IN THE UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF ARKANSAS
WESTERN DIVISION

DARLA DUNCAN, as guardian of
JOHNATHAN DUNCAN, DARREN NORMAN
KRISTIAN SMITH on behalf
Of themselves and all others similarly situated PLAINTIFFS

VS. CASE NO: 4:11cv325

CHARLES SMITH, STEVE DOMAN,
JAMES SCOGGINS, EACH INDIVIDUALLY AND
IN HIS OFFICIAL CAPACITY AS POLICYMAKERS,
Of the ARKANSAS STATE HOSPITAL;
JOHN SELIG, INDIVIDUALLY AND IN HIS OFFICIAL CAPACITY
AS DIRECTOR OF THE DEPARTMENT OF
HUMAN SERVICES, JAMES GREEN, IN HIS OFFICIAL
AND INDIVIDUAL CAPACITY, VERONICA WILLIAMS,
IN HER OFFICIAL AND INDIVIDUAL CAPACITY, and
ANN TUCKER IN HER OFFICIAL AND INDIVIDUAL CAPACITY,

DEFENDANTS

SECOND AMENDED COMPLAINT – CLASS ACTION

COMES Plaintiffs, by and through counsel, Harrill & Sutter, PLLC, and for their Second Amended Complaint, state:

PARTIES AND JURISIDICTION

1. Plaintiff Darla Duncan is the duly acting and appointed Guardian of her son, JOHNATHAN DUNCAN, who is also associated with a person with disability. Her son has been at ASH since November of 2010. Darren Norman is a person with a mental disability who was committed to the forensic unit, but who was released. Kristian Smith is a person with a mental disability who was a patient, but who was released because he was charged with raping another resident at ASH. Mr. Smith is currently incarcerated in the Pulaski County Jail on misdeameanor charges and is dire need of mental heath services the jail cannot provide. The Defendant Steve Doman and Veronica Williams each is a UAMS physician, duly licensed by the Arkansas State Medical Board, who is covered by a policy of insurance. James Scoggins is the Director of Nursing, a UAMS employee, covered by a policy of

insurance. Charles Smith, is the duly acting and appointed Administrator for the Arkansas State Hospital, a Division of the Arkansas Department of Human Services, until the end of the month. John Selig is the Director of the Department of Human Services. James Green is the Director of DDS. Ann Tucker is a nurse working at ASH that subjected young Duncan to abuse and who is sued only for her personal action actions. This is an action brought for medical negligence, negligence, and deprivation of young Duncan's and Norman's rights granted to them by the United States Constitution, and the Arkansas Civil Rights Act of 1993, as permitted by 42. U.S.C. §1983 and the Arkansas Civil Rights Act of 1993. Since this case involves a federal question, this Court has subject matter jurisdiction under 28 U.S.C. §1331, as well as personal jurisdiction over the parties. Since the events giving rise to this action arose within this Court's district, venue is proper under 28 U.S.C. §1391(b). All actions were taken under color of law. All natural persons are sued in their individual and official capacities. All named Plaintiffs have been patients at ASH within the past year, and the events described herein relate to those admissions.

PATTERN AND PRACTICE ALLEGATIONS

2. Defendants have a long history of creating a culture of abuse, as reflected in the report entitled Dirty Laundry. Residents have died, been verbally and physically abused, and inappropriately checically restrained for over a decade on a continuous basis. As an example, as well as to demonstrate a failure to train, policy, or custom, Brenda Shelton was a citizen of the State of Arkansas, who suffered from a severe mental illness that substantially limited her ability to think and concentrate.

3. Brenda Shelton admitted herself under Dr. Parker's care to the Arkansas State Hospital on or about October 20, 2008, where she was housed in Unit B, and immediately placed on suicide watch.

4. However, acting under the instructions of Dr. Parker, Ms. Shelton was inappropriately taken off suicide prevention.

5. Three (3) days later, Ms. Shelton attempted to hang herself in her room.

6. Before Ms. Shelton attempted to hang herself, the Arkansas State Hospital had recently moved to a new part of the facility.

7. Before the move, resuscitation supplies such as AMBU bags had been kept in the

common area.

8. However, after the move, the AMBU Bag, allegedly, under policy, was required to be kept in a locked medication room.

9. On October 25, 2008, the nurse responsible for the med room, accidentally locked the key card in the med room which prevented the other Arkansas State Hospital staff, including the Defendant nurses and physicians, from having access to the rebreather bag during the emergency.

10. There appears to have been promulgated a policy that allowed nurses to withhold rescue breathing in the absence of a protective device, as well as a policy of understafffing.

11. Alternatively, there was a failure to train these nurses, which resulted in Brenda Shelton's death.

12. When Ms. Shelton was found lying unconscious, she was still capable of being resuscitated.

13. However, because of Mr. Smith's, Ms. Hunter's, and Dr. Kittrell's failure to train, and failure to implement appropriate policies, the other Defendant nurses failed to give Ms. Shelton rescue breathing.

14. Arkansas State Hospital personnel had previously requested that protective devices be made readily available, but Arkansas State Hospital Administration made the deliberate policy choice not to offer protective barriers to its nursing staff.

15. It was reasonably foreseeable that persons like Ms. Shelton would suffer injury in the absence of a protective barrier.

16. Nonetheless, the three (3) nurses on duty and present at the time Ms. Shelton lay unconscious, refused to administer rebreathing. In fact, one nurse was instructed not to administer rebreathing, even though patients are routinely tested for infectious diseases upon admission to the hospital. Ms. Shelton's chart did not indicate she had any infectious diseases at the time of her admission.

19. By virtue of the surveys CMS has performed, admitted into the record at the injunction hearing and incorporated by reference herein, and frequent complaints from the DRC, Defendants failed

to take appropriate action. Defendants had notice of these injuries, yet did nothing that resulted in a positive solution until 5/27/11. In fact, the abuse and neglect was so frequent and pervasive, that Smith, Selig, Doman, and Scroggins tacitly approved these abuses, as indicated by their failure to act and train. This resulted in Smith and his direct supervisor being asked to resign because he decision expose Plainitiffs and the Class to this culture of abuse is based on substantive and procedural criteria that are substantially below the standards generally accepted in the mental health community.

20. This culture has continued, and this Court now has the ability to intervene before Mr. Duncan or Mr. Kristian Smith dies. As a proximate cause of ASH's staff abuse, Mr. Norman was admitted to UAMS. All of the named Plaintiffs are mentally ill and are likely to need mental health services form DHS and ASH. The practices identified above affect the operation of the entire hospital.

21. As an example, Defendants transferred experienced staff to 3l, the unit where Duncan is currently staying, resulting in inexpereinced staff being placed on other units and another immediate jeopardy in June of 2011.

JOHNATHAN DUNCAN

22. Young Duncan is unable to leave the Arkansas State Hospital voluntarily without losing his DDS waiver. Regardless of what the treatment plan stated, the treatment team, head by Veronica Williams, refused to allow him to visit his parent in the face of the parent's pleas.

23. In March of 2011, the treatment team recommended an inappropriate placement for young Duncan. The program at ASH did not envision treatment of the developmentall disabled, but only the acutely mentally ill. This resulted in young Duncan being inappropriately placed in an environment more restrictive than his needs indicated after a long delay. The delay in his placement included interference with his relationship with his parents, caused them mental and emotional distress, physical injury constituting a battery and excessive force, and inappropriate chemical restraint.

24. In February of 2011, young Duncan grabbed a sweater from behind a nurse's station, then threw it back. As a result, Ann Tucker taunted him and administered a sedative, not for a medical purpose, but simply to chemically restrain him. This was excessive force.

25. As another example, ASH, including Dr. Williams, fabricated a report of misconduct to punish the Duncans by denying him a pass. All Defendants knew that such was inappropriate and represented a substantial departure from generally accepted standards of the profession. In fact, all Defendants except Tucker knew that the Duncans had been denied a pass, yet did nothing until after this Court announced that there may be a substantial liklihood of success on the merits.

24. After the injunction hearing, an appropriate treatment plan was implement that is designed to place young Duncan in the community, but ASH's actions has resulted in a delay, as well as further mental damage to him and his parents. Duncan and his parents have no meaningful access to community services if they check him out of ASH at this time. Should they choose to check their son out of ASH, there will be no DDS waiver because their son will be bumped to the bottom of an impossibly long list.

DARREN NORMAN

25. Mr. Norman was committed to ASH. He is substantially limited in his ability to think and concentrate.

26. Norman has been denied timely services and has endured abuse. Mr. Norman is substantially limited in his ability to think and concentrate.

27. While in ASH, staff used excessive force and verbally and physically abused Mr. Norman, resulting in an inappropriate placement and severe mental, emotional, and physical abuse.

KRISTIAN SMITH

28. Mr. Smith was a patient at ASH. He is substantially limited in his ability to think and concentrate. He is now in the Pulaski County jail because the waiting list to be admitted into ASH is so long, there is a delay of months, as was the case in 4:01-cv-00458-BRW Terry, et al v. Hill, incorporated by reference herein.

29. ASH has been the subject of litigation regarding these abuses before in a litgation filed by the ACLU and Darin Winter. The ACLU litigation resulted in a consent decree, and the Winter litigation was notice to ASH of the problems inherent in warehousing prisoners like Kristian Smith in jails.

30. Jails are always inappropriate placements for the mentally ill, yet Defendants continue to all the mentally ill to languish in jails.

31. In fact, Defendants have a long practice of intentionally charging mental patients like Smith with felony offenses, not because there is probable cause, but simply to change their placement from ASH to a jail. This is an improper purpose, sufficient to state a claim for abuse of process. The practice is so frequent some jails have refused to book persons from ASH into their jail, as a matter of policy. This happened to Mr. Smith in December of 2010, when Mr. Smith, while incompetent, was charged with rape.

32. The Pulaski County jail released him, then Mr. Smith was arrested on trespassing charges because he simply did not understand the consequences of his actions. Now, he will be placed into the forensic process and experience the long wait experienced by hundreds of persons with mental disabilties before him. Thus, Plaintiff has been subjected to an abuse of process, malicious prosection, and has been illegally arrested.

COUNT I

33. Each Plaintiff re-alleges the foregoing as is fully set out herein.

34. Young Duncan, Mr. Smith, and Mr. Norman each is a person with a disability, as that term is defined by Title II of the Americans with Disabilities Act of 1990, and Section 504 of the Rehabilitation Act of 1973. Each Plaintiff is substantially limited in his ability to think and concentrate.

35. There has existed a culture of abuse at the Arkansas State Hospital for several years, as detailed in Dirty Laundry Report and the surveys filed herein, such that Plaintiffs and the Class have been denied meaningful access to mental health services. Mr. Duncan, Mr. Norman, Mr. Smith and other residents are in immediate jeopardy, but Defendants refuse to submit an appropriate plan of correction, as well as place the Class in an environment appropriate to their needs.

36. The Arkansas State Hospital, DDS, and The Arkansas Department of Human Services are recipients of federal financial aid.

37. The Defendants willfully, and intentionally failed to place Plaintiffs in an environment

appropriate to his needs, as required by the ADA, the Rehabilitation Act, and 28 C.F.R. §35.130. DDS's waiver program is dysfunctional, and this failure has lead to the warehousing of young people like Duncan. Mr. Norman's admission, after being committed to ASH, was unnecessarily delayed for an inappropriate amount of time on account of the violation. Mr. Smith has been denied the benefits of the programs at ASH and is now inappropriately placed at the Pulaski County jail and looking forward to a long wait without appropriate mental health care.

38. As a direct and proximate cause of Defendants' violation of the ADA and the Rehabilitation Act, Young Duncan has been physically and mentally abused with taunts, he has been punished by placing him in a seclusion room with excessive force, and he has been, and may be, in immediate jeopardy of death or other serious health injury. Mr. Norman has also been subjected to abuse, and he has been in UAMS as a result.. Mr. Smith also has been physically and mentally abused with taunts and abuse, and he has been punished by placing him in jail

COUNT II

25. Plaintiff re-alleges the foregoing as is fully set out herein.

26. Mr. Duncan. Mr. Smith, and Mr. Norman each has a constitutionally protected property right in each's life, as well as the right to the pursuit of happiness, and family. Plaintiffs have four federal constitutional claims: "(1) the right to protection from harm while in ASH care from abuse, illegal seizure, and excessive force; (2) the right to conditions and duration of care consistent with their needs; (3) the right not to be deprived of entitlements created by Arkansas law without due process; and (4) the right to associate with their biological family members. The right to family integrity is derived both from the First Amendment's broad right of association and the Fourteenth Amendment's general substantive due process protections. These rights are clearly established. *See Roberts v. United States Jaycees,* 468 U.S. 609, 617-20, 104 S.Ct. 3244, 3249-50, 82 L.Ed.2d 462 (1984); *Santosky v. Kramer*, 455 U.S. 745, 753, 102 S.Ct. 1388, 1394, 71 L.Ed.2d 599 (1982); *Quilloin v. Walcott*, 434 U.S. 246, 255, 98 S.Ct. 549, 554, 54 L.Ed.2d 511 (1978); *Moore v. City of East Cleveland*, 431 U.S. 494, 97 S.Ct. 1932, 52 L.Ed.2d 531 (1977). The Ninth Amendment also has been cited as a source of a right to privacy. *See Stanley v.*

Illinois, 405 U.S. 645, 651, 92 S.Ct. 1208, 1212, 31 L.Ed.2d 551 (1972) (citing *Griswold v. Connecticut,* 381 U.S. 479, 496, 85 S.Ct. 1678, 1688, 14 L.Ed.2d 510 (1965) (Goldberg, J., concurring)). However, under the circumstances alleged herein, each Plaintiff was denied these rights without due process, was subjected to cruel punishment, and Defendants were deliberately indifferent to an obvious and serious medical needs. This action is brought under substantive and due process theories. Duncan and Norman have been subjected to excessive force, and Mr. Smith was also charged without probable cause, all in violation of the 4th Amendment.

27. In addition to the above, all Defendants except Tucker are sued in their individual and official capacities for their failure(s) to train, for their ratification of co-Defendants' actions, for the deliberate policy decision not to provide staff with appropriate training, and for denying Mr. Duncan equal protection under the law. In fact, Mr. Duncan and Mr. Norman each has been chemically restrained or abused. Mr. Smith, Mr. Duncan and Mr. Norman have been physically, verbally, and emotionally abused by untrained staff, resulting in serious physical and emotional injury.

28. As a direct and proximate cause of the acts and omissions of Defendants as alleged herein, Mr. Duncan and Norman has suffered unnecessarily, incurred medical expenses that otherwise would not have been incurred, suffered severe mental and emotional distress. The Class has also been denied access to counsel.

29. All of Defendants' actions were taken under color of Arkansas State Law and were deliberately indifferent. As a direct and proximate cause of Defendants' acts and omissions alleged herein, each Plaintiff sues for all available relief under the law, pain and suffering, medical bills incurred because of the actions that occurred herein, for an injunction to require the Defendants to provide mentally ill or disabled patients with care in the least restrictive environment appropriate to their needs, for declaratory judgment that the Defendants violated the ADA and the Rehabilitation Act, and for all other proper relief.

30. Defendants' actions have been so egregious so as to warrant the imposition of punitive damages against them in their individual capacities.

CLASS ALLEGATIONS

31. Each Plaintiff is an individual with a disability, as that term is defined by the Americans With Disabilities Act, Section 504 and state law.

32. This action is a Class Action brought on behalf of all individuals with disabilities who require mental health services from the Arkansas State Hospital, now and in the future.

33. At this time, each Plaintiff is unsure of the number of members of the Class, but, upon information and belief, alleges that the members of the Class are too numerous to be joined individually and a Class is a superior method of adjudicating the claims herein.

34. One of the common issues of fact is whether there exists a culture of abuse at the ASH, aided and abetted by DHS and DDS, such that persons with disabilities are unnecessarily institutionalized and abused to the extent the ADA and Section 504 is violated.

35. Each Plaintiff's claims are typical of the Class, since each Plaintiff's claims arise from his status as a person with a disability. Further, the Defendants have an ongoing responsibility to evaluate new programs, projects, services, policies, and practices and re-evaluate any changes in services, policies, and practices in order to assure equal access to Plaintiffs and other class members. But they have failed. Plaintiffs specifically allege that defendants fail to:

(1) appropriately accept reports of abuse and neglect for investigation;

(2) investigate those reports in the time and manner required by law;

(3) provide mandated preplacement preventive services to enable the Class to remain at home whenever possible;

(4) provide the least restrictive, most family-like placement to meet the Class' individual needs;

(5) provide services to ensure that the Class does not deteriorate physically, psychologically, educationally, or otherwise while in DHS or DDS custody;

(6) provide the Class with appropriate placements;

(7) provide appropriate case management or plans that enable the Class to return home or be discharged to permanent placements as quickly as possible;

(8) provide services to assist the Class who are in jail to receive mental health care;

(9) provide the Class adequate services to prepare them to live independently once they leave the system;

(10) provide the administrative, judicial, or dispositional reviews to which the Class are entitled;

(11) provide caseworkers with training, support, or supervision; and

(12) maintain adequate systems to monitor, track, and plan for the Class.

36 The Defendants have failed to ensure that interested persons can obtain information as to the existence and location of accessible services, activities, and facilities as required by 28 C.F.R. § 35.163(a).

37. Therefore, as alleged herein, the common fact is whether the Defendants have failed to operate their services programs so that the service, program, or activity, when viewed in its entirety, is readily accessible to and usable by individuals with disabilities such as Plaintiffs and violated the Class' constitutional rights. This failure has lead to the damages and relief sought herein.

WHEREFORE, each Plaintiff sues for all available relief under the law, pain and suffering, medical bills incurred because of the actions that occurred herein, for an injunction to require the Defendants to provide mentally ill or disabled patients with care in the least restrictive environment appropriate to their needs, for an Order requiring Defendants to submit an appropriate plan of correction or declaratory judgment that the Defendants have violated the ADA and the Rehabilitation Act, for a trial by jury, for an Order enjoining the long practice of intentionally charging mental patients like Smith with felony offenses for improper purposes, for an Order requiring ASH to accept forensic patients in a timely manner to a proper environment, for an Order certifying the Class under Rule 23(b(2) and (b(3) for reasonable attorney's fees and costs, and for all other proper relief.

Respectfully submitted,

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/s/ Luther Oneal Sutter
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CERTIFICATE OF SERVICE

I hereby certify that a true copy of the foregoing has been served on this, the 26th day of June, 2011, upon counsel for the Defendant via ECF:

Gary L. Sullivan
Assistant Attorney General
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Little Rock, AR 72201

/s/ Luther Oneal Sutter
Luther Oneal Sutter