemental jurisdiction because the claims of violations of federal law are substantial and the supplemental claims derive from a common nucleus of operative facts and are so related to the federal claims that they form part of the same case or controversy under article 3 of the United States Constitution.

18. Plaintiff has complied with the requirements of Utah Code § 63G-7-402 *et seq.*

19. Plaintiff has filed an undertaking in the amount of $300 as required by Utah Code § 63G-7-601.

20. Plaintiff represents that she will post a bond in an amount determined by the Court as required by Utah Code § 78B-3-104.

General Allegations

1. Leland was booked at the Salt Lake County Metro Jail (ADC) on March 3, 2022.

2. Deputies assigned Leland to C-Pod.

3. Leland was locked in his cell alone and he was not allowed to talk with others in C-Pod.

4. On March 3, Defendant Virginia Terry, RN, conducted a comprehensive nurse examination of Leland in which she recorded his weight at 128 lbs, height at 6-2 (ft-in), Body Mass Index at 16.4.

5. Nurse Terry noted Leland's low body mass index and scheduled a follow up for April 1.

6. Beginning on March 3, Defendant Todd Wilcox, MD, prescribed Leland Promethazine with the instructions: "25MG PO PRN X 3 DAYS THEN 25MG PO BID PRN X 3 DAYS AS NEEDED."

7. Dr. Wilcox also prescribed Leland Loperamide 2mg: "TAKE 1 CAPSULE(S) ORALLY TWICE DAILY AS NEEDED.

8. On March 4, ADC medical staff received Leland's final lab reports for blood taken during the comprehensive nurse examination. The report indicated that Leland had abnormal Neutrophils (75.3), Lymphocytes (16.8), and Glucose (180).

9. On March 4, Defendant Nellie Johnson, RN, observed Leland in his cell. Nurse Johnson did not check Leland's weight or request additional treatment.

10. On March 4, Defendant Maria Montoya reviewed Leland's intake information and determined that Leland did not meet the criteria for Medication Assisted Treatment. Ms. Montoya did not request additional treatment.

11. On March 5, Defendant Angela Rivera observed Leland in his cell. Ms. Rivera did not request additional treatment.

12. On March 5, Defendant Jessica Quezada, RN, observed Leland in his cell. Nurse Quezada did not check Leland's weight or request additional treatment.

13. On March 6, Nurse Johnson observed Leland in his cell. Nurse Johnson did not check Leland's weight or request additional treatment.

14. On March 7, at around 9 am, Defendant Erin Bandey, RN, gave Leland a Boost supplement drink and checked Leland's weight. Nurse Bandey recorded Leland's weight at 112.6 lbs. Nurse Bandey did not request additional treatment.

15. On March 7, at around 1:30 pm, Nurse Johnson observed Leland in his cell. She did not check Leland's weight or request additional treatment.

16. Leland reported severe nausea, pain, and dehydration from his arrival at ADC on March 3 until his death on March 8.

17. In addition to weight loss, Leland's symptoms included, without limitation: vomiting blood and severe abdominal pain.

18. Leland's lower right lung showed acute bronchiolitis, likely due to aspiration from vomiting.

19. Leland was physically unable, without great difficulty and pain, to leave his cell because of his rapidly deteriorating, life-threatening medical condition, which required close medical observation, evaluation, checking of vital signs, and diagnosis and treatment, or referral for diagnosis and treatment, none of which was provided by Defendants.

20. Defendants failed and refused to monitor, evaluate, examine or treat Leland and refused to provide or arrange for a competent medical professional to monitor, evaluate, diagnose, examine, provide medical care for Leland.

21. Over the night of March 7, Deputy Matson Norman observed Leland lying on the ground in his cell. Leland was severely underweight, and he was vomiting blood.

22. Deputy Norman asked Leland why he was on the ground; and Leland replied that he was vomiting in the toilet.

23. Deputy Norman did not request medical assistance.

24. A few hours later, Deputy Norman observed Leland lying on the ground again.

25. Deputies Norman and Dakota Turner knocked on Leland's cell door to elicit a response from Leland.

26. Deputies Turner and Norman opened the door and observed Leland on the ground, partially underneath his bunk, with his pants pulled around his ankles.

27. Deputies Turner and Norman dragged Leland out from under the bunk to see if Leland was responsive.

28. At this time, Deputy Norman declared Leland non-responsive.

29. Nurse Megan Butler arrived at the cell and asked Deputy Turner to retrieve a gurney.

30. Nurse Butler also delivered NARCAN with no response.

31. Deputy Turner left Leland's cell to get the gurney from the medical exam room.

32. When Deputy Turner returned to the cell, he and other deputies dragged Leland out of the cell and into the day area to make more room.

33. With Leland out of the cell, Deputy Turner restrained him on the gurney with straps.

34. At this time, Nurse Butler took Leland's vitals and reported there was no pulse.

35. Deputies removed the restraints to allow Nurses Robert and Butler to begin chest compressions and placed an AED device on Leland's body.

36. The AED device indicated a shock was needed; after the shock was delivered, nurse staff and deputies continued chest compressions.

37. Leland vomited as the nurse staff and deputies conducted CPR.

38. Nurse staff and deputies continued making chest compressions and following directions from the AED device until South Salt Lake City EMS arrived.

39. After several minutes of attempting life saving measures, EMS declared Leland's death.

40. Leland's death would have been prevented if Defendants had called for qualified medical assistance or if the ADC medical staff had even provided basic diagnostic evaluation procedures.

41. Had Leland received proper diagnostic attention, it would have been readily apparent that he required urgent medical care.

42. Because of Defendants' failures to respond to Leland's obvious life-threatening medical condition, according to the Office of the Medical Examiner (OME), he died from the effects of upper gastrointestinal hemorrhage due to peptic ulcer disease.

43. On March 9, the OME conducted an examination of Leland's body. The OME observed evidence of gastric ulcers the stomach, dehydration, focal acute bronchiolitis due to vomiting, and that Leland was underweight.

44. The OME reported Leland showed sunken cheeks and eyes and temporal fossae.

45. The OME diagnosed Leland with hepatic centrilobular congestion, multiple gastric ulcers, history of dark-colored hematemesis prior to his

death, bloody stomach contents, dehydration, focal acute bronchiolitis, and underweight.

First Claim for Relief
Deprivation of Rights under Article 1, Sections 7 and 9 of the Utah Constitution

46. Defendants acts and omissions as set forth above deprived Leland of his constitutional rights guaranteed by Article 1, Sections 7 and 9 of the Utah Constitution, which provides that imprisoned persons shall not be subjected or treated with unnecessary rigor.

47. Defendants violations of Leland's rights secured by Article 1, Sections 7 and 9 of the Utah Constitution caused Leland to suffer substantial damages, including but not limited to the denial of Leland's constitutional rights, deprivation of personal liberty, loss of property, severe mental anguish, substantial physical pain, loss of income, and pain and suffering.

48. Defendants subjected Leland to unnecessary rigor by failing to reasonably assess, monitor, diagnose and treat Leland.

49. Defendants were on notice of Leland's serious medical condition from the moment first arrived at the ADC.

50. Defendants failed to provide adequate or timely medical care to Leland.

51. There was no reasonable justification for Defendants' failure to provide medical care.

52. Defendants foresaw, or should have foreseen, the possibility of inmates suffering from severe medical conditions while in the custody of ADC. However, Salt Lake County, Sheriff Rivera, Dr. Wilcox, and John/Jane Doe failed to provide adequate policies, procedures, or training to their employees or contractors to reasonably provide for the safety and health of inmates, including Leland, with such conditions. In this, Salt Lake County, Sheriff Rivera, Dr. Wilcox, and John/Jane Doe were deliberately indifferent to the health and safety of Leland, which deliberate indifference caused his death.

53. Defendants' lack of medical attention to Leland during his incarceration constitutions the unnecessary rigor of a detainee and violates Utah's constitution.

Second Claim for Relief
Negligence

54. Defendants owed a duty to exercise reasonable care provided by physicians and health care providers.

55. At all relevant times, Salt Lake County, Sheriff Rivera, and John/Jane Doe, were engaged in policy making to supervise and control all policies, practices, rules, guidelines, customs and regulations regarding treatment of inmates in ADC.

56. At all relevant times Salt Lake County, Sheriff Rivera, and John/Jane Doe had duties to hire, train, supervise, control, instruct, and discipline ADC employees with regard to, among other things, issues regarding medical treatment of inmates in ADC.

57. Salt Lake County, Sheriff Rivera, and John/Jane Doe had a duty to provide training that was necessary to ensure that ADC employees would recognize the signs of medical emergencies including but not limited to upper gastrointestinal hemorrhage; assess the degree of risk associated with symptoms of such emergencies; respond to reports of such emergencies in a timely and appropriate manner; know when a response or the lack thereof amounted to negligence under the common law or violated the Utah Constitution; understand the rights, remedies, requirements and obligations under these provisions of law; and understand the risks and consequences associated with violating these provisions of law.

58. Salt Lake County, Sheriff Rivera, and John/Jane Doe had a duty to supervise, control and instruct employees to ensure that they were not acting with deliberate indifference to the medical needs of inmates at ADC.

59. ADC employees assigned to care for Leland were negligently hired, trained, supervised, or disciplined.

60. Salt Lake County's negligence in hiring, training, supervision, or discipline of ADC deputies and medical staff who would come into contact with inmates in ADC's custody or otherwise posed imminent direct threat to them was the direct, proximate cause of the death of Leland and the injuries sustained by Plaintiff.

61. In the course of its treatment of Leland, Salt Lake County health care providers were employees, agents, apparent agents, and/or ostensible agents of Defendants Salt Lake County, and all of the acts or omissions of Salt Lake County health care providers complained of herein occurred during the course and scope of the employment or agency relationship and are imputed by law to Defendant Salt Lake County.

62. Salt Lake County employees and agents owed duties to Leland to exercise that degree of care, skill, caution, diligence, and foresight exercised by

and expected of a health care provider in the same specialty under the same or similar circumstances.

63. With respect to the care and treatment of Leland, Defendant Salt Lake County's employees and agents deviated from that standard of care and were negligent in the treatment of Leland by, including, without limitation, the following:

    a. Failing to reasonably assess, monitor, diagnose and treat Leland;

    b. Failing to properly develop, implement, monitor, and enforce proper policies and procedures for the protection of inmates such as Leland;

    c. Failing obtain a physician's referral;

    d. Failing to timely order appropriate interventions to Leland's weight loss;

    e. Failing to timely order appropriate interventions to control Leland's gastrointestinal hemorrhage;

    f. Failing to educate nurses regarding the severity of Leland's condition;

g. Failing to educate deputies regarding the severity of Leland's condition;

h. Failing to educate nurses regarding potential complications from treatment of Leland's medical conditions;

i. Failing to provide support to Leland;

j. Failing to follow policies and procedures;

k. Failing to provide adequate direction and timely communicate orders and direction nursing staff and deputies; and

l. Failing to provide reasonable care.

64. Defendant Salt Lake County health care providers' negligence as described herein was a cause of Plaintiff's injuries, damages, and losses.

65. Defendant Salt Lake County health care providers' negligence and breach of the standard of care was the proximate cause of the general and special injuries and damages sustained by Leland and Plaintiff.

66. As a direct and proximate result of Defendant Salt Lake County health care providers' negligence in the treatment of Leland, Plaintiff and Leland suffered significant damages, injuries, and losses.

67. As a further direct and proximate result of Defendant Salt Lake County health care providers' negligence in the treatment of Leland, Plaintiff has incurred incident and consequential damages in amounts to be proven at trial.

Third Claim for Relief
Survival Act as to Constitutional and Common Law Claims

68. Defendants' wrongful conduct and omissions, as stated above, were in violation of Leland's rights and directly and proximately caused his injury, pain, suffering, and untimely death.

69. Prior to his death, Leland was a loving father and was a source of joy, happiness, service, love, affection, guidance, and counsel to Plaintiff and their children. The heirs' losses proximately caused by Defendants' wrongful conduct and omissions entitle Plaintiff to receive in her personal capacity and on behalf of the heirs these and other damages recognized at law, for which Defendants are liable to Plaintiff as personal representative of Leland's Estate, for the benefit of Leland's heirs in an amount to be proven at trial.

Fourth Claim for Relief
Wrongful Death Act as to Constitutional and Common Law Claims

70. Pursuant to Utah's Wrongful Death Act, Plaintiff is entitled to recover all damages that may be just under the circumstances for Defendants' wrongful conduct and omissions that caused Leland's death. Defendants conduct and omissions described above constitute "wrongful acts" and "neglect" within the meaning of Utah Code § 78B-3-106.

71. Pursuant to the Wrongful Death Act, Plaintiff seeks all damages recoverable under the Act, including but not limited to pecuniary losses resulting from the loss of financial support Leland could have been expected to provide his next of kin, and the value of lost services (e.g. care, education, training, and personal advice) had he lived.

Prayer for Relief

WHEREFORE, Plaintiff prays for relief on her claims for relief against Defendants as follows:

Plaintiff demands judgment against Defendants, jointly and severally, as follows:

1. For general and non-economic damages, including but not limited to pain and suffering, emotional trauma, in an amount to be established at trial;

2. For special and economic damages, with applicable statutory interest including but not limited to loss of financial support;

3. For the loss of filial consortium cause to Plaintiff and Leland's heirs as they have been deprived of love, care, society, affection, counsel, advice, comfort, companionship, service, protection, solicitude, and the loss of financial support, in an amount to be established at trial;

4. For special and general damages for experiencing pain, grief, sorrow, anguish, stress, emotional and mental suffering, loss of quality of life, the amount of which will be established at trial;

5. For pre-judgment interest on all special damages;

6. For an award of punitive damages against all Defendants, except Salt Lake County, in an amount to be established at trial;

7. For an award of reasonable attorneys' fees and costs pursuant to Utah Code § 78B-3-104(3); and

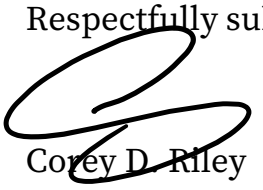
8. For such and other relief as the Court deems proper.

Demand for Jury

Plaintiff hereby demands a trial by jury on all her claims.

DATED March 1, 2024

Respectfully submitted,



Corey D. Riley
Deiss Law PC
10 West 100 South
Suite 700
Salt Lake City, Utah 84101
criley@deisslaw.com